United States Department of Labor
Employees' Compensation Appeals Board

K.O., Appellant	)	
and	)	**Docket No. 06-984 & 1820**
	)	**Issued: November 3, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Dallastown, PA, Employer	)	

Appearances:
Jeffrey Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 28, 2006 appellant's representative filed a timely appeal from a March 15, 2006 Office of Workers' Compensation Programs' schedule award. This appeal was docketed as No. 06-984. On July 28, 2006 appellant's representative also appealed a subsequent schedule award decision dated July 19, 2006 (pertaining to a different schedule member). This appeal was docketed as No. 06-1820. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over both schedule award determinations.

ISSUES

The issues are: (1) whether appellant has more than a seven percent impairment of her right upper extremity for which she received a schedule award; and (2) whether she has more than a 14 percent impairment of the larynx for which she received a schedule award.

FACTUAL HISTORY

On January 24, 2002 appellant, then a 35-year-old letter carrier filed an occupational disease claim alleging that she sustained injuries to her right arm, shoulder and back as a result of

casing and delivering mail. The Office accepted her claim for right shoulder tendinitis. On September 10, 2002 the Office expanded the claim to include cervical herniation. It authorized an anterior cervical discectomy and allograft fusion with anterior cervical plating for a right-sided C5-6 herniated nucleus pulposus and left-sided C6-7 herniated nucleus pulposus.

In an operative report dated March 7, 2003, Dr. Joseph P. Krzeminski, a Board-certified neurological surgeon, performed an anterior cervical discectomy and allograft fusion with anterior cervical plating. He indicated that the procedure included that Caspar screws were placed in C6 and C7 and that a bone screw was placed in C5. Dr. Krzeminski also explained that a Zephir plate was placed without difficulty and that this involved placing screws in the C5, C6 and C7 nerve roots. Appellant received appropriate compensation benefits. She returned to work full-time without restrictions on July 28, 2003.

On April 12, 2005 appellant completed a Form CA-7 claim for a schedule award.

In a May 9, 2005 report, Dr. James J. Sullivan, a Board-certified physiatrist and an osteopath, noted appellant's history of injury and treatment and conducted a physical examination. He utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*) and stated that appellant did not have any motor loss. Dr. Sullivan advised that she complained of pain in her entire right arm and had intermittent numbness and tingling in her right hand (digits 1-3). He referred to Figure 16-49[1] and explained that appellant's pain encompassed the C5-7 sensory dermatomes which were based on pain that interferes with some activities and referred to Table 15-15[2] and noted that this would warrant a 50 percent sensory deficit. Regarding sensory deficit impairment, Dr. Sullivan referred to Table 16-13[3] and advised that, for the C5 nerve root, appellant had a 5 percent maximal upper extremity impairment for sensory deficit, which was equal to a 2.5 percent impairment of the upper extremity. For the C6 nerve root, Dr. Sullivan explained that she had an 8 percent maximal upper extremity impairment for sensory deficit, which was equal to a 4 percent impairment of the upper extremity and that, for the C7 nerve root, appellant had a 5 percent maximal upper extremity impairment for sensory deficit, which was equal to a 2.5 percent impairment of the upper extremity. He combined these values for sensory deficit impairment to find nine percent impairment to the right upper extremity. Dr. Sullivan advised that appellant had reached maximum medical improvement.[4]

By letters dated July 26 and August 4, 2005, appellant's representative requested a schedule award and that the Office develop her claim with regard to her laryngeal nerve injury.

[1] A.M.A., *Guides* 490.

[2] *Id*. at 424.

[3] *Id.* at 489.

[4] Dr. Sullivan also advised that appellant's recurrent laryngeal function could not be rated as she had normal speech and normal cranial nerve function on neurologic examination and indicated that an additional evaluation and testing would be needed.

