United States Department of Labor
Employees' Compensation Appeals Board

JOHN M. TAGLIATELA, Appellant	)	
and	)	**Docket No. 05-1236**
	)	**Issued: January 5, 2006**
U.S. POSTAL SERVICE, POST OFFICE, East Hartford, CT, Employer	)	

Appearances:
Ron Watson, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 16, 2005 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated May 2, 2005 which denied modification of an earlier schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit schedule award decision in this case.

ISSUE

The issue is whether appellant has more than a 15 percent impairment of his left upper extremity.

FACTUAL HISTORY

On December 6, 2000 appellant, then a 53-year-old letter carrier, filed an occupational disease claim for ulnar neuritis which he alleged was due to factors of his federal employment. On May 28, 2002 the Office accepted his claim for the condition of left ulnar neuropathy. This was subsequently expanded to include the conditions of left cubital tunnel syndrome and left carpal tunnel syndrome.

On November 1, 2002 appellant filed a claim for a schedule award for impairment to his left upper extremity. In a September 10, 2003 decision, the Office issued a schedule award for a seven percent impairment of the left upper extremity. In a November 12, 2003 letter, appellant disagreed with the September 10, 2003 decision and requested reconsideration. Following a merit review of the claim, on March 31, 2004, the Office modified its prior decision to find a 15 percent impairment of the left upper extremity.

In a November 10, 2004 letter, appellant disagreed with the March 31, 2004 decision and requested reconsideration. He argued that he was entitled to a greater schedule award as the amended schedule award of March 31, 2004 was based solely on sensory deficit and did not account for his motor deficit. In support of his argument, appellant noted that section 16.5b at page 481 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, allowed for an impairment rating when both sensory and motor functions were involved.[1]

In a nonmerit decision dated January 28, 2005, the Office denied appellant's request for reconsideration.

In a letter dated March 10, 2005, appellant requested reconsideration of the Office's January 28, 2005 decision and submitted medical evidence. In a March 9, 2005 report, Dr. Robert Tross, a Board-certified plastic surgeon, with a specialty in hand surgery, noted that the Office medical adviser, Dr. George Cohen, had rated only the sensory components of the median and ulnar nerves but made no determination of the motor impairments which were clearly evident and enumerated in his previous report. Dr. Tross stated that appellant was reevaluated of his impairment determination on February 8, 2005, provided his physical findings and referenced his application of the tables in the A.M.A., *Guides.* His impairment rating of the left upper extremity consisted of 8 percent shoulder impairment; 13 percent impairment for ulnar nerve dysfunction which comprised of an 11 percent motor and 2 percent sensory impairment; and 9 percent impairment of the median nerve which comprised of 6 percent sensory and 3 percent motor impairment. Dr. Tross combined the values for shoulder loss, ulnar nerve loss and median nerve loss and arrived at 27 percent total left upper extremity impairment. He noted that, despite appellant's significant losses in grip and pinch strength, those losses, under the A.M.A., *Guides*, were presumed to be included in the motor impairment for the respective nerves involved and no additional impairment could be afforded.

In a report dated April 26, 2005, Dr. David I. Krohn, an Office medical adviser, reviewed Dr. Tross's March 9, 2005 report and rated impairment from his findings and the tables of the A.M.A., *Guides.* He found 6 percent sensory impairment due to cubital tunnel syndrome and 10 percent sensory impairment for mild left carpal tunnel syndrome and combined those impairments to arrive at 15 percent impairment of the left upper extremity. The Office medical adviser noted that Dr. Tross had assigned impairment for motor strength loss of both the ulnar and median nerves and commented on grip and pinch strength loss, but advised that page 508 of the A.M.A., *Guides* noted "decreased strength *cannot* be rated in the presence of … painful conditions.…" The Office medical adviser opined that no assignment for impairment for

[1] The A.M.A., *Guides* (5th ed. 2001).

strength loss could be included in the schedule award. With respect to the left shoulder, the Office medical adviser noted that the medical record did not contain a well-rationalized statement providing a causal relationship between impairment of the left shoulder to factors of appellant's employment and, therefore, Dr. Tross should have included the twisting in the determination of the schedule award. The Office medical adviser further noted that the date of maximum medical improvement was October 8, 2002, by Dr. Tross's statement to that effect, by his letter of that date.

