United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
	)	
and	)	**Docket No. 10-1870**
	)	**Issued: May 20, 2011**
NUCLEAR REGULATORY COMMISSION, Rockville, MD, Employer	)	
	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 7, 2010 appellant filed a timely appeal from the January 8, 2010 merit decision of the Office of Workers' Compensation Programs which granted him a schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant established that he has more than eight percent impairment of the right arm, five percent impairment of the left arm and three percent impairment of the left leg.

HISTORY

On January 22, 2001 appellant, then a 55-year-old nuclear engineer, filed a traumatic injury claim alleging that on January 3, 2001 he injured his neck, shoulder and low back when he

[1] 5 U.S.C. §§ 8101-8193.

fell out of his chair at work. He stopped work on January 5, 2001 and was granted disability retirement in November 2002. The Office accepted a cervical strain, displacement of a cervical intervertebral disc without myelopathy, spinal stenosis of the cervical region, intervertebral disc disorder with myelopathy and left thoracic outlet syndrome.[2]

A magnetic resonance imaging (MRI) scan of the lumbar spine dated April 29, 1999 revealed a herniated disc at L3-4 impressing upon the left L3 nerve root, a central herniated disc at L4-5 impressing upon the thecal sac and a right paracentral herniated disc at L5-S1 impressing upon the right thecal sac at the right S1 nerve root. A January 18, 2001 cervical spine MRI scan that showed central canal spinal stenosis due to bulging disc at C5-6 with flattening of the spinal cord, moderated central canal and bilateral neural foraminal stenosis at C6-7 with flattening of the spinal cord secondary to bulging disc and mild central canal spinal stenosis at C3-4 and C4-5 secondary to bulging disc. A June 18, 2001 electromyogram (EMG) revealed no abnormalities while a July 9, 2002 EMG showed findings suggestive of right carpal tunnel syndrome but no evidence of radiculopathy. An MRI scan of the cervical spine on December 9, 2002, revealed multilevel cervical spondylosis worse at C5-6 with posterior osteophyte formation with changes to a lesser degree at C6-7 and C3-4.

On November 19, 2002 appellant filed a claim for a schedule award. On May 12, 2003 the Office requested that appellant's treating physician provide an impairment evaluation in accordance with the fifth edition of the of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3]

In a July 17, 2003 report, Dr. Elizabeth M. Kilgore, a Board-certified physiatrist, advised that appellant sustained a 29 percent permanent impairment of the cervical spine in accordance with the A.M.A., *Guides*. Dr. Kilgore reviewed his history and diagnosed cervical spinal stenosis with multilevel degenerative disc disease, lumbar radiculopathy, multilevel disc herniations, thoracic outlet syndrome of the left upper extremity, chronic pain syndrome and obesity. She noted an intact neurological examination, normal motor examination of the right upper extremity, mild giveaway weakness of the left shoulder muscles with pain, intact sensory examination in the upper extremities and decreased grip strength in the left hand. Dr. Kilgore noted limited cervical range of motion, tenderness over the cervical paraspinals, normal reflexes in the upper and lower extremities and sensory deficit in the left lateral leg in the dermatomal distribution to pinprick. She opined that pain-related impairment was more accurately reflected the extent of appellant's impairment than the conventional impairment rating of either the upper or lower extremities or the spine diagnosis-related estimate method.[4] Appellant fit the pain criteria under 18.3d of the A.M.A., *Guides* and his total pain-related impairment score was 69 under Table 18-6, page 584 of the A.M.A., *Guides*. She noted that all four limbs were involved which impacted the severity of the pain rating. Dr. Kilgore opined that appellant had a 15 percent impairment of the cervical spine, 13 percent impairment of the lumbar spine and 3

[2] Appellant filed a separate claim for a work injury which occurred on September 15, 1996 and was accepted by the Office for aggravation of intervertebral disc, Claim No. xxxxxx045. This claim was consolidated with the current claim before the Board.

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

[4] *Id.* at 574, Figure 18-1.

percent impairment for pain for 29 percent impairment rating. She noted that appellant had reached maximum medical improvement.

