United States Department of Labor
Employees' Compensation Appeals Board

CONNIE J. JAMISON, Appellant	)	
and	)	**Docket No. 05-1705**
	)	**Issued: January 12, 2006**
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Richlands, VA, Employer	)	

Appearances:
Connie J. Jamison, pro se
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 August 11, 2005 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated August 4, 2005 which granted an additional schedule award of 17 percent impairment to her left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision in this case.

ISSUE

The issue is whether appellant has more than a 25 percent impairment of her left upper extremity for which she received a schedule award.

FACTUAL HISTORY

On November 10, 1999 appellant, then a 42-year-old coal mine inspector, filed a traumatic injury claim alleging that she struck her head while walking in a mine shaft. She stopped work the same day. The Office accepted the claim for the conditions of cervical and lumbar strains, a cervical herniated disc at C6-7 and an anterior cervical discectomy at C6-7, for

which appellant underwent surgery on January 13, 2000. On May 20, 2001 she was reemployed as a physical science technician. In a September 12, 2001 decision, the Office found that appellant's actual earnings as a physical science technician represented her wage-earning capacity and paid wage-loss compensation benefits commencing May 20, 2001.

On March 6, 2001 appellant filed a claim for a schedule award. By decision dated January 22, 2002, the Office granted a schedule award or 24.96 weeks of compensation for an 8 percent impairment of her left upper extremity for the period December 30, 2001 to June 22, 2002.[1] The case was remanded for further development of the medical evidence in the Office hearing representative's decisions dated December 18, 2002 and June 18, 2004. In the June 18, 2004 decision, the Office hearing representative noted that the medical evidence received from Dr. Samuel Breeding, a Board-certified family practitioner, found impairment to her C6, C7 and C8 dermatomes. He stated that, under Tables 15-16 and 15-17 page 424 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] appellant had a Grade 4 sensory and motor deficits at C6, C7 and C8 and sustained a 29 percent impairment to the left upper extremity. The Office hearing representative found a conflict in medical evidence with Dr. Daniel D. Zimmerman, an Office medical adviser, who noted no objective evidence to support the impairment ratings of her physicians, Dr. Clifford H. Carlson, a Board-certified orthopedic surgeon, and Dr. Matthew W. Wood, a Board-certified neurologist. The Office hearing representative determined that a conflict existed with regard to the percentage of impairment and remanded the case to the Office for a referral of appellant to an impartial medical examiner. The Office hearing representative directed that the results of her nerve conduction studies be made available for the impartial medical examination.

The Office referred appellant, together with a statement of accepted facts and the case file, to Dr. Richard R. Eckert, a Board-certified orthopedic surgeon, for an impartial medical examination. He was provided with guidelines on how to analyze radicular symptoms and signs affecting the upper extremities under the fifth edition of the A.M.A., *Guides*.

In a report dated August 27, 2004, Dr. Eckert noted the history of injury and presented his examination findings. Utilizing Tables 15-15 and 15-16 on page 424 of the A.M.A., *Guides*, he assigned the following sensory and motor deficits: For the C6 nerve, he noted that appellant's hand had no loss of sensibility, abnormal sensation or pain and assigned a 0 percent sensory deficit; as she had biceps weakness and biceps atrophy on the left side, a 20 percent motor deficit was assigned. For the C7 nerve, he stated that the area of innervation responsible for her pain as well as the diminished sensation in her long finger was equivalent to a Grade 3 sensory deficit

[1] In a February 8, 2002 letter, the Office noted that, although appellant's physician had initially rated the date of maximum medical improvement on November 17, 2001, the date was administratively changed to December 30, 2001 to place her "on the first schedule award period for 2002." The Office stated that as the medical evidence showed that appellant reached maximum medical improvement on January 13, 2001, that date would reflect the new date of maximum medical improvement. The Board notes, however, that Dr. Matthew W. Wood, appellant's Board-certified neurosurgeon, opined in a January 24, 2001 report that she reached maximum medical improvement from her cervical injury. The January 13, 2001 date appears to be an administrative change to appellant's actual date of maximum medical improvement so that her compensation benefits would not be interrupted. The Board notes that the Office paid appellant's schedule award for the period January 13, 2001 to February 27, 2002.

