

FACTUAL HISTORY

On November 28, 2000 appellant, then a 39-year-old rural letter carrier, filed an occupational disease claim alleging that he sustained pain in the left shoulder, neck and upper back. He stated that he was initially aware of his condition on October 27, 2000 and that he first realized it was caused by his employment on November 3, 2000. Appellant notified his supervisor on November 28, 2000 and stopped work that day.

On December 12, 2000 the Office accepted appellant's claim for left shoulder tendinitis. Appellant returned to work on February 3, 2001.

On May 14, 2001 appellant filed a second occupational disease claim alleging that he was diagnosed with cervical disc syndrome which caused left shoulder, arm and neck pain and excessive discomfort. He stated that he was aware of this condition and its relationship to his employment on March 9, 2001 which was also the day he reported his condition to his supervisor. Appellant stopped work on May 7, 2001. On May 24, 2001 appellant filed another claim for an occupational disease, stating that his doctor diagnosed carpal tunnel syndrome which caused left arm, wrist and hand pain. He stopped work on May 5, 2001 but was initially aware of this condition and that it was caused by his employment also on March 9, 2001, initially sought medical care for this condition on that same day, and first reported this condition to his supervisor on May 24, 2001. The Office doubled this claim with his prior claim. On July 26, 2001 the Office accepted appellant's claims for aggravation of cervical disc syndrome at C5-6 and C6-7 and left rotator cuff tendinitis. Appellant accepted a light-duty position on August 24, 2001.

On October 10, 2001 Dr. John W. Collins, an attending a Board-certified orthopedic surgeon, stated that appellant's magnetic resonance imaging (MRI) scan revealed degenerative changes at C5-6 and C6-7. On December 19, 2001 Dr. Vincent Key, appellant's attending Board-certified orthopedic surgeon,² observed a Neer impingement and Hawkin's sign of the left shoulder, and requested authorization for a left shoulder arthroscopy and subacromial decompression acromioplasty.

On December 20, 2001 the Office authorized the left shoulder arthroscopic surgery which Dr. Key performed on January 4, 2002. In a postsurgical report that day, Dr. Key noted no evidence of rotator cuff tear. However, he noted a moderate amount of synovitis in the subacromial bursa space which he debrided and an acromion spur which he shaved to a flat surface. The Office stated in a work capacity evaluation form it sent to Dr. Key after the surgery that appellant's accepted conditions were intervertebral cervical disc condition and left shoulder bursitis. Dr. Key replied to the Office's request for information by stating that appellant was able to return to limited duty from January 21, 2002. His subsequent reports decreased appellant's restrictions until April 24, 2002 when he released appellant to return to full-time work with no restrictions.

² The Office approved Dr. Key as appellant's attending physician.

From January 15 to April 25, 2002 appellant attended physical therapy sessions for his left shoulder and from May 10 to 15, 2002 for bilateral spine.

On May 29, 2002 Dr. Timothy Stepp, a Board-certified neurological surgeon who treated appellant for neck and shoulder pain, diagnosed an aggravation of cervical disc syndrome and recommended that the employing establishment should provide appellant a platform to stand on while casing mail and a waist-mounted mailbag. In a report dated the same day, he stated that appellant had full range of motion of the cervical spine and appeared to have full range of motion of the left shoulder, with focal tenderness along the neck. Appellant's motor strength was 5 by 5 and deep tendon reflexes were 1 by 4 and symmetrical.

In a work capacity evaluation report dated June 5, 2002, Dr. Key noted that appellant had reached maximum medical improvement and there were no restrictions associated with his medical conditions of shoulder bursitis and aggravation of cervical disc syndrome.

In a report dated June 6, 2002, the Office noted that the employing establishment provided appellant a platform for casing mail and a waist pack for mail delivery. The Office further noted that Dr. Key released appellant to full duty with no restrictions and that he had reached maximum medical improvement.

On May 2, 2003 appellant filed a claim for a schedule award. The Office prepared a statement of accepted facts indicating that it had accepted appellant's injuries of left rotator cuff tear and an aggravation of cervical degenerative disc disease. The Office also stated that it authorized acromioplasty and subacromial decompression that was performed on January 4, 2002.

On October 9, 2003 the Office referred appellant, the statement of accepted facts and his medical record to Dr. George Varghese, Board-certified in physical medicine and rehabilitation and a second opinion physician, for an evaluation regarding appellant's impairments.

In a report dated November 4, 2003, Dr. Varghese stated that he examined appellant that day, noted a familiarity with this history of injury finding that appellant's shoulder pain was predominantly in the anterior aspect with no history of a specific injury. He noted that appellant was symptomatic when lifting, carrying and with overhead activities. Dr. Varghese noted appellant's normal MRI scans, and noted a diagnosis of impingement syndrome for which he underwent surgery in January 2002. He noted that appellant improved after surgery, that he had good range of motion and that he had about 12 weeks of physical therapy following injection. Dr. Varghese related that appellant considered his shoulder "pretty good." However, he noted that symptoms would recur upon continuous lifting and overhead activities. Appellant also reported tingling and numbness in the fourth and fifth fingers. Appellant also complained about neck pain largely in the trapezius area and intermittent stiffness. Dr. Varghese noted two MRIs which revealed mild degenerative changes and possibly some foraminal narrowing at the C6-7 level. He noted that appellant also had three electromyogram evaluations, none of which revealed radiculopathy. Median and ulnar studies did not reveal carpal tunnel syndrome or cubital tunnel syndrome. Upon examination, Dr. Varghese noted a well-healed arthroscopic scar in the left area with no inflammatory changes or deformity or muscle atrophy. He then noted

range of motion findings, indicating that shoulder muscle strength was within normal limits, and that the drop arm test and Yergason's test were negative. Dr. Varghese also noted mild limitation of neck rotation and tenderness in the left upper trapezius. Spurling's test was negative, the left upper extremity neurological examination was normal, deep tendon reflexes were normal, the sensory examination revealed subjective tingling in the ulnar border of the hand, and two-point discrimination was seven millimeters.

