United States Department of Labor
Employees' Compensation Appeals Board

RUFUS BESTER, Appellant	)	
and	)	**Docket No. 05-456**
U.S. POSTAL SERVICE, POST OFFICE, Milwaukee, WI Employer	)	**Issued: September 12, 2005**

Appearances:
Rufus Bester, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 16, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated November 29, 2004. 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 27 percent impairment of each upper extremity.

FACTUAL HISTORY

On September 28, 1995 appellant, then a 45-year-old clerk, filed a traumatic injury claim alleging that he sustained a right elbow strain while keying in the performance of duty. He did not stop work. The record reflects that appellant also filed an occupational disease claim for stress and depression and right ulnar neuropathy.

The Office accepted appellant's claim for right ulnar neuropathy and authorized right ulnar nerve transposition surgery.[1] The Office also accepted the claim for bilateral C7, C8 cervical radiculopathy with surgery and aggravation of cervical spondylosis. The Office authorized another right ulnar nerve transposition on May 4, 1998.[2] On November 3, 1998 the Office also accepted appellant's claim for a left elbow strain and authorized diagnostic studies. It also authorized a posterior cervical decompressive laminectomy and anterior fusion from C3-7.[3] On July 12, 2001 the Office accepted his claim for major depression, single episode, resolved on June 27, 2001 and a claim for a recurrence of depression on December 28, 2001. Appellant received appropriate compensation benefits.

The record reflects that appellant received a schedule award on July 10, 1997 for 10 percent impairment to the right upper extremity. He subsequently received a schedule award for an additional 10 percent impairment to the right upper extremity on June 16, 1999. On November 30, 1999 appellant received a schedule award for three percent to the left upper extremity. On October 26, 2001 he received an additional schedule award for a total of 25 percent impairment to both upper extremities.

Appellant subsequently requested an additional schedule award on March 16, 2004.

In an August 4, 2004 report, Dr. Diane W. Braza, a Board-certified physiatrist and a treating physician, utilized the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* to provide an impairment rating. She noted that appellant had ongoing chronic pain and depression following his authorized cervical procedures, right ulnar nerve transposition and sub muscular transposition surgery. Dr. Braza addressed his complaint of chronic neck pain, muscle tightness, right upper extremity pain, bilateral upper extremity weakness, occasional tripping and constant numbness and tingling in the upper extremities. She noted that appellant's symptoms had progressed such that his degree of pain overall had worsened and advised that he remained on chronic narcotic therapy. He had a pain-related impairment score of 52 percent, noting this was in the category of moderate-to-severe impairment, as appellant previously was assigned a 35 percent whole person impairment for severe upper extremity neurologic compromise following his surgeries. Dr. Braza explained that, due to his significant functional limitations due to pain and depression, appellant's total pain-related impairment score of 52 appeared to be ratable and was not fully and adequately encapsulated in the conventional impairment rating given previously.

In an August 17, 2004 report, Dr. James B. Winston, a Board-certified psychiatrist, advised that he treated appellant for depression related to his chronic pain for over three years. He opined that appellant would continue to have chronic pain and depression and require permanent use of antidepressants. Dr. Winston advised that in addition to disability from chronic pain, he would be disabled from his depression.

[1] Appellant underwent this procedure on September 20, 1996. He did not work from September 20, 1996 through January 15, 1997. Appellant accepted a modified distribution clerk position on January 16, 1997.

[2] Appellant underwent this procedure on June 26, 1998. He returned to one handed limited duty on July 29, 1998.

[3] Appellant underwent surgery for the cervical laminectomy on May 15, 2000.

In a September 13, 2004 report, the Office medical adviser applied the findings of Dr. Braza to the A.M.A., *Guides* (5th ed.), noted appellant's history of injury and treatment, which included his previous awards of 25 percent to the right and left upper extremities for C7-8 cervical radiculopathy, cervical spondylosis, left elbow strain and right ulnar neuropathy. He noted that appellant continued to experience neck pain, muscle tightness, right arm pain, intermittent loss of balance in the lower extremities, a sensation of bilateral upper extremity weakness, as well as a sense of numbness and tingling in the upper extremities. The Office medical adviser noted that radiculopathy could cause arm pain while diffuse spondylosis caused only neck pain. He indicated that Dr. Braza awarded appellant a significant amount of impairment related to diffuse pain. The Office medical adviser noted that he was not entitled to an award for impairment of the axial skeleton or of the person as a whole, only of the upper extremities due to radicular pain. The Office medical adviser referred to Table 15-17, page 424, and combined with Table 16-10, page 482, of the A.M.A., *Guides* and noted that this would entitle appellant to an additional 3 percent for Grade 3 radicular pain in the distribution of the C8 nerve root. He referred to the Combined Values Chart on page 604 of the A.M.A., *Guides* and determined this would result in a total of 27 percent to the upper extremities. The Office medical adviser indicated that the date of maximum medical improvement was September 27, 2001.[4]

By letter dated October 13, 2004, the Office requested clarification with regard to whether appellant was entitled to an award to each extremity for pain or 27 percent impairment to each upper extremity.

In an October 18, 2004 response, the Office medical adviser indicated that appellant had an additional three percent to the upper extremity for both arms due to residual grade three radicular pain in the distribution of the C8 nerve roots. He explained that, when using the Combined Values Chart on page 604, the 25 percent (existing) left upper extremity impairment combined with the 3 percent (new) left upper extremity impairment was equal to 27 percent. He noted that a similar calculation was made on the right upper extremity and represented a 27 percent impairment.

