

the Office accepted his claim for left carpal tunnel syndrome and left ulnar neuropathy and paid compensation benefits.¹ Appellant retired on November 17, 2003.

The record reflects that appellant's has two other accepted claims. Under claim number xxxxxx057, the Office accepted a May 24, 2000 traumatic injury for a right rib contusion, right rib fracture, cervical strain and right trapezius strain. Under claim number xxxxxx013, it accepted a February 15, 2003 occupational disease claim for aggravation of degenerative disc disease at C5-6 with disc herniation, degenerative disc disease at C6-7 without nerve compromise and cervical strain. The Office approved a November 13, 2003 surgery for a herniated nucleus pulposus at C5-6. It combined the cases together with claim number xxxxxx057 as the master file and claim numbers xxxxxx013 and xxxxxx200.

On October 15, 2004 appellant filed a claim for a schedule award. By decision dated January 4, 2007, the Office granted appellant a schedule award for four percent left upper extremity impairment due to the accepted condition of left carpal tunnel syndrome.² The award ran for 12.48 from April 8 to July 4, 2005.

On February 11, 2005 appellant filed a claim for an increased schedule award. In a March 14, 2007 report, Dr. Charles R. Kershner, a Board-certified orthopedic surgeon and Office referral physician, diagnosed bilateral carpal tunnel syndrome, postoperative status following C5-6 fusion, mild left ulnar nerve neuropathy, healed right rib cage contusion and healed neck strain. He opined that appellant reached maximum medical improvement on March 7, 2007. Citing to Tables 16-10 and 16-15 on pages 482 and 492 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Kershner opined that appellant had 27 percent left arm impairment for Grade 3 median nerve deficit and Grade 4 ulnar nerve deficit. He advised that appellant had no upper extremity impairment secondary to the accepted C6-7 degenerative disc disease condition as there was no nerve compromise. Dr. Kershner concluded that appellant's upper extremity impairment was due to the left-sided carpal tunnel syndrome and ulnar neuropathy. An Office medical adviser reviewed the files and opined that Dr. Kershner's report supported that appellant had no impairment due to his cervical condition on either his right or left side.

By decision dated June 12, 2007, the Office found that appellant had no more than four percent impairment for the left upper extremity for which he previously received a schedule award.

On July 2, 2007 appellant requested an oral hearing, which was held telephonically on November 15, 2007.

In a December 28, 2007 report, Dr. Scott B. Taylor, Board-certified in physical medicine and rehabilitation, provided findings on examination and diagnosed cervical radicular syndrome status post anterior cervical discectomy with fusion. Utilizing the A.M.A., *Guides*, he opined

¹ The Office assigned this case claim number xxxxxx200.

² This was based on an August 9, 2006, the Office medical adviser's report and a July 17, 2006 report from Dr. Jeremy J. Hunt, a Board-certified family practitioner.

that appellant had a 22 percent whole person impairment consisting of impairments from the cervical spine and carpal tunnel syndrome. Dr. Taylor advised that under the A.M.A., *Guides* diagnosis-related estimate (DRE) categories of cervical spine impairment, appellant's current condition placed him under category three as indicated on Table 15-16 on page 392, which corresponded to 18 percent impairment. He also stated that, from page 495 of the A.M.A., *Guides*, appellant had five percent upper extremity impairment for carpal tunnel syndrome. Dr. Taylor combined these values under the Combined Values Chart on page 604 to find 22 percent whole person impairment.

By decision dated January 24, 2008, an Office hearing representative set aside the Office's June 12, 2007 decision, and remanded case for additional medical development as to appellant's permanent impairment. The hearing representative noted several problems with Dr. Kershner's second opinion report and instructed the Office to amend the statement of accepted facts to show the conditions it had accepted as work related.³ The hearing representative also instructed that an Office medical adviser review the medical evidence from Dr. Taylor.

On February 15, 2008 the Office amended the statement of accepted facts which clarified the accepted work-related conditions. It referred appellant, together with the case record and list of questions, to Dr. Alois E. Gibson, a Board-certified orthopedic surgeon, for a second opinion evaluation. Dr. Gibson was asked to address any residuals of the accepted medical conditions and determine the extent of any impairment to appellant's upper extremities.

In a March 17, 2008 report, Dr. Gibson reviewed the history of appellant's work-related injuries and provided findings on examination. He found that the conditions of cervical sprain or strain, right rib contusion, right rib fracture and right trapezius strain had all resolved. Dr. Gibson noted that there was residual neuropathy and left ulnar neuropathy as a result of the left carpal tunnel syndrome and that surgery was not warranted. He noted the aggravation of the degenerative disc disease at C5-6 had been treated surgically and that it was not possible to determine whether any residual neuropathy was due to the degenerative changes at C6-7 as it would overlap the median and ulnar neuropathies. Restricted motion in the cervical area was found as well as subjective, yet appropriate, complaints in the left upper extremity. Dr. Gibson opined that appellant reached maximum medical improvement. He found neuropathy involving the sixth, seventh and eighth cervical nerve roots and explained that the same nerve root was involved in cervical neuropathy, ulnar nerve neuropathy and median nerve neuropathy. Under Table 16-10 on page 482, Dr. Gibson opined that appellant had Grade 3 or 60 percent deficit. Under Table 16-13 on page 489, he noted the maximum sensory upper extremity impairment for each nerve root: C6 as eight percent, C7 as five percent, and C8 as five percent. Dr. Gibson then multiplied the maximum upper extremity impairment for each nerve root by the Grade 3 or 60 percent deficit to determine a total left upper extremity impairment of 11 percent due to pain.