In determining impairment, Dr. Varghese calculated that appellant had a 3 percent impairment of his left shoulder based on 140 degrees of forward flexion; extension of 55 degrees, which equated to a 0 percent impairment; a 2 percent impairment based on 140 degrees abduction; a 0 percent impairment based on 50 degrees of adduction; a 2 percent impairment for 60 degrees internal rotation; and a 0 percent impairment for 60 degrees external rotation. He also noted that appellant's pain was rated as part of the loss of range of motion findings and thus no rating for pain was provided. Dr. Varghese concluded that appellant had a seven percent permanent impairment of the left upper extremity. With respect to appellant's cervical radiculopathy, he found no evidence of entrapment syndrome at the elbow or wrist, noted no loss of strength in the neck and did not rate range of motion as this was considered in the impairment rating of the left upper extremity. However, Dr. Varghese noted pain and sensory symptoms at C8 distribution and, based on the two-point discrimination test, appellant had a 20 percent grade for sensory symptoms which converts to a 1 percent impairment for the left upper extremity. He concluded that appellant had a permanent impairment of the shoulder of seven percent and a permanent impairment of one percent for radicular symptoms. Dr. Varghese noted that appellant reached maximum medical improvement as of that date.

On November 24, 2003 the Office medical adviser reviewed Dr. Varghese's report and indicated that Dr. Varghese properly determined that appellant had a seven percent of the left upper extremity and one percent of the left upper extremity for the cervical spine condition. He noted that these ratings were acceptable based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). The physician then referred to the Combined Values Chart on page 604-06 of the A.M.A., *Guides* to combine a seven percent rating with a one percent rating to find an eight percent impairment rating of the left upper extremity.

By decision dated December 1, 2003, the Office awarded appellant an eight percent schedule award for permanent impairment of the left upper extremity. The award ran for 24.96 weeks from October 29, 2003 to April 20, 2004.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act³ and its implementing regulation⁴ 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

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404.

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* (5th ed. 2001) has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁵

ANALYSIS

In this case, the Office accepted left rotator cuff tear and an aggravation of cervical degenerative disc disease. Dr. Stepp, who treated appellant's cervical condition, found on May 29, 2002 that appellant appeared to have full range of motion of the cervical spine and left shoulder. Dr. Key, appellant's attending physician who treated him for his shoulder condition, stated on June 5, 2002 that appellant had reached maximum medical improvement and had no restrictions associated with his shoulder bursitis and cervical disc syndrome. Appellant did not provide additional medical evidence concerning his impairment with his claim for a schedule award. The Office therefore referred appellant to Dr. Varghese, a Board-certified orthopedic surgeon, for a second opinion regarding his impairment.

The Board finds that Dr. Varghese, Board-certified in physical medicine and rehabilitation who served as an Office referral physician, properly determined that appellant had an eight percent permanent impairment of the left upper extremity. In a November 4, 2003 report, he applied the proper standards of the A.M.A., *Guides* to find that appellant was entitled to such a schedule award due to the following impairments for the upper extremity: a 3 percent impairment rating for 140 degrees of forward flexion; a 2 percent rating for 140 degrees abduction; a 2 percent rating for 60 degrees internal rotation; a 0 percent rating for extension of 55 degrees; a 0 percent rating for 50 degrees of adduction; and a 0 percent rating for 60 degrees of external rotation.⁶ Dr. Varghese then added these limitations for range of motion to reach a seven percent impairment rating. He correctly determined that appellant had no loss of strength and therefore no impairment rating was given. Regarding appellant's cervical radiculopathy, Dr. Varghese advised that, based on a two-point discrimination test, appellant had a 20 percent sensory deficit in the C8 distribution, which, under Table 15-17 and 15-15, represented a 20 percent loss of function, which equaled a 1 percent impairment of the left upper extremity.⁷

The Office medical adviser then reviewed the findings of Dr. Varghese and combined the seven percent for loss of range of motion with one percent for cervical radiculopathy to find an eight percent impairment of the left upper extremity based on the Combined Values Chart on page 604-06 of the A.M.A., *Guides*.⁸

⁵ See 20 C.F.R. § 10.404; *Jacqueline S. Harris*, 54 ECAB ____ (Docket No. 02-303, issued October 4, 2002).

⁶ See A.M.A., *Guides* 476-79, Figures 16-40, 16-43, 16-45.

⁷ The maximum percentage loss for sensory deficit for the C8 nerve root is five percent. Dr. Varghese assessed a 20 percent grade. Twenty percent multiplied by 5 percent equals 1 percent. See *id.* at 424, Tables 15-17, 15-15.

⁸ *Id.* at 604-06, Combined Values Chart.

As the record contains no other probative evidence demonstrating that appellant had a permanent impairment of her left upper extremity greater than eight percent, the reports by Dr. Varghese and the Office medical adviser are the only evaluations of record of appellant's impairments that conform with the A.M.A., *Guides* and the Board finds that they constitute the weight of the medical evidence in the case record and establish that appellant has no more than an eight percent impairment of the left upper extremity.⁹

CONCLUSION

Appellant has not met his burden of proof to establish that he is entitled to a schedule award for a permanent impairment greater than eight percent for the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the December 1, 2003 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 28, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

⁹ See *Bobby L. Jackson*, 40 ECAB 593, 601 (1989).