U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ALICE M. PICKETT and U.S. POSTAL SERVICE,
POST OFFICE, Finksburg, MD

Docket No. 98-1637; Submitted on the Record;
Issued February 23, 2001

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has more than an eight percent permanent impairment of her right upper extremity, for which she received a schedule award.

On May 26, 1994 appellant, then a 58-year-old rural letter carrier, sustained an injury while in the performance of her duties when she was involved in a motor vehicle accident. The Office of Workers' Compensation Programs accepted her claim for the conditions of cervical strain, left elbow contusion, right hand sprain and herniated nucleus pulposus, (HNP) C5-6. The Office authorized cervical spine surgery and fusion performed on October 11, 1994. Appellant received compensation for temporary total disability.

This history of appellant's complaints shows involvement primarily of the right upper extremity. On October 5, 1994 appellant's attending orthopedic surgeon, Dr. Albert H. Dudley, III, noted that appellant had pain in the neck and both arms. Sensory examination was diffusely abnormal. On October 17, 1994 appellant's attending neurological surgeon, Dr. Kenneth J. Murray, reported that appellant had been unable to work, at his request, because she had a nerve injury that produced numbness and weakness of the right upper extremity, hand and fingers. He detected this neurological deficit on a clinical examination on September 21, 1994. Dr. Murray's operative note of October 11, 1994 stated that appellant had evidence of neck and predominantly right upper extremity pain which did not improve. The spinal cord was noted to have been significantly compromised particularly at C5-6 and moderately so at the bottom of C4. Dr. Dudley's operative report stated that appellant had pain in her neck and into her arm, right greater than left.

Postsurgical complaints also show involvement primarily of the right upper extremity. On November 14, 1994 Dr. Murray reported that appellant was complaining of some neck pain, which he believed to be all soft tissue in origin. Appellant had no radicular symptoms, but the thumb on her right hand was still numb. Dr. Murray advised that numbness was the last to improve. On January 9, 1995 appellant complained of a weak neck but offered no complaints of radicular arm pain. She did have numbness of the thumb, which he reported was residual of the

disc herniation stemming from C5-6. There was no evidence of motor deficit. On January 19, 1995 Dr. Anita M. Holloway, a Board-certified physiatrist, reported complaints of right thumb weakness, right shoulder pain, left hip pain,[1] which limited her ability to ambulate and marked neck stiffness. On March 27, 1995 appellant's chief complaint was neck pain. Dr. Murray stated that she had soft-tissue pain, in his opinion and not true neurological pain, though she did have residual numbness over the thumb on the right side that could represent permanent nerve damage. Dr. Murray noted improved arm pain and some limitation of abduction of the right shoulder. On April 10, 1995 Dr. Holloway noted an improvement in shoulder flexion but complained of pain at greater than 140 to 160 degrees. Appellant described persistent discomfort that progressed through the day with increased use. "She reported limitation in activity tolerance with persistent complaints of right [sic] hip discomfort." On May 15, 1995 appellant continued to complain of right thumb numbness, neck tightness and shoulder soreness with any amount of regular use. On June 12, 1995 appellant complained that when she lifted her arms she had pain in the shoulder, trapezius and proximal arm on the right side. She was dropping things with her right hand. Examination showed no significant weakness of grip, biceps, triceps or deltoids. Dr. Murray diagnosed postsurgical C4-6 anterior cervical fusion surgery with persistent and intermittent neck and right upper extremity pain, no sign of infection, rule out right shoulder pathology. On June 19, 1995 appellant presented with complaints of exacerbation of neck pain, persistent soreness "and right shoulder activities that exacerbates with mail sorting activity." On September 11, 1995 Dr. Holloway noted complaints of weakness around the neck, a feeling of weakness around the hip where the graft was obtained and persistent numbness over the right thumb area.

On February 7, 1996 appellant filed a claim for a schedule award. The Office notified appellant that her attending physician should submit a report evaluating any permanent impairment resulting from the employment injury. After appellant had difficulty getting her physician to provide the information needed, she was examined on October 28, 1996 by Dr. Marcia D. Wolf, who is Board-certified in physical medicine.