In a July 29, 2005 report, an Office medical adviser noted appellant's history of injury and treatment. He indicated that she did not have any motor loss. The Office medical adviser opined that a fusion of C5-6 and C6-7 would only involve the nerve roots at C6 and 7 and would not involve the C5 nerve root. Because of this, he did not agree with Dr. Sullivan's rating impairment of the C5 nerve root. The Office medical adviser referred to Table 16-13[5] and determined that the maximum upper extremity impairment due to unilateral or sensory motor deficits and individual spinal nerves were combined 100 percent deficits. He explained that this would indicate that for the C6 nerve root appellant would have 8 percent maximum sensory deficit and 35 percent maximum motor deficit.[6] For the C7 nerve root, the Office medical adviser indicated that appellant would have a maximum sensory deficit of 5 percent and a motor deficit of 35 percent. He indicated that he agreed with Dr. Sullivan regarding the proposed 50 percent sensory loss and noted that Table 15-15 at page 424 would entitle appellant to a grade of 3. The Office medical adviser multiplied 50 percent of 8 percent for the maximum sensory loss for C6 and noted that this would equal 4 percent. He explained that for the C7 nerve roots, appellant had a sensory deficit of 5 percent and multiplied this by the 50 percent of Grade 3 sensory loss for the nerve root at C6-7 and determined that this equated to 2.5 percent. The Office medical adviser combined the 2.5 percent of nerve root C7 with the 4 percent for nerve root C6 pursuant to the Combined Values Chart and determined that this would equal 6.5 percent, which he rounded up and concluded that appellant was entitled to no more that 7 percent to the right upper extremity. The Office medical adviser indicated that appellant reached maximum medical improvement on May 9, 2005.[7]

In a March 15, 2006 decision, the Office awarded appellant a schedule award for seven percent impairment of the right arm. The award ran from May 9 to October 8, 2005.

On April 18, 2006 the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Clifford N. Steinig, an osteopath, Board-certified in otolaryngology and facial plastic surgery.

In an April 25, 2006 report, Dr. Steinig noted appellant's history of injury and treatment. He stated that, after the March 7, 2003 surgery, she lost her voice and noted that, while it had returned, "[appellant] still has a raspy quality to it." Dr. Steinig advised that she had difficulty singing and could not hold a note in a higher octave, but that appellant was able to eat and drink. He noted that appellant did not have any signs of regurgitation, but that she had an "odd feeling in her throat." Dr. Steinig conducted an examination of the neck and determined that there was "some fullness in the surgical site." He indicated that otherwise there was no adenopathy and her ears and throat were normal. Dr. Steinig noted that appellant had a deviated septum on the left, but explained that this was "due to an attack by a dog." He performed a flexible fiber optic nasopharyngolaryngoscopy of the larynx and determined that she had "complete paralysis" of the right vocal cord. Dr. Steinig indicated that the left vocal cord moved well, but opined that

[5] A.M.A., *Guides* 489.

[6] The Office medical adviser actually indicated two percent; however, this appears to be a typographical error as his calculations utilize the eight percent sensory deficit indicated in the table.

[7] Regarding appellant's recurrent laryngeal nerve, the Office medical adviser recommended an examination by an ear, nose and throat specialist.

"clearly the problem with the right vocal cord is secondary to the anterior cervical discectomy." He advised that appellant could perform her current job and noted that she was "back to work and is doing quite well." Dr. Steinig opined that the injury to the nerve caused appellant's vocal cord paralysis and advised that there were procedures that she could undergo to help with the situation by "repositioning the vocal cord itself."

On May 9, 2006 the Office expanded appellant's claim to include paralysis of the right vocal cord and authorized treatment with an ear, nose and throat specialist.

By letters dated May 12 and 26, 2006, appellant's representative advised that she did not wish to seek additional surgery and requested that the Office process appellant's request for a schedule award for her injury to the larynx.

On June 6, 2006 the Office requested an impairment rating from its medical adviser, utilizing the fifth edition of the A.M.A., *Guides.*

In a June 6, 2006 report, the Office medical adviser noted appellant's history of injury and treatment. He noted that she had right vocal cord paralysis related to her accepted cervical surgery and opined that this "abnormality is responsible for some voice/speech limitations including significant difficulty singing and cannot hold a note when she sings in a higher octave. [Appellant] has an odd feeling in her throat." The Office medical adviser referred to Table 11-8[8] and opined that she would fall into a Class I category, which equated to 14 percent speech impairment. He requested that the Office obtain an opinion from Dr. Steinig regarding appellant's impairment and the date of maximum medical improvement as he was an ear, nose and throat specialist and more experienced in rating these disorders.

