United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 08-1807**
	)	**Issued: February 4, 2009**
DEPARTMENT OF AGRICULTURE, FOOD SAFETY & INSPECTION SERVICE, Minneapolis, MN, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On June 10, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' hearing representative schedule award decision dated March 5, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained more than a 14 percent permanent impairment of his left upper extremity.

FACTUAL HISTORY

On January 23, 2006 appellant, then a 54-year-old import surveillance liaison officer, filed a traumatic injury claim alleging that, while in the performance of duty on January 19, 2006, he sustained injuries to his left shoulder, neck, arm and upper back as a result of slipping on ice on the floor as he came into the door of the warehouse freezer.

On June 9, 2006 the Office accepted the claim for herniated cervical disc at C5-6 and C5-6 anterior microdiscectomy with fusion and instrumentation surgery on April 10, 2006.

On June 30, 2007 appellant completed a Form CA-7 claim for a schedule award. In support of his claim, he submitted a December 7, 2006 report from Dr. Nicholas Diamond, a Board-certified osteopath, specializing in osteomanipulative medicine. Dr. Diamond noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, 166 (5th ed. 2001) (A.M.A., *Guides*). He noted that appellant had difficulty performing activities of daily living such as his household chores, cooking, cleaning and personal hygiene. Dr. Diamond also advised that appellant could no longer lift using the left upper extremity and that fine dexterity, pulling, pushing and gripping utilizing the left hand was difficult. He also noted that appellant denied difficulty with fine dexterity or grasping objects involving the right upper extremity, denied any decreased gripping strength or clumsiness involving the left hand. For the left shoulder, Dr. Diamond advised that appellant had acromioclavicular tenderness, anterior cuff tenderness and restricted range of motion, painful forward elevation, adduction and cross over adduction and internal rotation. He noted for manual muscle strength that testing of the supraspinatus was graded at 4/5 on the left and deltoid testing was graded at 4/5 bilaterally. Dr. Diamond provided findings for grip strength, pinch key testing and two-point discrimination. He advised that, for the left upper extremity, appellant had 4/5 motor strength deficit for the left deltoid equal to nine percent,[1] 4/5 motor strength deficit of the left supraspinatus of four percent,[2] a Grade 2 sensory deficit for the left C6 nerve root of 6 percent[3] and left grip strength deficit of 30 percent.[4] Dr. Diamond combined the above values and opined that appellant had an impairment of 42 percent to the left upper extremity. He opined that appellant reached maximum medical improvement on December 7, 2006.[5]

In a report dated July 28, 2007, the Office medical adviser noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He initially noted that Dr. Diamond incorrectly provided calculations for individual muscles as opposed to nerve root calculations as required by the A.M.A., *Guides.* The Office medical adviser noted that Dr. Diamond provided

[1] A.M.A., *Guides* 484 & 497, Tables 16-11 & 16-15.

[2] *Id.*

[3] A.M.A., *Guides* 424, Tables 15-15 & 15-17.

[4] A.M.A., *Guides* 509, Table 16-34.

[5] The physician also provided an impairment rating for the right upper extremity, noting that appellant had a 4/5 motor strength deficit of the right deltoid equal to 9 percent and a pain-related impairment of 3 percent, which he combined for a 12 percent impairment to the right upper extremity.