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

and accorded a 50 percent sensory loss. Using the triceps weakness as a measure of C7's motor deficit, Dr. Eckert assigned a 25 percent motor deficit. For the C8 nerve, he stated that appellant dropped objects due to ulnar sided weakness and assigned a 50 percent sensory loss and a 25 percent motor loss. Dr. Eckert then utilized Tables 15-17 on page 424 to obtain the maximum impairment for loss due to sensory deficit and loss of function to strength and multiplied those percentages by appellant's sensory and motor deficits. For the C6 nerve, he multiplied eight percent by zero percent sensory loss to find a zero percent sensory impairment. Dr. Eckert multiplied 35 percent by 20 percent motor loss to find a 7 percent motor impairment. For the C7 nerve, he noted that half of the maximum sensory loss of 5 percent equaled a 2.5 percent sensory impairment. Dr. Eckert multiplied the 35 percent maximum motor impairment by 25 percent motor loss to find a 8.75 percent motor impairment. For the C8 nerve, he multiplied the 5 percent maximum sensory deficit by 50 percent sensory deficit to find a 2.5 percent sensory deficit. Dr. Eckert also multiplied the 45 percent maximum loss of strength by the 25 percent motor loss to find a 11.25 percent motor impairment. He then used the Combined Values Chart to combine each of the sensory and motor values for the listed nerve root levels to find a C6 contribution to upper extremity impairment of 7 percent, a C7 contribution of 11 percent and a C8 contribution of 14 percent. Those values were then converted to a whole person impairment and combined using the Combined Values Chart. That calculation resulted in a four percent C6 whole person contribution, a seven percent C6 whole person contribution and an eight percent C8 whole person contribution. Utilizing the Combined Values Chart, Dr. Eckert found that appellant had a 21 percent whole person impairment.

Dr. Eckert opined that the date of maximum medical improvement should be two years post operation as appellant's symptoms had continued to improve.[3] He also provided an impairment rating under a diagnosis-related estimate as opposed to a range of motion method. Under Table 15-5 of the A.M.A., *Guides*, Dr. Eckert stated that, as appellant had a C2-3 congenital fusion and has had surgery at the C6-7 level with fusion, she belonged in a diagnosis-related estimate cervical Category IV, which indicated a 25 to 28 percent impairment of the whole person and opined that appellant had a 25 percent whole person impairment due to her injuries.

In a September 14, 2004 letter, the Office requested that Dr. Eckert provide an impairment percentage in terms of the upper extremity based on both the diagnosis-related estimate method and the range of motion method. In an addendum received October 19, 2004, he opined that appellant had a 28 percent upper extremity impairment based on the diagnosis related estimate method. This was derived by using the Combined Values Chart of the A.M.A., *Guides* with the upper extremity impairment of each nerve deficit. Combing C8 nerve deficit of 14 percent and the C7 nerve deficit of 11 percent, a 23 percent impairment was obtained which was then combined with C6 nerve deficit of 7 percent to obtain the 28 percent total upper extremity impairment.

In using the range of motion method, Dr. Eckert found that appellant had a 37 percent impairment of the cervical spine. Under Table 15-2, a 45 degree flexion equaled 7 degrees of

[3] The Board notes that appellant's operation occurred on January 13, 2000. Two years post operation would be January 13, 2002, which Dr. Eckert opined was the more appropriate date of maximum medical improvement.

cervical motion which equated to 1 percent whole person impairment. An extension of 25 degrees equaled 35 degrees cervical motion which equated to a 3 percent impairment for the whole person. Under Table 15-13, lateral bending of 10 degrees to the left indicates a loss of 35 degrees of cervical motion which equals 3 percent whole person impairment. Lateral bending of 20 degrees to the right equals 1 percent whole person impairment. Under Table 15-14, a 60 degree rotation equals 1 percent whole person impairment. The impairments for flexion and extension were then added to obtain 4 percent impairment, the impairments for lateral bending were added to obtain 4 percent impairment and the impairments for right and left turning were added to obtain 2 percent impairment of the whole person. The Combined Values Chart was then utilized to combine the percentages to yield 10 percent whole person impairment. Utilizing Chapter 15.13 of the A.M.A., *Guides,* Dr. Eckert converted the 10 percent whole person impairment to a regional estimate by dividing 0.80 for the cervical spine to obtain 12.5 percent impairment. He then took the 28 percent combined whole person impairment for the C6, C7 and C8 nerve involvement for sensory and motor deficits and, utilizing Table 15.20 and combined that with the 12.5 percent regional estimate to obtain a 37 percent impairment of the cervical spine.

