U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PALMER REEVES and U.S. POSTAL SERVICE,
POST OFFICE, Philadelphia, PA

Docket No. 03-56; Submitted on the Record;
Issued April 28, 2003

DECISION and ORDER

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

The issue is whether appellant has more than an 11 percent permanent impairment of each upper extremity, for which he received a schedule award.

On December 15, 1998 appellant, then a 43-year-old mailhandler, filed an occupational disease claim asserting that he sustained a herniated disc as a result of his federal employment duties. The Office of Workers' Compensation Programs accepted his claim for bilateral cervical herniated nucleus pulposus at C4-5 and approved discectomy with fusion and a plate, which was performed on January 19, 1999. On August 28, 2000 appellant filed a claim for a schedule award.

On July 11, 2000 Dr. David Weiss, an attending osteopath and Board-certified orthopedic surgeon, noted that appellant had reached maximum medical improvement on July 6, 2000 and that on examination appellant exhibited neck pain, numbness and tingling in the upper extremities, muscle spasms and an altered gait. Range of motion testing revealed forward flexion at 40/45 degrees, backward extension of 45/45 degrees, left lateral rotation of 40/80 degrees and right rotation of 65/80 degrees. Dr. Weiss also noted that sensory examination revealed a perceived sensory deficit over the L3 dermatome of both the right and left lower extremities, but that appellant's upper extremities tested normal. He further noted that grip strength measured 21 kilograms on the right and 9 kilograms on the left. Dr. Weiss diagnosed herniated nucleus pulposus at C5-4 and cervical myelopathy with an upper and lower extremity radiculopathy. Referring to Tables 11 and 83 on pages 48 and 130, respectively, and Tables 32 and 34 on page 65, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fourth edition), he calculated that appellant had a 4 percent impairment of each lower extremity due to sensory deficit and a 30 percent impairment of the right upper extremity and a 20 percent permanent impairment of the left upper extremity due to loss of grip strength.

On October 31, 2000 an Office medical adviser reviewed Dr. Weiss' evaluation and noted that, while there was no doubt that appellant had suffered some permanent impairment due to his cervical myelopathy stemming from his fusion, Dr. Weiss' grip strength ratings were

inconsistent with the 5/5 strength rating recently found by Dr. Richard Kanoff, another treating physician. Therefore, the Office medical adviser recommended that appellant be referred for a second opinion.

On December 15, 2000 Dr. Robert D. Aiken performed a second opinion evaluation at the request of the Office. The Office provided Dr. Aiken with a statement of accepted facts, a list of questions to be addressed and copies of the relevant medical evidence of record. In his report, Dr. Aiken noted that neurological examination was remarkable for normal higher cortical function, with all pairs of cranial nerves normal. Motor examination was remarkable for 4+/5 weakness of the extensor digitorum and interosseous muscle groups, with mildly increased tone in both arms and moderately increased tone in both legs. Sensation was notable for dullness to pinprick throughout forearms and hands and proprioception was normal. Deep tendon reflexes were 3/5 in both arms, 4/5 at both knees and 5/5 at both ankles, and plantar reflexes were extensor bilaterally. Coordination was remarkable for slowing of rapid successive finger and hand movements and heel tapping, and nose-finger-nose was executed slowly but accurately. Dr. Aiken further noted that appellant exhibited mild postural instability and ambulated with a stiff broad-based gait that appeared slower than normal, with arms swinging actively and mildly abducted from the torso. He stated that appellant suffered from a cervical spondylolisthesic myelopathy and had a preexisting cervical spinal cord compression from a herniated intervertebral disc at C4-5. Dr. Aiken noted that appellant had undergone decompressive cervical spine surgery but did not appear to have significantly improved since that surgery, with persistent mild weakness of his hands, a loss of feeling in his forearms and hands, spastic stiff fatigue and pathological deep tendon reflexes. He concluded that appellant had reached maximum medical improvement, but that it was possible that he might benefit from further spinal surgery.

