United States Department of Labor
Employees' Compensation Appeals Board

C.E., Appellant	)	
and	)	**Docket No. 11-637**
	)	**Issued: October 14, 2011**
DEPARTMENT OF JUSTICE, FEDERAL CORRECTIONAL INSTITUTION, El Reno, OK, 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 January 13, 2011 appellant filed a timely appeal from the December 2, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP), which increased his schedule award. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

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

FACTUAL HISTORY

On February 22, 1993 appellant, a 28-year-old correctional officer, sustained an injury while training in the performance of duty: "While lifting 225 pounds on a bench press, I felt

[1] 5 U.S.C. § 8101 *et seq.*

something give way in my upper back and immediately was in pain." He underwent multiple surgeries. OWCP accepted appellant's claim for thoracic sprain, cervical strain, closed dislocation of C6, an open fracture of the cervical vertebra without spinal cord injury, limb pain, brachial neuritis or radiculitis not otherwise specified and postlaminectomy syndrome of the cervical region. In 2002 appellant received a schedule award for four percent impairment of each upper extremity.

In 2010 appellant filed a claim for an increased permanent impairment. Dr. John W. Ellis, a Board-certified family physician, evaluated appellant and diagnosed, among other things, bilateral C6-8 spinal nerve root impairment. He estimated a 41 percent impairment of each upper extremity using ratings for brachial plexus injury.[2] OWCP's medical adviser observed that Dr. Ellis found weakness of the upper extremities, shoulders, elbows and wrists, but appellant's attending physician reported a 5/5 motor examination (no weakness) throughout both upper extremities. The medical adviser recommended a second opinion examination for an accurate assessment of motor function.

OWCP referred appellant to Dr. M. Shawn Smith, Board-certified in physical medicine and rehabilitation, who reviewed appellant's medical records and related his history of injury and medical treatment. Current complaints included some decreased grip strength bilaterally, some weakness in his biceps and some numbness in his hands. Dr. Smith noted that all records indicated persistent paresthesias bilaterally but were mixed on the issue of muscle strength. Findings on physical examination included slight weakness in the biceps 4+/5 bilaterally, "but it is very subtle." There was also decreased grip strength bilaterally. Dr. Smith further found decreased light touch and two-point discrimination in the median distribution bilaterally and, on the right, in some of the ulnar distribution as well. He diagnosed C6-7 disc herniation with bilateral radiculopathy and subsequent C5-7 fusion with previous pseudoarthrosis with permanent upper extremity dysesthesias and some persistent weakness.

Dr. Smith rated appellant's upper extremity impairment using the tables and procedures developed by the American Medical Association for rating impairment due to spinal nerve injury. Based on appellant's history, examination and previous electrodiagnostic findings, he determined that appellant's bilateral impairment was due to radiculopathy in the C6 nerve distribution. The default impairment value for a mild sensory deficit of the C6 nerve root was one percent. As appellant's functional history showed a severe problem and imaging studies showed moderate pathology, Dr. Smith adjusted the default impairment value to two percent, which was the maximum impairment rating possible for a mild sensory deficit of the C6 nerve root. Likewise, he increased the default impairment value for motor deficit to nine percent, the maximum impairment rating possible. Combining the sensory and motor impairments, Dr. Smith concluded that appellant had an 11 percent impairment of each upper extremity.

In a decision dated December 2, 2010, OWCP issue a schedule award for an additional seven percent impairment of each upper extremity, less he had already received for four percent on each side.

[2] Dr. Ellis did not explain how he used to the table to obtain impairments of C6, C7 or C8.

On appeal, appellant contends that Dr. Smith did not read the records given to him properly: the injury was not only to the C6 vertebra but resulted in surgery with plates and screws to C5-7. He offered several corrections to Dr. Smith's report: he was injured training, not playing; he worked in El Reno, not Weatherford; and "elect" bone graft should be "iliac" bone graft. Appellant stated that an electromyogram (EMG) is not normal if it suggests compression of the median nerves, and he adds that subtracting 4 percent for a previous award would leave him with a total rating of 18 percent, not the 14 percent OWCP decided.