In an October 21, 2004 report, Dr. Zimmerman, an Office medical adviser, opined that the date of maximum medical improvement was August 27, 2004 based on Dr. Eckert's examination and presented his review of Dr. Eckert's examination findings, which he opined were subjective and inconsistent strength assessments. He noted that Dr. Eckert reported nerve grades as follows: C6 motor of 20 percent; C7 motor of 25 percent, sensory of 50 percent; and C8 motor of 25 percent and sensory of 50 percent. Using the maximum percentages of impairment from Table 15-17 page 424 of the A.M.A., *Guides* to Dr. Eckert's reported nerve grades, Dr. Zimmerman stated that the impairment rating, gave an enormous weight to subjective inconsistent strength assessments could be calculated by using the grades from Table15-15 page 424. For C6 nerve involvement: sensory deficit equaled 0 percent and motor deficit equaled 2 percent, (20 percent times 8 percent) for a total of 2 percent. For C7 involvement: sensory deficit equaled 8.75 percent (25 percent times 3.5 percent) and motor deficit equaled 2.5 percent (50 percent times 5 percent) for a total of 11 percent. For C8 involvement: sensory deficit equaled 11.25 percent, (25 percent times 45 percent) and motor deficit equaled 2.5 percent, (50 percent times 50 percent) for a total of 14 percent. Utilizing the Combined Values Chart page 604, Dr. Zimmerman found that 14 percent combined with 11 percent equaled 23 percent and the 23 percent combined with 2 percent equaled an overall impairment of 25 percent due to the cervical spine condition. He opined that, as appellant previously received a schedule award of 8 percent for her left upper extremity, that amount must be subtracted from the current impairment rating to allow an increase in the schedule award of 17 percent. Dr. Zimmerman reiterated that such increase in the schedule award "require[d] that the criteria for validity in strength assessment set forth in the fifth edition of the A.M.A., *Guides* be ignored with reference to the strength rating (which this mostly is) for weakness."

By decision dated October 27, 2004, the Office granted appellant a schedule award for a 17 percent impairment of her left upper extremity (for a total impairment of 25 percent), for the period October 31, 2004 to November 6, 2005 or an additional 53.04 weeks of compensation. By decision dated November 4, 2004, the Office reissued the October 27, 2004 decision, noting that the period of the award was from February 28, 2002 to March 6, 2003.

Appellant disagreed with the Office's November 8, 2004 decision and filed an appeal to the Board. In an order remanding case, the Board found that the Office failed to timely transmit the case record and remanded the case for reconstruction and proper assemblage of the case record. In order to protect appellant's appeal rights, the Board directed the Office to issue an appropriate decision.[4]

In a decision dated August 4, 2005, the Office reissued the schedule award for 17 percent impairment of the left upper extremity, less the amount of wage loss previously paid for the same period based on a wage-earning capacity.

On appeal, appellant argues that the Office, in paying her additional schedule award of 17 percent for impairment to her left upper extremity, should have paid the full amount of the schedule award without deducting the wage-loss compensation received under her loss of wage-earning capacity.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[5] 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.[6]

The Act and the implementing regulation provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7] In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[8] As a general rule in schedule award cases, the physician should describe the impairment in sufficient detail to permit clear visualization of the impairment and the restrictions and limitations that have resulted.[9] The Office's procedures

[4] Docket No. 05-690 (issued June 7, 2005).

[5] 5 U.S.C. § 8107.

[6] *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).

[7] 5 U.S.C. § 8123; 20 C.F.R. § 10.321.

[8] *Manuel Gill*, 52 ECAB 282 (2001).

[9] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a(2) (June 2003).

indicate that, referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained.[10]

ANALYSIS

Dr. Zimmerman, the Office medical adviser, found that appellant was not entitled to an additional schedule award over the eight percent previously awarded as her physicians, Dr. Carlson and Dr. Wood did not support their impairment ratings with objective evidence. Dr. Breeding, however, opined that appellant had 29 percent impairment to the left upper extremity. As there existed a conflict in medical opinion evidence between the Office medical adviser and Dr. Breeding as to the degree of impairment under the A.M.A., *Guides*, the Office properly referred her to Dr. Eckert to resolve this conflict. The Office directed Dr. Eckert to provide an impairment percentage in terms of the upper extremity based on both the diagnosis-related estimate method and the range of motion method. He opined that appellant had a 28 percent upper extremity impairment and a 37 percent regional spine impairment.

Where an impartial medical examination is arranged to resolve a conflict created between a claimant's physician and an Office medical adviser with respect to a schedule award issue, the same Office medical adviser should not review the impartial medical specialist's report. Rather, another Office medical adviser or consultant should review the file.[11] In this case, it was improper for the Office to have referred the case to the same Office medical adviser, Dr. Zimmerman, who originally created the conflict with respect to appellant's impairment.[12] Rather, another Office medical adviser should have reviewed the reports of Dr. Eckert, the impartial medical specialist.[13]

In reviewing Dr. Eckert's reports, Dr. Zimmerman opined that Dr. Eckert's examination findings were "subjective and inconsistent strength assessments," but opined that appellant had 25 percent impairment due to the cervical spine condition if "the criteria for validity in strength assessment set forth in the fifth edition of the A.M.A., *Guides* was ignored." As he disagreed with Dr. Eckert's examination findings, Dr. Zimmerman provided no opinion on Dr. Eckert's diagnosis-related estimate impairment rating. The Board cannot make a determination as to whether appellant had greater than a 25 percent impairment based on the diagnosis-based method. In any event, it must be the impartial medical examiner, not the Office medical adviser who resolves the medical conflict.[14]

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims* Chapter 2.810.11(d) (August 2002); *Richard R. Lemay*, 56 ECAB ___ (Docket No. 04-1652, February 16, 2005).

