United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	
DEPARTMENT OF VETERANS AFFAIRS, JAMES A. HALEY VETERANS ADMINISTRATION HOSPITAL, Tampa, FL, Employer	)	**Docket No. 07-337** **Issued: November 19, 2007**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 20, 2006 appellant filed a timely appeal of the April 26, 2006 merit decision of the Office of Workers' Compensation Programs and an October 18, 2006 decision of an Office hearing representative, finding that she had no more than a 12 percent impairment of the left upper extremity, for which she received a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than a 12 percent impairment of the left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On May 15, 1998 appellant, then a 35-year-old program support assistant, filed a traumatic injury claim. On that date she slipped and fell on sand that was on the floor at work.

Appellant fell on her left arm/elbow, her right hand bumped the back of her head and she twisted her right knee. The Office accepted her claim for cervical sprain/strain, herniated disc at L4-5, contusion of the left elbow, lumbar strain, neurotic depression (dysthymic disorder), cervical disc rupture and reparative fusion and radial tunnel syndrome.

To determine whether appellant had any continuing residuals of her accepted employment injuries the Office, by letter dated January 22, 2004, referred her along with a statement of accepted facts, the case record and a list of questions to be addressed to, Dr. Adam S. Bright, a Board-certified orthopedic surgeon, for a second opinion medical examination. In a February 6, 2004 medical report, Dr. Bright provided his loss of motion and grip strength findings on physical examination and his findings on x-ray examination. He opined that appellant sustained a herniated disc at C4-5 and C5-6 which resulted in nerve damage/radiculopathy in the left upper extremity, as well as, an injury to the left elbow with probable radial tunnel syndrome. Dr. Bright stated that she had residual stiffness inside the neck from fusion, weakness inside the arm from nerve damage and chronic pain. In an accompanying work capacity evaluation, he stated that appellant could not perform her regular work duties but she could work four hours per day with restrictions.

On February 9, 2004 appellant filed a claim for a schedule award.

On March 3, 2004 an Office medical adviser reviewed appellant's case record including Dr. Bright's February 6, 2004 findings. He found that appellant reached maximum medical improvement on February 6, 2004. The medical adviser determined that she sustained a 10 percent impairment of the left upper extremity based on Table 16 on page 509 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

By decision dated March 23, 2004, the Office granted appellant a schedule award for a 10 percent impairment of the left upper extremity based on the Office medical adviser's March 3, 2004 medical opinion. The period of the award was from February 22 through September 27, 2004.

The Office received a March 25, 2004 report of Dr. Jorge J. Inga, an attending Board-certified neurosurgeon, who provided a history of appellant's cervical conditions and medical treatment. Dr. Inga noted that a February 27, 2004 magnetic resonance imaging (MRI) scan of her cervical spine revealed status post vertebral body fusion at C4-5 and C5-6 and evidence of a left paracentral disc protrusion at C3-4 and a bulging disc at C6-7. He provided essentially normal findings on neurological examination. Dr. Inga opined that appellant was status post anterior cervical discectomies and fusion at C4-5 and C5-6 and she had a left paracentral disc protrusion at C3-4 and radial tunnel syndrome on the left side. In a March 31, 2004 report, he found that appellant was totally disabled and unable to engage in any type of gainful employment due to persistent residual cervical symptomatology and radial tunnel syndrome. Dr. Inga determined that she had a 6 percent impairment related to her cervical pathology, a 12 percent impairment related to pain in her upper extremities and a 14 percent impairment related to permanent partial loss of use of her left arm, wrist and elbow, totaling a 32 percent impairment of the whole body based on the A.M.A., *Guides*. He stated that appellant reached maximum medical improvement on January 4, 2001 and September 11, 2003.

On March 30, 2004 appellant requested a review of the written record by an Office hearing representative regarding the Office's March 23, 2004 decision.

By decision dated August 18, 2004, a hearing representative set aside the March 23, 2004 decision and remanded the case to the Office for further development of the medical evidence. He found that the Office medical adviser's impairment rating solely relied on loss of grip strength while other physicians of record including, Dr. Bright, reported numbness in appellant's left upper extremity. The hearing representative further found that earlier medical reports which indicated persistent swelling in this extremity were unaddressed by the medical adviser. He determined that the Office inappropriately advised the medical adviser not to recommend a second opinion medical examination. On remand, the hearing representative directed the Office to refer appellant and the case file to a second opinion medical examiner to determine the extent of permanent impairment of her left upper extremity based on the A.M.A., *Guides*.