On June 27, 2006 the Office requested that the second opinion physician provide an impairment rating in accordance with the A.M.A., *Guides.*

In a July 10, 2006 report, Dr. Steinig utilized the A.M.A., *Guides* and opined that appellant fell into a Class I impairment for voice and speech, as she fell into all the parameters described in that category. He also indicated that she was already back to work with no other problems noted.

In a July 12, 2006 report, the Office medical adviser noted that he had reviewed the record and concurred with Dr. Steinig. He agreed that appellant had a speech impairment of 14 percent and determined that she reached maximum medical improvement on July 29, 2005.

By decision dated July 19, 2006, the Office awarded appellant compensation for 22.4 weeks from July 29, 2005 to January 1, 2006 based upon a 14 percent impairment of the larynx.

[8] A.M.A., *Guides* 265.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[9] and its implementing regulation[10] sets forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all appellants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all appellants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[11]

ANALYSIS -- ISSUE 1

In support of her claim for a schedule award, appellant submitted the May 9, 2005 report of Dr. Sullivan who utilized the fifth edition of the A.M.A., *Guides* and explained that she was entitled to a schedule award to the right arm even though the cause of the impairment originated in the neck, shoulders or spine.[12] Dr. Sullivan determined that appellant did not have any motor loss and that she had complaints of pain in her entire right upper limb and intermittent numbness and tingling in appellant's right hand and referred to her digits from one to three. He referred to Figure 16-49[13] and explained that appellant's pain encompassed the C5-7 sensory dermatomes which were based on pain that interferes with some activities and referred to Table 15-15[14] and noted that this would warrant a 50 percent sensory deficit.[15] Regarding sensory deficit impairment, he referred to Table 16-13[16] and determined that for the C5 nerve root, appellant had a 5 percent maximal upper extremity impairment for sensory deficit, which when multiplied by the 50 percent sensory deficit for pain was equal to a 2.5 percent impairment of the upper extremity. For the C6 nerve root, Dr. Sullivan explained that appellant would be entitled to an 8 percent maximal upper extremity impairment for sensory deficit, which when multiplied by the 50 percent sensory deficit for pain was equal to a 4 percent impairment of the upper extremity. For the C7 nerve root, he explained that appellant had a 5 percent maximal upper extremity impairment for sensory deficit, which when multiplied by the 50 percent sensory deficit for pain

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

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

[12] *See Richard R. Lemay*, 56 ECAB ___ (Docket No. 04-1652, issued February 16, 2005); *see also Thomas J. Engelhart*, 50 ECAB 319 (1999).

[13] A.M.A., *Guides* 490.

[14] *Id*. at 424.

[15] As noted earlier, while Dr. Sullivan referred to Table 15-15 at page 424 of the A.M.A., *Guides*, this table is functionally equivalent to Table 16-10 at page 482 of the A.M.A., *Guides*. Therefore, since the amounts are functionally equivalent, any reference to the spine in Chapter 15 would be harmless error.

[16] A.M.A., *Guides* 489.

was equal to a 2.5 percent impairment of the upper extremity. Dr. Sullivan combined these sensory impairment values pursuant to the Combined Values Chart[17] and determined that appellant had a total nine percent impairment to the right arm and had reached maximum medical improvement. However, the Board notes that paragraph 16.5c regarding regional impairment determinations[18] indicates that, for spinal nerves, evaluating impairment of the spinal nerves due to injuries or disease is based on the severity of loss of function of the peripheral nerves receiving fibers from specific spinal nerves. Because each spinal nerve transmits fibers to more than one peripheral nerve, the loss of function is greater with the involvement of two or more spinal nerves transmitting fibers to the same peripheral nerve than with the involvement of a single spinal nerve. Therefore, in multiple spinal involvement the impairment is evaluated according to the brachial plexus values (Table 16-14) rather than combining the individual spinal nerve values shown in Table 16-13.[19] Dr. Sullivan should have utilized Table 16-14[20] to determine the extent of appellant's permanent impairment and his report is of limited probative value.