By decision dated May 2, 2005, the Office denied modification of its prior schedule award. The Office found that the weight of the medical evidence rested with Dr. Krohn, the Office medical adviser, who appropriately applied the A.M.A., *Guides* to his left arm condition. The Office noted that, although Dr. Tross had also used the A.M.A., *Guides* in his determination he had included the left shoulder as part of the evaluation and the claim had not been accepted for a left shoulder condition.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulation, schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[3]

The standards for evaluating the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[4] Chapter 16 of the fifth edition of the A.M.A., *Guides* provides a detailed grading scheme and procedure for determining impairments of the upper extremities due to pain, discomfort, loss of sensation or loss of strength.[5]

The Office procedures note that after obtaining all necessary medical evidence the file should be reviewed by an Office medical adviser for an opinion concerning the nature and percentage of any impairment.[6]

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[2] 5 U.S.C. § 8107.

[3] *See Joseph Lawrence, Jr.*, 53 ECAB 331 (2002); *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[4] *See Paul A. Toms*, 28 ECAB 403 (1987).

[5] A.M.A. *Guides*, Chapter 16, The Upper Extremities, pages 433-521 (5th ed. 2001).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, Evaluation of Schedule Awards, Chapter 2.808.6(d) (August 2002).

ANALYSIS

It is appellant's burden to submit sufficient evidence to establish entitlement to a schedule award.[7] With respect to his left shoulder condition, the Office excluded the impairment rating from the schedule award as his claim had not been accepted for any left shoulder injury. However, it is well established that, in determining entitlement to a schedule award, preexisting impairment to the schedule member is to be included.[8] As the Office was determining the amount of impairment to appellant's left upper extremity, it erred in not including evidence of his left shoulder impairment in its schedule award determination.

In determining the amount of the schedule award, the Office accorded determinative weight to the opinion of its Office medical adviser, who rated appellant's left upper extremity impairment for sensory impairment due to cubital tunnel syndrome and mild left carpal tunnel syndrome. The Office medical adviser opined that no impairment could be assigned for motor strength loss of the ulnar and median nerves and specifically excluded those impairment determinations in the calculation of the schedule award.

Section 16.5 of the fifth edition of the A.M.A., *Guides* describes the method to be used for evaluation and calculation of impairments of the upper extremity based on loss of strength and sensory deficit or pain. The method for deriving impairments of the upper extremities due to peripheral nerve disorder is located in section 16.5, page 480 of the A.M.A., *Guides*, which state at page 482, that upper extremity impairments due to sensory deficits or pain resulting from peripheral nerve disorders are determined according to the grade of severity in diminution of loss of function and the relative maximum upper extremity impairment value of the nerve structure involved, as shown in the classification (a) and procedural (b) steps described in Table 16-10 and the impairment determination method detailed in section 16.5b. Table 16-10 provides a classification for determining impairment of the upper extremity due to a sensory deficit or pain resulting from a nerve disorder. At page 484 of the A.M.A., *Guides* it is stated, upper extremity impairments due to motor deficits and loss of power resulting from peripheral nerve disorders are determined according to the grade of severity of loss of function and the relative maximum upper extremity impairment value of the nerve structure involved, as shown in the classification (a) and procedural (b) steps described in Table 16-11 and the impairment determination method detailed in section 16.5b. The examiner must use clinical judgment to estimate the appropriate percentage of motor deficits and loss of power within the range of values shown for each severity grade.

As section 16.5 of the A.M.A., *Guides* allows for the calculation of an upper extremity impairment due to both sensory and motor deficits resulting from peripheral nerve disorders. There are several methods under the A.M.A., *Guides* by which impairment may be rated. In such instances the Board has used that the report of the examining physician should take precedence.

[7] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[8] *Michael C. Milner*, 53 ECAB 446 (2002); *Lela M. Shaw*, 51 ECAB 372 (2000).

Accordingly, this case will be remanded to the Office for a recalculation of appellant's left upper extremity impairment based on Dr. Tross's clinical findings pertaining to both sensory and motor deficits resulting from the ulnar and median nerves. The Office should also consider all preexisting impairments that may be present. After such further development as the Office deems necessary, it should issue a *de novo* decision with regard to appellant's left upper extremity impairment for schedule award purposes.

CONCLUSION

The Board finds that this case is not in posture for a decision. The case will be remanded for further development.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 2, 2005 is set aside and the case is remanded for further action consistent with this opinion.

Issued: January 5, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board