Dr. Wolf described appellant's history and the following complaints:

> "'My right arm is still weak and my shoulder is down. I can't unscrew a jar. I avoid heavy objects. I have difficulty with my arm overhead. It goes to sleep when I set my hair or when I'm getting things out of cabinets. It gets numb. The vacuum bothers it. I can use my left arm some. I can't get my thumb to hold a pen.' She denied tremors. 'I can't write well.'
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> "'It's numb where the bone graft was taken and it's tight. My whole side is numb. I feel heaviness in my neck, and I can't sit up too long.' She uses a recliner with pillows. 'After 10 to 15 minutes, I can't hold my head up at my desk. I have to move around.' At work, she sorts parcels, answers [tele]phones and does certified mail. She does not use a computer.
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> "She complains of right thumb numbness. She describes ulnar neuropathy with a history of positive Tinel's sign when sitting or leaning on her elbow. Previous

[1] A graft of bone was obtained from this area during surgery.

EMG [electromyogram] testing was positive for carpal tunnel syndrome on the left. She has had a verbrectomy at C5, C4 and C6. I will obtain her cervical spine films and records from LaSalle."

On physical examination Dr. Wolf reported the following findings:

"Thoracic flexion is 40 degrees and extension is 0 degrees. Range of motion of the cervical spine using the double goniometer reveals forward flexion is 30 degrees with pain, flexion is 50 degrees, bilateral rotation is 60 degrees, lateral flexion to the right is 25 degrees and lateral flexion to the left is 25 degrees with pain. Left shoulder range of motion using the inclinometer reveals abduction is 120 degrees, adduction is full, internal rotation is full, external rotation is full, forward flexion is 130 degrees, extension is 48 degrees, protraction is full and retraction is limited. Right shoulder range of motion using the inclinometer reveals abduction is 135 degrees, adduction is full, internal rotation is full, external rotation is full, forward flexion is 130 degrees with pain, extension is 50 degrees, protraction is full and retraction is limited.

"There is decreased grip strength of the right hand. Tinel's test is positive at the right elbow and negative at the right wrist. Grip strength using the dynamometer reveals right is 25 pounds (49 percent loss; 49.06) and left is 30 pounds (25 percent loss; 40.04). Three pounds two jaw chuck on the right. Five pounds two jaw chuck on the left. Bilateral wrist, elbow and finger range of motion is full without pain. There is wasting of the left abductor pollicis brevis muscle. Tinel's test is negative at the left wrist and elbow.

"Deep tendon reflexes of the upper and lower extremities are equal and symmetrical except the right patellar reflex, which is brisk. There is a well-circumscribed area of decreased sensation just below the left iliac crest to the left greater trochanter, which is 19.5 centimeters long by 12.5 centimeters wide. There is decreased sensation to the left thenar eminence and the right thenar greater than hypothenar eminences. There is decreased sensation to the right thumb and index finger and over the left deltoid muscle. Strength of the remaining upper extremities is within functional limits."

Dr. Wolf diagnosed the following: (1) status post cervical fusion; (2) left carpal tunnel syndrome; (3) C6 radiculopathy; (4) limited range of motion of the cervical spine; (5) partial frozen right and left shoulder secondary to decreased use for a prolonged period of time secondary to (1) and (2); (6) weakness in both hands, right worse than left; and (7) peripheral numbness left iliac crest to greater trochanter (at bone donor site).

Dr. Wolf compared her findings to specific pages, tables and figures in the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993) ("A.M.A., *Guides*"). She found a three percent impairment of the left and right upper extremity secondary to decreased shoulder flexion (page 43, Figure 38). Dr. Wolf found a three percent impairment of the left upper extremity and a two percent impairment of the right upper extremity secondary to decreased shoulder abduction (page 44, Figure 41). Adding these impairments, she

reported a six percent impairment of the left upper extremity and a five percent impairment of the right upper extremity secondary to loss of range of motion.