On January 29, 2001 an Office medical adviser reviewed Dr. Aiken's evaluation and noted that the 4+/5 weakness in the extensor digitorum and interosseous muscles described by Dr. Aiken are areas innervated by the C5 spinal nerve, which was the area of compression associated with appellant's employment injury. Applying his findings to the applicable tables of the A.M.A., *Guides*, the Office medical adviser concluded that appellant had an 11 percent permanent impairment of each upper extremity.[1]

On May 1, 2001 the Office issued a schedule award for an 11 percent permanent impairment of each upper extremity. By letter dated May 4, 2001, appellant requested an oral hearing and in a decision dated January 23, 2002, an Office hearing representative affirmed the Office's prior decision.

The Board finds that appellant has no more than an 11 percent permanent impairment of each upper extremity.

[1] The Board notes that, while the Office medical adviser applied the fourth edition of the A.M.A., *Guides*, rather than the applicable tables of the fifth edition of the A.M.A., *Guides*, which became effective February 1, 2001, as the Office medical adviser properly pointed out, the corresponding tables in the fifth edition of the A.M.A., *Guides* contain identical values.

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations 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*[4] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5] Effective February 1, 2001, the fifth edition of the A.M.A., *Guides* is utilized to calculate any awards.[6]

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 and procedure set forth in Table 16-11, page 484, "determining impairment of the upper extremity due to motor and loss-of-power deficits resulting from peripheral nerve disorders based on individual muscle rating." The Office medical adviser identified the nerve structure involved as the C5 spinal nerve. According to Table 16-13, page 489, the maximum upper extremity impairment due to motor deficit of the C5 spinal nerve is 30 percent and the maximum upper extremity impairment due to sensory deficit of the C5 spinal nerve is 5 percent.

The Office medical adviser classified the degree of muscle function in both upper extremities as Grade 4, which appears appropriate as it closely corresponds with Dr. Aiken's finding of 4+/5 muscle weakness. This grade corresponds to motor deficits that are between 1 and 25 percent.

Following the procedure set forth in Table 16-11, page 484, the Office medical adviser multiplied the severity of the motor deficits by the maximum impairment value of the nerve structure involved to obtain the upper extremity impairment for that structure. For each upper extremity, this means multiplying appellant's 25 percent loss of strength by the maximum impairment value of 30 percent, resulting in an impairment rating of 7.5 percent, which the Office rounded to 8.

Regarding appellant's sensory losses, the Office medical adviser classified the degree of sensory deficit in both upper extremities as Grade 3, "Distorted superficial tactile sensibility with some abnormal sensations or slight pain, that interferes with some activities." This grade corresponds to sensory deficits that are between 26 and 60 percent.

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB ___ (Docket No. 01-1361, issued February 4, 2002).

[5] *See Joseph Lawrence, Jr., supra* note 4; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] FECA Bulletin No. 01-05 (issued January 29, 2001).

Following the procedure set forth in Table 16-10, page 482, the Office medical adviser multiplied the severity of the sensory deficits by the maximum impairment value of the nerve structure involved to obtain the upper extremity impairment for that structure. For each upper extremity, this means multiplying appellant's 60 percent loss of strength by the maximum impairment value of 5 percent, resulting in an impairment rating of 3 percent.

Regarding appellant's lower extremities, the Office medical adviser properly noted that Dr. Aiken's description of appellant's stiff broad-based gait does not correspond with any of the ratable gait derangement standards described in the A.M.A., *Guides*,[7] which are applicable only to persons dependent on assistive devices.

The Board finds that the Office correctly followed standardized procedures for calculating the impairment of appellant's upper extremities due to spinal nerve involvement based on the findings of the Office second opinion physician. While appellant's treating physician, Dr. Weiss, concluded that appellant has a 30 percent impairment of the right upper extremity and a 20 percent permanent impairment of the left upper extremity due to loss of grip strength, the Board notes that the fifth edition of the A.M.A., *Guides* specifically provides, at section 16.8A, page 508, that motor weakness associated with disorders of the peripheral nervous system are to be evaluated according to the guidelines described in section 16.5, as properly applied by the Office medical adviser and not under the portion of the A.M.A., *Guides* pertaining to grip strength.

The January 23, 2002 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
April 28, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[7] A.M.A., *Guides*, *supra* note 4, Table 17-5, page 529.