In a November 15, 2004 report, an Office medical adviser determined appellant's impairment in accordance with the A.M.A., *Guides.* He noted that the January 18, 2001 MRI scan which revealed a centrally herniated disc at C5-6 and a right-sided disc herniation at C6-7 and a 1999 MRI scan which revealed pathology at L2-3 with nerve root impingement at L3. The medical adviser noted that appellant had three percent impairment for Grade 3 sensory deficit or pain in the L3 nerve root in the left lower extremity.[5] With regard to the arms, he noted that appellant had an impairment rating due to a central disc herniation at C5-6. Appellant had five percent impairment for Grade 3 sensory deficit or loss in the C6 nerve root in the left arm.[6] The medical adviser noted that the C5-6 disc herniation was centrally located and the right arm was also affected. Appellant had five percent impairment for Grade 3 sensory deficit or loss in the C6 nerve root in the right arm.[7] The medical adviser further noted that appellant had a right-sided disc at C6-7 causing unilateral impairment at the C7 nerve root on the right. He noted that appellant had three percent impairment for Grade 3 sensory deficit or loss in the C7 nerve root in the right arm.[8] The medical adviser concluded that appellant had eight percent impairment of the right arm, five percent impairment of the left arm and three percent impairment for the left leg under the A.M.A., *Guides*.

In a decision dated December 29, 2004, the Office granted appellant schedule awards for eight percent impairment of the right arm and five percent impairment of the left arm. The period of the schedule award was from November 15, 2004 to August 25, 2005.

On January 29, 2005 appellant asserted that he had greater impairment than that which was granted by the Office. He contended that the Office medical adviser improperly denied pain-related impairment as set forth by Dr. Kilgore without explanation.

On May 12, 2005 the Office requested clarification from the Office medical adviser. In a May 17, 2005 statement, the medical adviser noted that Dr. Kilgore's impairment rating was not appropriate because she rated impairment of the spine and not of the extremities. He advised that Dr. Kilgore's ratings of the cervical and lumbar spine were not acceptable.

In a July 8, 2005 letter, the Office requested that Dr. Kilgore clarify her impairment rating. In a July 28, 2005 report, Dr. Kilgore noted that appellant had reached maximum medical improvement at the time of her evaluation. She stated that the rating she provided related more to pain impairment and allowed inclusion of the extremities.

In an August 12, 2005 decision, the Office denied modification of the December 29, 2004 decision.

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[5] *Id.* at 424, Table 15-15, Table 15-18.

[6] *Id.* at 424, Table 15-15, Table 15-17.

[7] *Id.* at 424, Table 15-15, Table 15-17.

[8] *Id.*

On November 1, 2005 appellant appealed to the Board. In a November 29, 2006 order, the Board remanded the case for reconstruction of the record and proper assemblage.[9]

On February 27, 2007 the Office requested that the Office medical adviser address whether appellant had three percent impairment for pain as set forth in Dr. Kilgore's July 13, 2003 report. On April 6, 2007 the Office medical adviser stated that Dr. Kilgore used Chapter 18 of the A.M.A., *Guides* for pain-related impairment totaling 29 percent and based this determination on a finding of severe pain involving four limbs and thoracic outlet syndrome. He noted that appellant's condition was not accepted for all four limbs. The medical adviser opined that Dr. Kilgore based her rating on pain-related impairment which did not relate to appellant's accepted conditions.

In a decision dated April 27, 2007, the Office denied modification of the December 29, 2004 decision.

In a decision dated June 7, 2007, the Office granted appellant a schedule award for three percent permanent impairment to the left leg. The period of the schedule award was from November 15, 2004 to January 14, 2005. On May 9, 2008 appellant requested reconsideration.

Appellant requested reconsideration and submitted an August 5, 2005 report from Dr. Dennis Kleban, a Board-certified otolaryngologist, who treated him for allergies.

On August 18, 2008 appellant appealed to the Board. In a September 16, 2009 order, the Board remanded the case to the Office to issue an appropriate decision consistent with its procedures and Board precedent.[10]

In a January 8, 2010 decision, the Office denied modification of its prior schedule award decisions, finding that the medical evidence did not support greater impairment.

LEGAL PRECEDENT

The schedule award provision of the Act[11] and its implementing regulations[12] set 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

[9] Docket No. 06-184 (issued November 2, 2005).

[10] Docket No. 08-2372 (issued September 16, 2009).

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404 (1999).

appropriate standard for evaluating schedule losses. For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[14] Neither the Act nor the implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back, spine or the body as a whole. A claimant is not entitled to such a schedule award.[15] The Board notes that section 8109(19) specifically excludes the back from the definition of "organ."[16] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originates in the back or spine.[17]

ANALYSIS

On appeal, appellant contends that he has greater impairment than what was granted by the Office. The Office granted schedule awards for eight percent impairment of the right arm, five percent impairment of the left arm and three percent impairment for the left leg.