LEGAL PRECEDENT

FECA authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body.[3] Such loss or loss of use is known as permanent impairment. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[4]

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[5] Neither FECA nor the implementing regulations authorize the payment of a schedule award for the permanent loss of use of the back or spine.[6] A claimant is not entitled to such an award.[7]

ANALYSIS

The sixth edition of the A.M.A., *Guides* do not provide a separate mechanism for rating spinal nerve injury as extremity impairment; radiculopathy was reflected in the spinal rating process, which FECA does not recognize. Impairment to the upper extremities caused by a spinal injury should be rated, therefore, consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July/August 2009 edition of *The Guides Newsletter* published by the American Medical Association and adopted by OWCP.[8]

Dr. Ellis, the family physician who rated 41 percent impairment of each upper extremity, diagnosed spinal nerve root impairment but did not rate the impairment under the tables and procedures set out in the American Medical Association's newsletter on spinal nerve injury.

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[5] *William Edwin Muir*, 27 ECAB 579 (1976).

[6] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

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

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1.5 (January 2010).

Instead, he used a table in the sixth edition that was intended for brachial plexus injury. For this reason, his estimate of appellant's impairment is of diminished weight.

Dr. Smith, the second opinion physiatrist, applied the proper table and procedures. Based on appellant's history, examination and previous electrodiagnostic findings, he identified radiculopathy in the C6 nerve root distribution, and he assessed the deficits as mild. He then properly adjusted the default impairment values for the effect on appellant's functional capacity and the extent of pathology shown on clinical studies. Dr. Smith gave appellant the highest impairment rating possible for mild sensory deficit of the C6 nerve root and the highest impairment rating possible for any kind of motor deficit of the C6 nerve root. These ratings, 2 percent and 9 percent respectively, combined for an 11 percent impairment of each upper extremity. As appellant had already received schedule awards for a four percent impairment of each upper extremity, OWCP properly awarded compensation for an additional seven percent impairment on each side.

The Board finds that appellant has no more than an 11 percent impairment of each upper extremity resulting from sensory and motor deficits of the C6 nerve root. Dr. Smith properly evaluated the impairment, and OWCP properly compensated appellant for his increased impairment. The Board will therefore affirm the December 2, 2010 schedule award.

Appellant expressed concern that Dr. Smith seemed to focus only on the C6 vertebra, while the record shows surgery with plates and screws from C5 through C7. He underwent surgery involving multiple cervical vertebrae, but that does not mean there was an injured nerve root at each of those levels contributing to the impairment of his upper extremities. The source of any radiculopathy resulting from appellant's multiple surgeries must be judged from his history, his physical examination and the results of clinical studies. Dr. Smith identified the C6 nerve root as the cause of the sensory and motor deficits in appellant's upper extremities. This is the first step in rating impairment for a spinal injury: identifying the involved nerve, not the involved vertebrae.

The several corrections appellant offered are not material to the impairment rating. Appellant was indeed training, he did work in El Reno, and the bone graft was taken from his iliac, not "elect" (a probable transcription error). Also, an EMG/nerve conduction study measures the electrical activity of muscles at rest and during contraction. The nerve conductions study measures how well and how fast the nerves can send electrical signals. So it is entirely possible, as Dr. Smith reported, that needle EMG examination can be within normal limits while nerve conduction studies show evidence suggestive of compression neuropathies.[9]

When adjusting for the prior schedule award, OWCP must subtract four percent from Dr. Smith's rating of the right upper extremity and four percent from his rating of the left. A schedule award is granted for permanent impairment of members identified under section 8107, or each arm in this case. OWCP correctly subtracted four percent from the impairment to each upper extremity (11 minus 4 equals 7). It properly awarded compensation based on each upper extremity impairment.

[9] This is exactly what Dr. Michael A. Tribbey found in his September 6, 2005 EMG and nerve conduction study.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than an 11 percent impairment of each upper extremity, for which he received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the December 2, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 14, 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