an impairment rating for weakness and sensory deficit; however, he explained that Table 16.8a of the A.M.A., *Guides* precluded utilizing strength measurements in the presence of painful conditions.[6] He also noted that Dr. Diamond recommended an impairment rating for appellant's right upper extremity, however; there was no evidence of strength deficit or pain. The Office medical adviser noted that appellant denied difficulty with fine dexterity or grasping objects involving the right hand and difficulty with pushing or pulling of the right upper extremity. He also noted that appellant had pain in the cervical spine of 4-8/10 for the left upper extremity and pain in the right upper extremity of 0-5/10 despite the absence of neurologic deficits or abnormalities. The Office medical adviser referred to Table 15-17 and advised that, for the C6 nerve root, appellant was entitled to a maximum percentage loss of function due to sensory deficit or pain of 8 percent and 35 percent for loss of function due to strength.[7] He referred to Table 15-15 and explained that, Grade 2 sensory loss for the nerve root at C6 provided by Dr. Diamond would equate to 80 percent.[8] The maximum 8 percent for C6 combined with 80 percent sensory loss equaled a 6 percent sensory deficit. The Office medical adviser also referred to Table 15-16 and noted a Grade 4 motor deficit of 25 percent.[9] He explained that the 25 percent motor deficit multiplied by 35 percent loss of function due to strength[10] was equal to 9 percent for motor loss of C6. The Office medical adviser referred to the Combined Values Chart and explained that 9 percent motor deficit combined with 6 percent sensory deficit was equal to an impairment of 14 percent.[11] He noted that appellant reached maximum medical improvement on December 7, 2006.

By decision dated September 7, 2007, the Office awarded appellant compensation for 43.68 weeks from December 7, 2006 through October 8, 2007 based upon a 14 percent permanent impairment of the left upper extremity.

By letter dated September 12, 2007, appellant's representative requested a hearing, which was held on December 12, 2007. During the hearing, appellant's attorney alleged that the Office medical adviser provided insufficient rationale regarding appellant's grip strength. He also stated that additional development of the medical evidence was required.[12]

[6] A.M.A., *Guides* 508.

[7] A.M.A., *Guides* 424.

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] A.M.A., *Guides* 604.

[12] Appellant's attorney indicated that appellant had received a retroactive promotion and that the schedule award needed to be recomputed to reflect the change in his pay rate, as of September 18, 2005. He provided a copy of a settlement agreement, which revealed that appellant received a retroactive promotion to GS-12/step 5 on September 18, 2005. The Office also received a salary schedule.

By decision dated March 5, 2008, the Office hearing representative affirmed the Office's September 7, 2007 decision.[13]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[14] and its implementing regulation[15] 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 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 implementing regulations as the appropriate standard for evaluating schedule losses.[16]

ANALYSIS

In support of his claim for a schedule award, appellant provided a December 7, 2006 report from his treating physician, Dr. Diamond, a Board-certified osteopath, specializing in osteomanipulative medicine. Dr. Diamond noted appellant's history of injury and treatment and utilized the A.M.A., *Guides*. Regarding activities of daily living, he noted that appellant had difficulty with the left upper extremity but noted that appellant denied any difficulty regarding the right upper extremity. Dr. Diamond provided findings for the left shoulder, which included painful motion. He determined that testing of the supraspinatus was graded at 4/5 on the left and deltoid testing was graded at 4/5 bilaterally. Dr. Diamond advised that appellant had 4/5 motor strength deficit for the left deltoid equal to 9 percent,[17] 4/5 motor strength deficit of the left supraspinatus of 4 percent,[18] a Grade 2 sensory deficit for the left C6 nerve root of 6 percent[19] and left grip strength deficit of 30 percent.[20] Dr. Diamond combined the above values and opined that appellant had an impairment of 42 percent to the left upper extremity. He opined that appellant reached maximum medical improvement on December 7, 2006.

The Board initially notes that a claimant is not entitled to a schedule award for the back as neither the Act nor the Office's regulations provide for the payment of a schedule award for

[13] The Office hearing representative recognized that action was necessary to recompute appellant's compensation using an increased pay rate, in effect, as of September 18, 2005 in accordance with an EEOC settlement.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

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

[17] *Id.* at 484 & 497, Tables 16-11 & 16-15.

[18] *Id.*

[19] *Id*. at 424, Tables 15-15 & 15-17.