³ The hearing representative found that it was not apparent from Dr. Kershner's report that he was aware that any conditions other than C6-7 disc disease without nerve compromise were accepted by the Office. It was further found that Dr. Kershner did not discuss how he arrived at his 27 percent left upper extremity impairment rating based on specific findings on examination of the upper extremity.

In a May 13, 2008 report, an Office medical adviser reviewed appellant's file and determined that appellant reached maximum medical improvement on June 1, 2004, approximately one year after his cervical spinal surgery. He opined that there was no demonstrated impairment to the right upper extremity as appellant had a full range of motion and a normal motor and sensory examination. The Office medical adviser concurred with Dr. Gibson's finding that appellant had 11 percent impairment of the left upper extremity. This was based on full range of motion of the left upper extremity with a normal motor examination and Grade 3 sensory deficit of the involved dermatomes.

By decision dated May 22, 2008, the Office granted a schedule award for an additional seven percent impairment of the left upper extremity as appellant previously received an award for four percent impairment of the left arm. The award ran for 21.84 weeks for the period July 5 to December 4, 2005.⁴

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act⁵ and its implementing regulations⁶ sets forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of schedule members or functions of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. For consistent results and to ensure equal justice, under the law to 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 for evaluating schedule losses.⁷

It is well established that no schedule award is payable for a member, organ or function of the body not specified in the Act or in the regulations.⁸ Because neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back, neck or spine, no claimant is entitled to such an award.⁹ Indeed, the Act specifically excludes the spine from the definition of organ.¹⁰ However, the schedule award provisions of the

⁴ The Office's decision did not make a finding on permanent impairment of the right arm.

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ See 20 C.F.R. § 10.404; see also *David W. Ferrall*, 56 ECAB ____ (Docket No. 04-2142, issued February 23, 2005).

⁸ See *J.Q.*, 59 ECAB __ (Docket No. 06-2152, issued March 5, 2008); *William Edwin Muir*, 27 ECAB 579 (1976) (this principle applies equally to body members that are not enumerated in the schedule provision as it read before the 1974 amendment, and to organs that are not enumerated in the regulations promulgated pursuant to the 1974 amendment).

⁹ E.g., *Timothy J. McGuire*, 34 ECAB 189 (1982) (back); *Robert Henry Guy*, 29 ECAB 734 (1978) (neck, esophagus, chest); *Luis Manalo*, 15 ECAB 400 (1964) (spine).

¹⁰ 5 U.S.C. § 8101(19).

Act include the extremities and a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of such impairment originates in the spine.¹¹

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale for the percentage of impairment specified.¹²

ANALYSIS

Appellant previously received a schedule award for four percent impairment of his left upper extremity due to his accepted carpal tunnel condition. He subsequently filed a claim for an increased schedule award for his accepted conditions, including cervical disc disease.

In a March 17, 2008 report, Dr. Gibson, a second opinion physician, reviewed an updated statement of accepted facts along with appellant's file. He found left-sided residual ulnar and median neuropathy from carpal tunnel syndrome, restricted motion in the cervical area and subjective, yet appropriate, complaints in left upper extremity. Dr. Gibson advised it was not possible to determine any residual neuropathy due to degenerative changes at C6-7 as it would overlap the median and ulnar neuropathies, but explained the same nerve root was involved in cervical, ulnar nerve and median nerve neuropathy. He opined that appellant reached maximum medical improvement. Citing to Tables 16-10 on page 482 and 16-13 on page 489, Dr. Gibson found that appellant had 11 percent left upper extremity impairment due to Grade 3 sensory deficit of the C6, C7 and C8 dermatomes. On May 13, 2008 an Office medical adviser applied the A.M.A., *Guides* to Dr. Gibson's March 17, 2008 findings. He determined that appellant reached maximum medical improvement on June 1, 2004, approximately one year after his cervical spinal surgery. For the left upper extremity, the Office medical adviser noted that Dr. Gibson found full range of motion, a normal motor examination, but an abnormal sensory examination which resulted in a Grade 3 sensory deficit of the C6, C7 and C8 dermatomes. Citing to Tables 16-13 on page 489 and Tables 16-10 page 482, he multiplied the Grade 3, 60 percent, sensory deficit by the maximum sensory impairment for the involved spinal nerves (8 percent for C6, 5 percent for C7 and 5 percent for C8) for a total impairment of 11 percent. A Grade 3 sensory loss (60 percent) when multiplied by the 8 percent maximum value for C6 spinal nerve results in a 4.8 percent (rounded to 5 percent) impairment. A Grade 3 sensory loss (60 percent) of the C7 and C8 spinal nerves (which each have a 5 percent maximum value) results in 3 percent impairment each. The Office medical adviser properly applied the provisions of the A.M.A., *Guides* to the clinical findings of Dr. Gibson to rate 11 percent impairment of the left upper extremity.

The Board notes, however, that the record contains a December 28, 2007 report from Dr. Taylor, who opined that appellant had 22 percent whole person impairment comprised of impairments from the cervical spine and carpal tunnel syndrome under the criteria set forth in the

¹¹ See *J.Q.*, *supra* note 8.

¹² See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

A.M.A., *Guides*. As noted, the Act does not provide for a schedule award based on impairment to the spine. Moreover, impairment ratings based on permanent impairment of the whole person does not adhere to the Office's standards for impairment ratings.¹³

CONCLUSION

The Board finds that appellant has no more than 11 percent impairment to his left arm.

ORDER

IT IS HEREBY ORDERED THAT the May 22, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 21, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

¹³ *E.g., Ernest P. Govednick, 27 ECAB 77 (1975).*