The Board also notes that the Office medical adviser utilized Table 16-13 instead of Table 16-14.[21] As appellant had more than one spinal nerve involved he should have utilized Table 16-14.[22] Furthermore, the Office medical adviser opined that a fusion of C5-6 and C6-7 would only involve the nerve roots at C6 and 7 and would not involve nerve root C5. Because of this, the medical adviser did not agree with Dr. Sullivan regarding an award for the C5 nerve root. However, he did not provide rationale to explain this conclusion. The Office medical adviser did not explain why the fusion at C5 would not involve that nerve root. Accordingly, the case will be remanded for further development.

On remand, the Office should refer appellant, together with the case record and statement of accepted facts, to an appropriate Board-certified specialist for an evaluation and calculation of her work-related impairment of her right upper extremity based on correct application of the fifth edition of the A.M.A., *Guides*. After such further development as it deems necessary, the Office shall issue a *de novo* decision.

LEGAL PRECEDENT -- ISSUE 2

The larynx is a scheduled member of the body for which an award is payable for 160 weeks for a total impairment.[23] Under the A.M.A. *Guides*, impairment to the larynx is

[17] *Id*. at 604.

[18] *Id*. at 488.

[19] *Id.*

[20] *Id*. at 490.

[21] *Id*. at 489, 490.

[22] *Id*. at 490.

[23] 20 C.F.R. § 10.304(b). *See* 5 U.S.C. § 8107(c)(22).

determined by impairment of a claimant's ability to speak.[24] For voice and/or speech impairments, the classifications in Table 11-8 and Table 11-9 should be used. The impairment ratings for speech and/or voice impairments are not evaluated separately. The degree of impairment of speech and/or voice is equivalent to the greatest percentage of impairment recorded in any one of the three sections (audibility, intelligibility, or functional efficiency) of the classification chart (Table 11-8).[25]

ANALYSIS -- ISSUE 2

The Office accepted appellant's claim for paralysis of the right vocal cord and authorized treatment with an ear, nose and throat specialist.

In an April 25, 2006 report, Dr. Steinig utilized the fifth edition of the A.M.A., *Guides* laryngeal impairment. He explained that after she underwent a right anterior cervical discectomy and allograft fusion on March 7, 2003 appellant lost her voice. Dr. Steinig noted that it had returned but, that she still had a raspy quality to it. He advised that appellant had difficulty singing and could not hold a note in a higher octave, but that she was able to eat and drink. Dr. Steinig examined appellant and advised that a flexible fiber optic nasopharyngolaryngoscopy of the larynx revealed a "complete paralysis" of the right vocal cord which was secondary to the anterior cervical discectomy. On July 10, 2006 he opined that she fell into a Class I impairment for voice and speech, under Table 11-8.

The Office medical adviser reviewed Dr. Steinig's report and also referred to Table 11-8.[26] He opined that appellant fell into Class I category for which 0 to 14 percent impairment is allowed. The medical adviser agreed with Dr. Steinig, in that she had 14 percent speech impairment. The Board notes that a Class I category under this table would include audibility such that an individual can produce speech of an intensity sufficient for most needs of every day speech, although this sometimes may require effort and occasionally may be beyond the individual's capacity.[27] This is consistent with Dr. Steinig's observation that appellant had raspy quality to her speaking voice. The Board finds that both Dr. Steinig and the Office medical adviser properly provided an opinion on impairment that is consistent with Class I in Table 11-8. The evidence does not suggest a greater impairment. The Board finds that there is no other medical evidence of record based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than a 14 percent impairment of the larynx for which she received a schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision regarding appellant having a nine percent impairment of her right upper extremity for which she received a schedule award.

[24] A.M.A., *Guides*, 264-271. *See also Martin J. Epp*, 38 ECAB 855, 858-59 (1987).

[25] AM.A., *Guides* 265.

[26] *Id*.

[27] *Id*.

The Board also finds that she has no more than a 14 percent impairment of the larynx, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 15, 2006 is set aside and the case remanded for further development consistent with this decision. The decision of the Office dated July 19, 2006 is affirmed.

Issued: November 3, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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