[12] *Id.*

[13] *Richard R. Lemay*, 56 ECAB ___ (Docket No. 04-1652, issued February 16, 2005).

[14] *See id.*

The case will be remanded to the Office to have another Office medical adviser review Dr. Eckert's reports for a determination of whether there is an accurate description of appellant's impairment based on the diagnosed-based method or objective findings based on the range of motion method. The Board additionally notes that as the impairment rating for an axial spine condition can be based only on radicular symptoms and signs affecting an upper extremity or extremities, only such examination findings should be used for the grades offered from Tables 16-10 and 16-11 on pages 482 and 484 and from Tables 15-15, 15-16 and 15-17 on page 424 of the A.M.A., *Guides*. Should Dr. Eckert's opinion require clarification, the Office should request a supplemental opinion consistent with Board precedent.[15] Following such further development as is necessary, the Office shall issue an appropriate merit decision on the schedule award issue.

The Board notes that the Office paid appellant's additional schedule award for the period February 28, 2002 to March 6, 2003. The Board has found, "[w]here the medical evidence establishes ... maximum improvement by such date, [a retroactive] determination is proper, assuming that it is made within a reasonable time after the date of maximum improvement."[16] A retroactive schedule award, however, may not be proper where the date of the award is set years in the past and the employee has been prevented by residuals of the employment injury from returning to work. The evidence of record reflects that appellant's original schedule award ran from January 13, 2001 to February 27, 2002 based on a date of maximum medical improvement of January 13, 2001, which is supported by evidence of the record.[17] In an August 27, 2004 report, Dr. Eckert opined that the more appropriate date of maximum medical improvement was two years post operation or January 13, 2002, as appellant's symptoms had continued to improve.[18] There is no medical evidence disputing Dr. Eckert's findings that appellant's symptoms continued to improve two years post operation. As Dr. Eckert had full access to appellant's medical record and he performed a full evaluation and his opinion is sufficiently rationalized, his opinion that January 13, 2002 is the more appropriate date of maximum medical improvement is accorded the weight of the medical evidence with regard to the new date of maximum medical improvement.[19] Accordingly, the date of maximum medical improvement is January 13, 2002. As this date falls within the period that the original schedule award was paid, January 13, 2001 through February 27, 2002, it was proper that the Office appended the additional schedule award onto that period and commenced payment for the period February 28, 2002 to March 6, 2003.

[15] *See Harry T. Mosier*, 49 ECAB 688, 693 (1998).

[16] *Marie Born*, 27 ECAB 623 at 630 (1976), *order denying petition for reconsideration*, 28 ECAB 89 (1976).

[17] *See supra* note 1.

[18] *See supra* note 3.

[19] *See Maurissa Mack*, 50 ECAB 498 (1999). In assessing the medical evidence of record, the Board considers the physician's relative area of expertise, the opportunity for and thoroughness of physical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the level of analysis manifested in reaching his or her stated conclusions and the medical rationale expressed in support of the physician's opinion.

Appellant noted that her compensation based on her loss of wage-earning capacity was deducted during the same period as her schedule award. The Board notes that Office procedures allow a schedule award to be paid consecutively but not concurrently with wage-loss compensation for the same injury.[20] The Office may not pay appellant compensation for her loss of wage-earning capacity and schedule award when they cover the same period. The Board notes that section 8107 of the Act was intended by Congress to only apply to cases in which federal employees sustain a permanent impairment of a listed member of the body due to an employment injury.[21] The provisions for schedule awards are separate from any factors that would be used to determine disability based on wage loss.[22] The amounts payable pursuant to a schedule award are defined by weeks of compensation for the listed schedule members. Section 8107 does not take into account the effect the impairment may have on employment opportunities, sports, hobbies or other lifestyle activities.[23] Appellant's argument for an equitable schedule award must be denied as neither the Office nor the Board has the authority to enlarge the terms of the Act or to make an award of benefits under any terms other than those specified in the Act.[24]

CONCLUSION

The Board finds that this case is not in posture for decision with respect to the schedule award determination as further development of the medical evidence is required.

[20] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims* Chapter 2.0808.5(a)(3) (February 2004).

[21] 5 U.S.C. § 8107.

[22] *See Harry D. Butler*, 43 ECAB 859, 863-64 (1992).

[23] *See Ruben France*, 54 ECAB ___ (Docket No. 02-2194, issued March 21, 2003); *Timothy J. McGuire*, 34 ECAB 189 (1982).

[24] *See Gary M. Goul*, 54 ECAB ___ (Docket No. 03-1235, issued July 14, 2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers Compensation Programs dated August 4, 2005 is hereby set aside and the case remanded for further consideration in a manner consistent with this opinion.

Issued: January 12, 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