[20] *Id*. at 509, Table 16-34.

the permanent loss of use of the back.[21] However, an award may be payable for permanent impairment of the lower extremities that is due to an employment-related back condition.[22] Section 15.12 of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities as follows. The nerves involved are to be first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity.[23] The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve. Dr. Diamond incorrectly utilized muscles instead of nerve roots for his first two findings above.[24] The Board notes that he correctly explained his finding of 6 percent for the left C6 nerve root. The Board notes that a Grade of 2 would equate to an 80 percent sensory deficit, which when multiplied by 8 percent, the maximum loss of function due to sensory deficit or pain, would result in 6.4 percent impairment.[25] It is proper Office policy to round the calculated percentage of impairment to the nearest whole number.[26] Fractions are rounded down from 0.49 and up from 0.50.[27] The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Only in rare cases should grip strength be used and only when it represents an impairing factor that has not been otherwise considered adequately.[28]

In a report dated July 28, 2007, the Office medical adviser noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He explained that Dr. Diamond incorrectly provided calculations for individual muscles as opposed to nerve root calculations as required by the A.M.A., *Guides*.[29] The Office medical adviser also explained, as noted above, that section 16.8a of the A.M.A., *Guides* precluded utilizing strength measurements in the presence of painful conditions.[30] He referred to Table 15-17 and advised that, for the C6 nerve root, appellant was entitled to a maximum percentage loss of function due to sensory deficit or pain of 8 percent and 35 percent for loss of function due to strength.[31] The Office medical

[21] *George E. Williams*, 44 ECAB 530 (1993).

[22] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[23] A.M.A., *Guides* 423-24.

[24] The left deltoid and the supraspinatus.

[25] A.M.A., *Guides* 424.

[26] *J.Q.*, 59 ECAB ___ (Docket No. 06-2152, issued March 5, 2008).

[27] *Carl J. Cleary*, 57 ECAB 563 (2006).

[28] *Mary L. Henninger*, 52 ECAB 408 (2001).

[29] *See supra* note 23.

[30] A.M.A., *Guides* 508.

[31] *Id*. at 424.

adviser referred to Table 15-15 and explained that a Grade 2 sensory loss for the nerve root at C6 provided by Dr. Diamond would equate to 80 percent. The maximum 8 percent multiplied by 80 percent sensory deficit equals 6.4 percent, when rounded down, resulted in a 6 percent sensory deficit.[32] He also referred to Table 15-16 and explained that the Grade 4 motor deficit would equate to 25 percent motor deficit.[33] The Office medical adviser explained that 25 percent multiplied by 35 percent, the maximum percentage loss of function due to strength, was equal to 8.75, which when rounded up, was equal to 9 percent for motor loss of C6.[34] He referred to the Combined Values Chart and explained that 9 percent combined with 6 percent was equal to an impairment of 14 percent.[35] The Office medical adviser noted that appellant reached maximum medical improvement on December 7, 2006.[36]

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 permanent impairment of the left upper extremity for which she received a schedule award or an impairment of the left upper extremity. Accordingly, the Board finds that appellant has no more than a 14 percent permanent impairment of the left upper extremity.

On appeal, appellant's representative alleged that he suffered from greater than 14 percent impairment to the left upper extremity and that he sustained more than 0 percent impairment to the right upper extremity. However, as noted above, there is no medical evidence of record to support greater than the 14 percent permanent impairment of the left upper extremity. The Board notes that this does not preclude appellant from submitting relevant medical evidence to the Office in support of a request for an additional schedule award. Regarding the right upper extremity, the Board notes that the Office did not issue a final decision and therefore the Board does not have jurisdiction over the matter.[37]

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a 14 percent permanent impairment of his left upper extremity.

[32] *See supra* note 25.

[33] *See supra* note 29.

[34] *See supra* note 25.

[35] A.M.A., *Guides* 604.

[36] Regarding the right upper extremity, the Office medical adviser indicated that there was no evidence of strength deficit or pain and noted that Dr. Diamond indicated that appellant denied difficulty with fine dexterity or grasping objects involving the right hand and difficulty with pushing or pulling of the right upper extremity. Additionally, he explained that although appellant had subjective complaints of in the right upper extremity there was an absence of neurologic deficits or abnormalities.

[37] *See* 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 5, 2008 is affirmed.

Issued: February 4, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board