By letter dated October 14, 2004, the Office referred appellant, along with a statement of accepted facts, the case record and a list of questions to be addressed to Dr. David H. Baras, a Board-certified physiatrist, for a second opinion medical examination. In an October 27, 2004 report, Dr. Baras found that appellant was status post anterior cervical discectomies and fusion at C4-5 and C5-6. He did not find evidence of any impairment involving her left upper extremity as a result of a work-related injury. Dr. Baras opined in an addendum report dated November 5, 2004 that appellant had no permanent impairment and there was no permanent impairment rating involving her left upper extremity.

On November 17, 2004 the Office issued a decision finding that appellant did not sustain any additional impairment of the left upper extremity based on Dr. Baras' opinion. On December 4, 2004 appellant requested an oral hearing before a hearing representative.

By decision dated October 27, 2005, a hearing representative set aside the November 17, 2004 decision and remanded the case to the Office for further medical development. He found that the Office failed to follow its procedures in finding that appellant had no additional impairment of the left upper extremity based on Dr. Baras' opinion without the benefit of having an Office medical adviser review his findings. Further, the hearing representative found that Dr. Baras did not specifically utilize the A.M.A., *Guides* in determining appellant's impairment rating. On remand, the hearing representative instructed the Office to refer appellant along with an updated statement of accepted facts and case record to a new Board-certified specialist in the appropriate medical area for a second opinion medical examination to determine the extent of her permanent impairment based on the A.M.A., *Guides*. He further instructed the Office to inform the referral physician that a schedule award had been previously granted to appellant for a 10 percent impairment of the left upper extremity. Lastly, the hearing representative directed the Office to refer the case record to a medical adviser upon receipt of the second opinion specialist's report.

By letter dated January 16, 2006, the Office referred appellant, together with an updated statement of accepted facts, the case record and a list of questions to be addressed to, Dr. Michael W. Meriweather, a Board-certified neurosurgeon, for a second opinion medical examination. In a February 23, 2006 report, Dr. Meriweather provided appellant's symptoms and history of her employment-related injuries and medical treatment. On physical examination,

he reported diminished sensation in the left arm involving the C4, C5, C6 and C7 nerves. Dr. Meriweather noted a well-healed scar on the left side of appellant's neck from previous cervical surgery. He reviewed MRI scans of her cervical spine which demonstrated fusion at the C4-5 and C5-6 levels and an unchanged left central disc protrusion at C3-4. Dr. Meriweather diagnosed status post anterior cervical discectomy with fusion at C4-5 and C5-6, a known central herniated nucleus pulpsous at C3-4, left arm weakness with numbness and chronic pain. He opined that in applying Table 15-15 on page 424 of the A.M.A., *Guides* to appellant's symptoms, she sustained a 12 percent impairment of the left upper extremity.

On March 14, 2006 an Office medical adviser reviewed appellant's medical records including, Dr. Meriweather's February 23, 2006 findings. The medical adviser opined that appellant reached maximum medical improvement on March 3, 2004. The medical adviser noted that Dr. Meriweather utilized Tables 15-15 and 15-17 on page 424 of the A.M.A., *Guides*. The medical adviser opined that, by multiplying the severity of sensory loss by the maximum impairment of each nerve, appellant sustained a 12 percent impairment of the left upper extremity. The medical adviser, therefore, determined that appellant had an additional two percent impairment above the previous 10 percent schedule award granted by the Office on March 3, 2004.

In a decision dated April 26, 2006, the Office granted appellant a schedule award for an additional 2 percent impairment based on the opinion of Dr. Meriweather and the Office medical adviser, totaling a 12 percent impairment of the left upper extremity. The Office noted that appellant previously received a schedule award for a 10 percent impairment of the left upper extremity. The period of the award was from April 16 through May 29, 2006.

On May 15, 2006 appellant requested a review of the written record by a hearing representative. In a letter dated May 19, 2006, she contended that Dr. Meriweather did not conduct a thorough examination. Appellant stated that no instruments were used to test the strength in her hand or arm. No measurements were taken in the swollen area of her forearm which had been present since her work-related fall. Appellant stated that she was not asked to turn her head to the left or right, noting that, if this had taken place, she would have shown loss of movement. She had to turn her body completely around to look behind herself. Appellant further stated that she was not asked about her symptoms and overall daily discomfort.