On November 29, 2004 the Office granted appellant an additional schedule award for two percent impairment of both upper extremities, for a total of 27 percent impairment to both upper extremities. The award covered a period of 12.48 weeks from October 23, 2004 to January 18, 2005.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[5] sets forth the number of weeks of compensation to be paid for the permanent loss of use, of specified members, functions and organs of the body.[6] The Act, however, does not specify the manner by which the

[4] This is the date of a medical report by Dr. Braza, upon which appellant's October 26, 2001 schedule award decision was based.

[5] 5 U.S.C. §§ 8101-8193.

[6] 5 U.S.C. § 8107.

percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The Act's implementing regulations has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.[8]

The standards for evaluating the percentage of impairment of upper extremities can be found in Chapter 16 of the A.M.A., *Guides* (5th ed. 2005). Upper extremity impairment ratings evaluate factors such as abnormal motion, pain, weakness and sensory loss. Multiple impairments are combined to determine the total impairment of the unit (*e.g.*, finger) before conversion to the next larger unit (*e.g.*, hand).[9] Similarly, multiple regional impairments, such as those of the hand, wrist, elbow and shoulder, are first expressed individually as upper extremity impairments and then combined to determine the total upper extremity impairment.[10] Section 16.1 states that regional impairments resulting from the hand, wrist, elbow and shoulder regions are combined to provide the upper extremity impairment. Regarding the Combined Values Chart, section 1.4 of the A.M.A., *Guides*, provides that in general, impairment ratings within the same region are combined before combining the regional impairment rating from another region.[11]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[12] As neither the Act, nor its regulations provide for the payment of a schedule award for the permanent loss of use, of the back or the body as a whole, no claimant is entitled to such a schedule award.[13] The Board notes that section 8109(19) specifically excludes the back from the definition of organ.[14] 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 originated in the neck, shoulders or spine.[15]

ANALYSIS

In support of his claim for an additional schedule award, appellant submitted an August 4, 2004 report in which Dr. Braza noted that he had chronic pain and depression, was on

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[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] 20 C.F.R. § 10.404.

[9] *See* A.M.A., *Guides*, Chapter 16.1(c), Combining Impairment Ratings, page 438.

[10] A.M.A., *Guides*, 16.1c, page 438.

[11] A.M.A., *Guides*, pages 9-10. *See also Cristeen Falls*, 55 ECAB ___ (Docket No. 03-1665, issued March 29, 2004).

[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] 5 U.S.C. § 8107; *see also Richard R. Lemay*, *supra* note 12.

[14] 5 U.S.C. § 8109(19).

[15] *See Richard R. Lemay* and *Thomas J. Engelhart*, *supra* note 12.

chronic narcotics therapy and advised that appellant's activities of daily living were substantially impacted. She indicated that he had a pain-related impairment score of 52 percent, which was in the category of moderate-to-severe impairment. Dr. Braza noted that she previously received a 35 percent whole person impairment for appellant's severe upper extremity neurologic compromise and explained that due to his significant functional limitations due to pain and depression, appellant had a total pain-related impairment score of 52, which was not considered in the previous impairment rating. The Board notes that Dr. Braza did not explain how her calculations were derived in accordance with the protocols of the A.M.A., *Guides*. She did not refer to any specific tables of the A.M.A., *Guides* to explain where she obtained these figures. It is well established that, when an attending physician's report gives an estimate of impairment, but does not indicate that the estimate is based upon the application of the A.M.A., *Guides*, the opinion of the physician is of diminished probative value. The Office may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.[16]

The Office medical adviser reviewed Dr. Braza's report and noted the history of injury and treatment which included previous scheduled awards for 25 percent impairment of both the right and left upper extremities for C7-8 cervical radiculopathy, cervical spondylosis, left elbow strain and right ulnar neuropathy. He explained that appellant had not received an impairment rating for residual pain in either arm and explained that radiculopathy could cause arm pain while diffuse spondylosis caused only neck pain. The Office medical adviser also indicated that Dr. Braza awarded appellant a significant amount of impairment related to his diffuse pain but explained that he was not entitled to an award for impairment of the axial skeleton or of the person as a whole, only of the extremities.

The Office medical adviser explained that appellant was entitled to impairment for his C8 radicular pain. He referred to Table 15-17[17] and Table 16-10[18] and determined that he had three percent impairment for Grade 3 radicular pain in the distribution of the C8 nerve root. The Board notes that, under Table 15-17, the maximum percentage loss due to sensory deficit or pain of the C8 nerve root is five percent. When multiplied the Grade 3 classification of 60 percent for sensory deficit under Table 16-10 for distorted superficial tactile sensibility, this totals 3 percent impairment of the upper extremity for sensory deficit. The Office medical adviser subsequently referred to the Combined Values Chart on page 604 of the A.M.A., *Guides*. He combined with the previous award of 25 percent impairment with the 3 percent sensory loss impairment to total 27 percent impairment of the upper extremities. The Office medical adviser properly concluded that appellant was entitled to an additional two percent impairment for each upper extremity.

[16] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).

[17] A.M.A., *Guides* 424, Table 15-17. Although this table noting loss of function due to pain is in the chapter of the A.M.A., *Guides* pertaining to the spine and not the upper extremity, an essentially identical table, Table 16-13 appears on page 489 of the A.M.A., *Guides* and pertains to the upper extremities.

[18] A.M.A., *Guides* 482, Table 16-10.

There is no medical evidence in the record establishing that appellant had more than the 27 percent impairment of the right and left upper extremities for which he received a schedule award.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a 27 percent impairment of both upper extremities, for which he received a schedule award.[19]

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 29, 2004 is affirmed.

Issued: September 12, 2005
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[19] On appeal, appellant questions whether he is entitled to compensation based on a loss of wage-earning capacity. However, the Board only has jurisdiction over final decisions of the Office. *See* 20 C.F.R. § 501.2(c). As the Office has not issued a decision regarding this issue, the Board does not have jurisdiction to considerate it on appeal.