Dr. Wolf found a 19 percent impairment of the left and right upper extremities secondary to decreased sensation (50 percent times 38 percent) median nerve right and left (page 54, Table 15). She found a 20 percent impairment of the right upper extremity and a 10 percent impairment of the left upper extremity secondary to decreased grip strength (page 65, Figures 32 and 34). Dr. Wolf also found a two percent impairment of the left upper extremity secondary to atrophy of the left abductor pollicis brevis muscle; a one percent impairment of the left upper extremity secondary to decreased musculocutaneous sensation on the left; and a one percent impairment of the whole person secondary to decreased lateral femoral cutaneous sensation (page 54, Table 15).

Dr. Wolf found a 10 percent impairment of the whole person secondary to cervical spine fusion at two levels (page 113, Table 75 (II)). She found an 11 percent impairment of the whole person secondary to retrolisthesis at two levels (page 113, Table 75 (IV)). Dr. Wolf found a three percent impairment of the whole person secondary to decreased cervical spine extension (page 118, Table 76). She found a two percent impairment of the whole person secondary to decreased cervical spine lateral flexion to the right one percent and lateral flexion to the left one percent (page 120, Table 77). She found a two percent impairment of the whole person secondary to decreased cervical spine rotation to the right one percent and rotation to the left one percent (page 122, Table 78). Adding the cervical spine range of motion impairments, Dr. Wolf reported a seven percent impairment of the whole person.

Dr. Wolf combined impairments and reported a 38 percent total impairment of the right upper extremity and a 33 percent total impairment of the left upper extremity. She converted these into whole person impairments, combined the whole-person impairments and reported a 54 percent total permanent impairment of the whole person secondary to the injuries sustained in the May 26, 1994 motor vehicle accident.

On December 3, 1997 an Office medical adviser reviewed Dr. Wolf's findings and determined that appellant had an eight percent permanent impairment of the right upper extremity secondary to C6 unilateral nerve involvement. He noted that the date of maximum medical improvement was October 11, 1995.

On December 16, 1997 the Office medical adviser explained that the only permanent impairment involved the C6 cervical nerve root. There was no radiculopathy to the left upper extremity; therefore, all relevant findings were to the right upper extremity. The medical adviser reported that Dr. Wolf inappropriately rated such areas as the shoulders and grip strength and inappropriately rated multiple anatomic areas that were not involved.

On January 13, 1998 the Office issued a schedule award for an eight percent permanent impairment of the right upper extremity.

On December 22, 1997 appellant requested a review of the written record by an Office hearing representative. On April 14, 1998 she filed an appeal with the Board requesting its review of the Office's January 13, 1998 schedule award decision. Thereafter, on April 30, 1998,

an Office hearing representative affirmed the schedule award. Under the principles discussed in *Douglas E. Billings*,[2] the April 30, 1998 decision of the Office hearing representative, issued while the Board had jurisdiction over the case, is null and void.

The Board finds that this case is not in posture for decision.

Section 8107 of the Federal Employees' Compensation Act[3] and section 10.304 of the implementing federal regulations[4] authorize the payment of a schedule award for the loss or permanent impairment of specified members, functions or organs of the body. Neither the Act nor the regulations specify how the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the A.M.A., *Guides* as the standard for determining the percentage of impairment and the Board has concurred in such adoption.[5]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the regulations.[6] Because neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the neck or back,[7] no claimant is entitled to such an award.[8] Dr. Wolf's impairment ratings for cervical spine fusion, retrolisthesis and cervical range of motion provide no basis for the payment of a schedule award.

The Act also does not authorize the payment of a schedule award for the permanent impairment of "the whole person."[9] None of Dr. Wolf's whole-person ratings, whether for the neck, back or extremities, may be used to determine appellant's entitlement to schedule compensation.

Amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of the Act include the extremities, a claimant may be entitled to a

[2] 41 ECAB 880 (1990).

