

for a seven percent impairment of the left upper extremity. By decision dated March 31, 2004, the Office modified its prior decision to reflect a 15 percent permanent impairment of the left upper extremity. A subsequent request for reconsideration was denied in a merit decision dated May 2, 2005. By decision dated January 5, 2006,² the Board set aside the Office's May 2, 2005 decision. The Board found that the Office erred in not including evidence of appellant's left shoulder impairment as all preexisting impairments of the scheduled member must be considered in appellant's left upper extremity impairment evaluation. The Board also found that the Office's recalculation of the schedule award should be based on Dr. Robert Tross' March 9, 2005 clinical findings pertaining to sensory and motor deficits from the ulnar and median nerves.³

In his March 9, 2005 report, Dr. Tross opined that appellant had a 27 percent left arm impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) which consisted of 8 percent shoulder impairment; 13 percent impairment for ulnar nerve dysfunction, comprised of 11 percent motor and 2 percent sensory impairment; and 9 percent impairment of the median nerve function, comprised of 6 percent sensory and 3 percent motor impairment. In calculating ulnar nerve dysfunction, Dr. Tross opined that the ulnar nerve was a Grade 3 or 30 percent deficit under Table 16-10 page 482 of the A.M.A., *Guides* and the sensory value of the ulnar nerve was 7 percent under Table 16-15, page 492 of the A.M.A., *Guides*, which resulted in a 2 percent impairment (30 percent times 7 percent) of ulnar sensory dysfunction on the left arm. He opined that the motor component of the ulnar nerve was a Grade 4 or 25 percent deficit under Table 16-11, page 484 of the A.M.A., *Guides* and the maximum motor deficit of the nerve was 46 percent under Table 16-15, page 492 of the A.M.A., *Guides*, which resulted in an 11 percent impairment (25 percent times 46 percent) of the left arm. Dr. Tross combined the ulnar sensory and motor impairments under the Combined Values Chart, page 604 of the A.M.A., *Guides*, to find 13 percent upper extremity impairment for ulnar nerve dysfunction. In calculating the median nerve dysfunction, he assigned a Grade 2⁴ or 15 percent impairment of the left upper extremity under Table 16-10, page 482 of the A.M.A., *Guides* and as, the maximum sensory deficit of the median nerve was 39 percent under Table 16-15, page 492, found that appellant had a 6 percent impairment of the upper extremity due to sensory dysfunction of the median nerve. Dr. Tross assigned a Grade 4 or 25 percent deficit of motor function of the median nerve under Table 16-11, page 484 of the A.M.A., *Guides* and as, the maximum motor deficit of the median nerve was 10 percent under Table 16-15, page 492, found that appellant had a 3 percent impairment due to motor dysfunction of the median nerve. Dr. Tross then combined the six percent sensory and the three percent motor dysfunction of the median nerve under the Combined Values Chart, page 604 of the A.M.A., *Guides* and found a nine percent upper extremity impairment for median nerve dysfunction. He then combined the impairment values for shoulder loss (8 percent),⁵ ulnar nerve

² *Id.*

³ Dr. Tross is a Board-certified plastic surgeon specializing in hand surgery.

⁴ The Board notes that a Grade 2 appears to be a typographical error in Dr. Tross' report as a 15 percent impairment rating would fall into a Grade 4 category under Table 16-10, page 482 of the A.M.A., *Guides*.

⁵ The details of Dr. Tross' shoulder impairment calculation is not set forth for reasons discussed in the analysis section.

(13 percent) and median nerve (9 percent) loss and arrived at a 27 percent total left upper extremity impairment. He noted that under the A.M.A., *Guides* appellant's losses in grip and pinch strength were presumed to be included in the motor impairment for the respective nerves involved and thus no additional impairment could be afforded.

Following the Board's decision, the Office requested that its Office medical adviser recalculate appellant's left arm impairment. The Office medical adviser was provided a copy of appellant's medical record and a statement of accepted facts dated March 28, 2006, which included the Board's instruction to recalculate appellant's left arm impairment based on Dr. Tross' March 9, 2005 clinical findings pertaining to sensory and motor deficits from the ulnar and median nerves and to consider all preexisting impairments which were present.