In support of his claim, appellant submitted reports from Dr. Kilgore dated July 17, 2003 and July 28, 2005. The Board notes that Dr. Kilgore did not address permanent impairment of the upper or lower extremities in accordance with the A.M.A., *Guides*. Dr. Kilgore rated appellant's impairment in terms of the back or spine. As noted, the Act does not allow for a schedule award based on impairment to the back or spine. Although Dr. Kilgore noted that her pain-related spine impairment rating allowed for inclusion of the extremities, she did not explain how she rated any impairment to the extremities pursuant to the A.M.A., *Guides*. She also rated impairment based on pain under Chapter 18 of the A.M.A., *Guides*.[18] The Board has held that physicians should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[19] Dr. Kilgore did not explain why appellant's pain could only be rated under Chapter 18 instead of under provisions in the A.M.A., *Guides* pertaining to the upper and lower extremities. As Dr. Kilgore did not properly use the A.M.A., *Guides* to rate appellant's impairment, her opinion is of diminished probative value.[20]

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[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). As of May 1, 2009, the sixth edition will be used. FECA Bulletin No. 09-03 (issued March 15, 2009).

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

[15] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[16] 5 U.S.C. § 8109(c).

[17] *Thomas J. Engelhart, supra* note 14.

[18] A.M.A., *Guides* 574, Figure 18-1.

[19] *See Frantz Ghassan*, 57 ECAB 349 (2006); *Linda Beale*, 57 ECAB 429 (2006).

[20] *See Richard A. Neidert*, 57 ECAB 474 (2006) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

The Office medical adviser reviewed Dr. Kilgore's findings to rate impairment to appellant's upper and lower extremities. The medical adviser calculated that appellant had three percent impairment of the left leg for sensory deficit or pain in the distribution of the L3 nerve root, under Table 15-15 and Table 15-18 of the A.M.A., *Guides*.[21] He advised that, for sensory deficit or pain, appellant would be classified as Grade 3, for a 60 percent grade for sensory deficit or pain,[22] in the distribution of L3 nerve root.[23] The A.M.A., *Guides* provides that the maximum allowed for total impairment of the L3 nerve root is five percent. The Board notes that when the maximum for the L3 nerve root, 5 percent is multiplied by the 60 percent allowed for a Grade 3 sensory deficit, this yields 3 percent impairment for sensory loss.[24] With regard to the upper extremities, the medical adviser calculated a five percent impairment of the left and right upper extremities for sensory deficit or pain in the distribution of the C6 nerve root, under Table 15-15 and Table 15-17 of the A.M.A., *Guides*.[25] He advised that, for sensory deficit or pain, appellant would be classified as Grade 3, for a 60 percent grade for sensory deficit or pain,[26] in the distribution of C6 nerve root.[27] The A.M.A., *Guides* provides that the maximum allowed for total impairment of the C6 nerve root is eight percent. The Board notes that, when the maximum for the C6 nerve root, 8 percent, is multiplied by the 60 percent allowed for a Grade 3 sensory deficit, this yields 4.8 percent impairment rounded up to 5 percent for sensory loss.[28] The medical adviser further noted that appellant had a right-sided disc herniation at C7 resulting in unilateral impairment of the C7 nerve root on the right side for which appellant would be entitled to an impairment rating. He found three percent impairment of the right arm for sensory deficit or pain in the distribution of the C7 nerve root, under Table 15-15 and Table 15-17 of the A.M.A., *Guides*.[29] The medical adviser advised that, for sensory deficit or pain, appellant would be classified as Grade 3, for a 60 percent sensory deficit or pain,[30] in the C7 nerve root distribution.[31] The A.M.A., *Guides* provides that the maximum allowed for total impairment of the C7 nerve root is five percent. When the maximum for the C7 nerve root, 5 percent, is multiplied by the 60 percent allowed for a Grade 3 sensory deficit, this yields 3 percent impairment for sensory loss.[32]

[21] A.M.A., *Guides* 424, Figure 15-15, Figure 15-18.

[22] *Id.* at 424, Figure 15-15.

[23] *Id.* at 424, Figure 15-18.

[24] *Id.*

[25] *Id.* at 424, Figure 15-15, Figure 15-17.

[26] *Id.* at 424, Figure 15-15.

[27] *Id.* at 424, Figure 15-17.

[28] *Id.*

[29] *Id.*

[30] *Id.* at 424, Figure 15-15.

[31] *Id.* at 424, Figure 15-17.

[32] *Id.*

Appellant submitted no other medical evidence which conforms to the A.M.A., *Guides* and which supports a greater impairment than that which was granted by the Office.

CONCLUSION

The Board finds that appellant has no more than eight percent impairment of the right upper extremity, five percent impairment of the left upper extremity and three percent impairment for the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 8, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 20, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

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