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.304.

[5] *See, e.g., Leisa D. Vassar*, 40 ECAB 1287 (1989).

[6] *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); *see also Thomas E. Montgomery*, 28 ECAB 294 (1977).

[7] The Act itself specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[8] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).

[9] *Ernest P. Govednick*, 27 ECAB 77 (1975).

schedule award for the permanent impairment of an upper or lower extremity even though the cause of the impairment originated in the spine.[10]

In this case, the Office accepted appellant's claim for the conditions of cervical strain, left elbow contusion, right hand sprain and HNP, C5-6. As there is no evidence to support a permanent impairment resulting from the soft-tissue conditions of strain, sprain and contusion, appellant is entitled to a schedule award for any permanent impairment to a scheduled member caused by her HNP at the C5-6 level or by her authorized surgery.

In this regard Dr. Wolf reported a 33 percent total impairment of the left upper extremity. She offered no medical reasoning, however, to show how this impairment was a result of the May 26, 1994 injury or subsequent surgery. Appellant's complaints both before and after her anterior cervical fusion and again upon examination by Dr. Wolf make little or no reference to the left upper extremity. She has, on the other hand, consistently related complaints about her neck, right upper extremity and left hip and the Office medical adviser observed that all relevant findings were to the right upper extremity. Although Dr. Wolf diagnosed left carpal tunnel syndrome, she neglected to show how the medical record supported that this condition, together with any decreased use of the left upper extremity or weakness of the left hand, was caused by the employment injury or surgery. For these reasons, the Board finds that the Office properly denied a schedule award for the left upper extremity.

With respect to the right upper extremity, Dr. Wolf combined decreased range of motion, decreased sensation due to a deficit of a major peripheral nerve and decreased grip strength. The A.M.A., *Guides* cautions, however, that characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, have been taken into consideration in preparing the estimated percentages for impairment due to peripheral nerve disorders. Thus, if an impairment results strictly from a peripheral nerve lesion, the physician should not apply impairment percents for range of motion and for sensory or motor deficits resulting from peripheral nerve disorders because a duplication and unwarranted increase in the impairment percent would result.[11] Duplication aside, an issue arises whether appellant's impairment should be evaluated on the basis of a peripheral nerve or spinal nerve disorder. The Office accepted a HNP at the C5-6 level and authorized an anterior cervical fusion. Further, the Office medical adviser observed that the only involvement was that of the C6 spinal nerve root. It appears, therefore, that the grading scheme and procedure set forth on page 51 of the A.M.A., *Guides* for evaluating impairment due to spinal nerve injury is more appropriate in this case.

Table 13, page 51, shows that the maximum percentage impairment of the upper extremity due to sensory deficit of the C6 spinal nerve is eight percent. The Office medical adviser awarded the maximum percentage allowable, implicitly grading the severity of the sensory deficit at 100 percent under Table 11, page 48. On this basis the Office issued a schedule award for an eight percent permanent impairment of the right upper extremity. What remains unclear from Dr. Wolf's evaluation is whether appellant suffered any impairment of the right upper extremity due to a unilateral motor deficit of the C6 spinal nerve. Any loss of power

[10] *Rozella L. Skinner*, 37 ECAB 398 (1986).

[11] A.M.A., *Guides* 46.

or motor deficit resulting from injury to the C6 spinal nerve could increase appellant's entitlement substantially. Table 13, page 51, shows that the maximum percentage impairment of the upper extremity due to combined sensory and motor deficits of the C6 spinal nerve is 40 percent.

Because Dr. Wolf's report and the notes of the Office medical adviser are unclear whether appellant's employment injury and authorized surgery caused an impairment of the right upper extremity due to motor deficit of the C6 spinal nerve, the Board will set aside the January 13, 1998 schedule award and remand the case for further development and an appropriate final decision on appellant's entitlement to schedule compensation.

The January 13, 1998 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, DC
February 23, 2001

David S. Gerson
Member

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member