In a March 25, 2006 report, an Office medical adviser opined that appellant had a 25 percent left arm impairment. The medical adviser noted that on February 2, 2004 he reviewed the evidence and found 6 percent sensory impairment of the left arm due to cubital tunnel syndrome and a 10 percent sensory impairment due to carpal tunnel syndrome. Based on Dr. Tross' March 9, 2005 report and his February 2, 2004 sensory impairment findings, the Office medical adviser found a 14 percent impairment for ulnar nerve compression, comprised of 9 percent impairment for weakness caused by ulnar nerve compression and 6 percent impairment due to pain as a result of cubital tunnel syndrome and a 13 percent impairment for median nerve compression, comprised of 3 percent impairment for weakness and 10 percent impairment due to pain as a result of carpal tunnel syndrome. For the ulnar nerve calculation, the medical adviser noted a 35 percent maximum impairment of the left arm due to weakness under Table 16-15, page 492 of the A.M.A., *Guides* and a 25 percent impairment or Grade 4 mild weakness under Table 16-11, page 484 of the A.M.A., *Guides*, which resulted in a 9 percent impairment (25 percent times 35 percent) for weakness caused by ulnar nerve compression. Utilizing the Combined Values Chart, page 604 of the A.M.A., *Guides*, the Office medical adviser combined the 6 percent sensory impairment of the left arm due to cubital tunnel syndrome with the 9 percent impairment for weakness caused by ulnar nerve compression to find a 14 percent impairment for ulnar nerve compression. For the median nerve calculation, the medical adviser assigned a 10 percent impairment of the left arm under Table 16-15, page 492 of the A.M.A., *Guides* and a 25 percent impairment or Grade 4 mild weakness under Table 16-11, page 484 of the A.M.A., *Guides*, which results in a 3 percent impairment (25 percent of 10 percent) for weakness due to median nerve compression. Utilizing the Combined Values Chart, page 604 of the A.M.A., *Guides*, the Office medical adviser combined the 10 percent sensory impairment due to carpal tunnel with the 3 percent impairment for weakness due to the median nerve to find a 13 percent impairment. The Combined Values Chart was then used to combine 14 percent impairment for the ulnar nerve compression with 13 percent impairment for the median nerve compression to find a total left arm impairment of 25 percent.

By decision dated May 3, 2006, the Office found that appellant had a 25 percent permanent impairment of his left upper extremity. Appellant received an additional 10 percent award for his left upper extremity or a 25 percent permanent impairment of his left upper extremity minus the 15 percent already awarded.

On appeal, appellant's representative argued that the Office failed to include appellant's preexisting impairments of the scheduled member in calculating the permanent impairment of appellant's left upper extremity.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act⁶ 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.⁷

The standards for evaluation of 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.⁸ 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.⁹

Office procedures provide 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.¹⁰

⁶ 5 U.S.C. § 8107.

⁷ 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).

⁸ See *Paul A. Toms*, 28 ECAB 403 (1987).

⁹ A.M.A. *Guides* 433-521, Chapter 16, the upper extremities (5th ed. 2001).

¹⁰ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

ANALYSIS

The Office issued the schedule award based on the Office medical adviser's March 28, 2006 report. In his March 28, 2006 report, the Office medical adviser reported that appellant had a 25 percent left upper extremity impairment comprised of 14 percent impairment for ulnar nerve compression and 13 percent impairment for median nerve compression. The impairment calculation was based on Dr. Tross' March 9, 2005 examination findings, from which the Office medical adviser calculated the motor dysfunction of the ulnar and median nerves and the Office medical adviser's February 2, 2004 impairment evaluation, from which the Office medical adviser imported his previous sensory impairment findings due to the ulnar and median nerves.

The Office medical adviser's reliance on his February 2, 2004 sensory impairment evaluation is not consistent with the Board's earlier decision directing an impairment evaluation based on Dr. Tross' March 9, 2005 examination findings.¹¹ The Office medical adviser's February 2, 2004 sensory impairment findings of 6 percent for the ulnar nerve and 10 percent for the median nerve differ from Dr. Tross' March 9, 2005 sensory impairment findings of 2 percent for the ulnar nerve and 6 percent for the median nerve and predate Dr. Tross' examination. The Board has recognized that an attending physician, who has an opportunity to examine appellant, is often in a better position to make certain judgments regarding schedule awards.¹² The Board has also held that, with respect to schedule awards, the opinion of an examining specialist in the appropriate field of medicine takes precedence over the opinion of an Office medical adviser when considering subjective factors.¹³ The Office medical adviser did not provide adequate reasoning to explain why the selection of sensory impairment findings prior to Dr. Tross' March 9, 2005 examination were appropriate in this case.

Furthermore, the Office medical adviser failed to discuss or include any evidence of appellant's left shoulder impairment, as noted in Dr. Tross' March 9, 2005 examination and previously directed by the Board, when determining the amount of impairment to appellant's left upper extremity. Appellant is entitled to a schedule award for the full amount of the permanent loss of use of the member, including the loss caused by a preexisting impairment to the scheduled member.¹⁴

Accordingly, the Board will set aside the Office's May 3, 2006 decision and remand the case to the Office for a recalculation of appellant's left upper extremity impairment based on Dr. Tross' clinical findings pertaining to both sensory and motor deficits resulting from the ulnar

¹¹ See *Rob D. Klinger*, 46 ECAB 693 (1995) (the Board has final authority to determine questions of law and its determinations are binding upon the Director).

¹² See *Richard Giordano*, 36 ECAB 134, 139 (1984); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (August 2002). The procedure manual notes that, when the A.M.A., *Guides*, ask for a percentage within a range, the physician may be asked why he assigned a particular percentage of impairment.

¹³ *Michelle L. Collins*, 56 ECAB ____ (Docket No. 05-443, May 18, 2005); *Richard Giordano*, *supra* note 12.

¹⁴ *Michael C. Milner*, 53 ECAB 446 (2002); *Lela M. Shaw*, 51 ECAB 372 (2000).

and median nerves and appellant's preexisting shoulder impairment. 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 3, 2006 is set aside and the case is remanded for further action consistent with this opinion.

Issued: January 19, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board