

accepted his claim for left shoulder sprain, left hand sprain, cervical sprain and cervical radiculopathy. On August 20, 2001 appellant filed a claim for a schedule award.

On May 16, 2001 Dr. R.C. Krishna, a Board-certified neurologist, reported that appellant had reached maximum medical improvement on May 15, 2001. He examined appellant on March 1, 2001 and found 4/5 weakness of the left deltoid, supraspinatus and biceps muscle with tenderness, as well as a one-inch atrophy of the left mid-arm circumference. Dr. Krishna diagnosed multilevel cervical disc herniations resulting in left C5-6 radiculopathy and chronic neuropathic pain syndrome. He also diagnosed focal upper extremity atrophy on the left. Dr. Krishna reported that, based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* 499 (5th ed. 2001) (Table 16-18, Maximum Impairment Values for the Digits, Hand, Wrist, Elbow and Shoulder Due to Disorders of Specific Joints or Units), appellant's left upper extremity exhibited a 75 percent loss of use.

On September 19, 2001 Dr. Sanford R. Wert, an orthopedic surgeon, reported that based on his July 20, 2001 examination appellant had 30 degrees of abduction and 1 inch of atrophy in his left upper extremity, as well as subjective complaints of pain, weakness and tingling. Applying the A.M.A., *Guides*, he determined that appellant had a 2 percent impairment of the left upper extremity due to loss of abduction and an 18 percent impairment due to carpal tunnel syndrome, resulting in sensory deficit of the radial and ulnar digit branches of the median nerve. Dr. Wert determined that appellant also had a 51 percent impairment of the cervical spine, which combined for a 71.4 percent impairment of the whole person.

On April 9, 2004 Dr. Krishna again rated appellant's left upper extremity impairment at 75 percent. His findings on April 9, 2004 included left shoulder abduction of 50 degrees, adduction of 30 degrees, forward flexion of 70 degrees, extension of 25 degrees, internal rotation of 15 degrees and external rotation of 36 degrees. Dr. Krishna also found decreased sensation to pinprick on the outer aspect of the left arm and a left biceps jerk reflex of only one plus. He reported that he based appellant's impairment rating of 75 percent on his examination findings and a functional capacity evaluation performed on November 6, 2003.

The Office referred appellant to Dr. Kenneth A. Falvo, a Board-certified orthopedic surgeon, for a second opinion. An Office medical adviser reviewed Dr. Falvo's March 6, 2003 report and noted that the physician had not identified the individual nerve roots responsible for appellant's upper extremity impairment and had provided no opinion on the date of maximum medical improvement. Due to these deficiencies, the Office medical adviser offered no opinion on maximum medical improvement or on whether appellant had any permanent impairment of his left upper extremity.

In decisions dated February 19 and November 4, 2004, the Office denied appellant's claim for a schedule award.

On appeal, the Board set aside the denial of appellant's claim for a schedule award and remanded the case for further development. The Board found that the Office, having undertaken development of the evidence by referring appellant to Dr. Falvo, had an obligation to secure a report that adequately addressed the issues of maximum medical improvement and permanent impairment. The Board remanded the case to the Office for clarification from Dr. Falvo, for

such further development as the Office deemed necessary and for an appropriate decision on appellant's claim for a schedule award. The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

On remand, the Office was unable to obtain clarification from Dr. Falvo. The Office referred appellant to Dr. Robert M. Israel, a Board-certified orthopedic surgeon.

On September 30, 2005 Dr. Israel related appellant's history, reviewed the statement of accepted facts and the medical record, and described his findings on physical examination. His examination of the left shoulder, left arm, left elbow and left wrist and hand was entirely normal, with no loss of motion and no motor or sensory deficit. Dr. Israel diagnosed resolved cervical spine sprain, resolved left shoulder sprain, resolved left elbow sprain, resolved left wrist and hand sprain and resolved left arm sprain. He rated appellant's impairment at zero percent under the A.M.A., *Guides*. Dr. Israel added that appellant had reached maximum medical improvement and required no further treatment.

On October 20, 2005 an Office medical adviser reviewed Dr. Israel's findings and reported that normal findings did not support permanent impairment of the left upper extremity. Appellant did have subjective complaints of pain and numbness, however, and so the medical adviser rated appellant's permanent impairment at three percent under Figure 18-1, page 574, of the A.M.A., *Guides*.

In a decision dated October 28, 2005, the Office awarded schedule compensation for a three percent permanent impairment of appellant's left upper extremity.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act² authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.³

ANALYSIS

On the prior appeal, the Board remanded the case to the Office for clarification from Dr. Falvo, for such further development as the Office deemed necessary and for an appropriate decision on appellant's claim for a schedule award. The record shows that the Office attempted to refer appellant to Dr. Falvo for a reexamination, but when an appointment could not be made, the Office secured an appointment with Dr. Israel, a Board-certified orthopedic surgeon, who examined appellant on September 30, 2005 and reported no abnormal findings upon examination of the left upper extremity. Appellant had full range of motion, and there was no motor or

² 5 U.S.C. § 8107.

³ 20 C.F.R. § 10.404 (1999). Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

sensory deficit. An Office medical adviser reviewed this report and correctly determined that there was no objective basis for rating permanent impairment.

Nonetheless, the Office medical adviser noted appellant's subjective complaints of pain and numbness and applied a section of the A.M.A., *Guides* for rating pain-related impairment: "If pain-related impairment appears to increase the burden of the individual's condition *slightly*, the examiner can increase the percentage found in step 1 by up to three percent. No formal assessment of pain-related impairment is required."⁴

The Board finds that the October 28, 2005 schedule award, which compensated appellant for a three percent permanent impairment of his left upper extremity based on subjective complaints of pain and numbness, properly reflects the findings reported by Dr. Israel on September 30, 2005. The Board will therefore affirm the Office's October 28, 2005 decision.

The prior medical evidence in this case gives an inconsistent picture of appellant's impairment. On May 15, 2001 Dr. Krishna, a neurologist, reported a 75 percent loss of use. Although he reported that appellant had reached maximum medical improvement, another examination later that year indicated significantly less impairment. Dr. Wert, an orthopedic surgeon, examined appellant on September 19, 2001 and found a 2 percent impairment due to loss of shoulder abduction and an 18 percent impairment due to carpal tunnel syndrome. On April 9, 2004 Dr. Krishna repeated his rating of 75 percent and indicated that his rating was now based in part on a 2003 functional capacity evaluation, which showed loss of motion and loss of strength. He did not diagnose carpal tunnel syndrome. These evaluations are not only inconsistent, they are not reasonably contemporaneous to the October 28, 2005 schedule award. The most recent evaluation comes from Dr. Israel on September 30, 2005 and indicates that if appellant once had a significant impairment of his left upper extremity, his condition has improved considerably, leaving him with no loss of motion and no objective sensory or motor deficit. As there is no reasonably contemporaneous evaluation to the contrary, the Office properly based appellant's October 28, 2005 schedule award on Dr. Israel's findings and properly determined that the date of his examination was the date of maximum medical improvement.⁵

CONCLUSION

The Board finds that appellant has no more than a three percent permanent impairment of his left upper extremity.

⁴ A.M.A., *Guides* 574 (Figure 18-1). In "step 1" the evaluator determines the individual's diagnosis, measures organ function and conducts an informal assessment of pain-related impairment.

⁵ Impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized: "It is understood that an individual's condition is dynamic. Maximal medical improvement (MMI) refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI, a permanent impairment rating may be performed." *Id.* at 19.

ORDER

IT IS HEREBY ORDERED THAT the October 28, 2005 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 11, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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