By decision dated October 18, 2006, the hearing representative affirmed the April 26, 2006 decision. He found that Dr. Meriweather and the Office medical adviser properly utilized the A.M.A., *Guides* in determining that appellant had a 12 percent impairment of the left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] sets forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[3] 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 for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[4]

Although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the back or spine.[5] In 1960 amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[6] An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized.[7]

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the protocols of the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[8]

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[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] 20 C.F.R. § 10.404.

[3] 5 U.S.C. § 8107(c)(19).

[4] *See supra* note 2.

[5] *Pamela J. Darling*, 49 ECAB 286 (1998).

[6] *Thomas J. Engelhart*, 50 ECAB 319 (1999). Section 15.12 of the fifth edition 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. The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve. A.M.A., *Guides* 424.

[7] *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

[8] *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

ANALYSIS

The Office accepted that appellant sustained cervical sprain/strain, herniated disc at L4-5, contusion of the left elbow, lumbar strain, neurotic depression (dysthymic disorder), cervical disc rupture and reparative fusion and radial tunnel syndrome in the performance of duty on May 15, 1998. On March 23, 2004 the Office granted appellant a schedule award for a 10 percent impairment of the left upper extremity. On April 26, 2006 the Office granted appellant a schedule award for an additional 2 percent impairment, totaling a 12 percent impairment of the left upper extremity.

In a March 31, 2004 report, Dr. Inga found that appellant was totally disabled and unable to engage in any type of gainful employment due to persistent residual cervical symptomatology and radial tunnel syndrome. He determined that she had a 6 percent impairment related to her cervical pathology, a 12 percent impairment related to the pain in her upper extremities and a 14 percent impairment related to permanent partial loss of use of her left arm, wrist and elbow, totaling a 32 percent impairment of the whole body based on the A.M.A., *Guides*. Dr. Inga, however, failed to specifically identify what section, table or figure of the A.M.A., *Guides* upon which he based his 32 percent impairment rating. Consequently, his opinion is of diminished probative value and is insufficient to establish that appellant has any greater left upper extremity impairment than that for which she has already received a schedule award.

Dr. Meriweather, an Office referral physician, examined appellant on February 23, 2006. On physical examination, he reported diminished sensation in the left arm involving the C4, C5, C6 and C7 nerves and a well-healed scar on the left side of appellant's neck from previous cervical surgery. Dr. Meriweather found that appellant was status post anterior cervical discectomy with fusion at C4-5 and C5-6 and that she had a known central herniated nucleus pulposus at C3-4, left arm weakness with numbness and chronic pain. He opined that she sustained a 12 percent impairment due to sensory loss of the left upper extremity (A.M.A., *Guides* 424, Table 15-15).

On March 14, 2006 the Office medical adviser reviewed Dr. Meriweather's report and agreed with the impairment rating. The medical adviser found that appellant reached maximum medical improvement on March 4, 2004. The medical adviser indicated that Dr. Meriweather utilized Tables 15-15 and 15-17 on page 424 of the A.M.A., *Guides*. The medical adviser opined that, by multiplying the severity of sensory loss by the maximum impairment of each nerve, appellant sustained a 12 percent impairment of the left upper extremity. The medical adviser concluded that appellant was entitled to an additional 2 percent impairment above the 10 percent schedule award she previously received.

Although Dr. Meriweather and the Office medical adviser stated that appellant sustained a 12 percent impairment for sensory loss and nerve impairment of the left upper extremity based on the A.M.A., *Guides*, they did not identify a grade of sensory deficit between 1 and 5 as set forth in Table 15-15 of the A.M.A., *Guides* or maximum impairment for sensory deficit of appellant's C5, C6 and C7 nerve roots based on Table 15-17 on page 424 of the A.M.A., *Guides*. Further, the Board notes that maximum impairment for sensory deficit of the C4 nerve root is not contained in Table 15-17. Accordingly, the Board finds that the record does not include a probative medical opinion on the nature and extent of appellant's impairment. The case will be

remanded to the Office for further development of the medical evidence, as appropriate, followed by a *de novo* decision regarding appellant's entitlement to an additional schedule award for her left upper extremity.

CONCLUSION

The Board finds that this case is not in posture for decision as to whether appellant has more than a 12 percent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the October 18, 2006 decision of the Office of Workers' Compensation Programs' hearing representative and the April 26, 2006 decision of the Office are set aside and the case is remanded to the Office for further proceedings consistent with this decision.

Issued: November 19, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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