United States Department of Labor
Employees' Compensation Appeals Board

CERITA J. SLUSHER, Appellant	)	
and	)	**Docket No. 04-1584**
	)	**Issued: May 10, 2005**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Leavenworth, KS, Employer	)	

Appearances:
Cerita J. Slusher, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On June 4, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated September 23, 2003. 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 her burden of proof to establish that she sustained more than a 10 percent permanent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On June 10, 1998 appellant, then a 40-year-old supervisor in health information management, was injured when she was struck on the left side while entering an elevator at work. She did not stop work. On October 16, 1998 the Office accepted appellant's claim for left

shoulder sprain. The Office also indicated that the claim was accepted for a neck strain and lumbar back sprain, which resolved on July 19, 1998. The claim was expanded to include aggravation of degenerative osteoarthritis and impingement syndrome and a left shoulder arthroscopy on December 28, 1999.[1] Appellant received compensation benefits and returned to regular duty on August 3, 2000.

On March 3, 2001 appellant filed a notice of recurrence alleging that her recurrence was on and off since June 1998.[2] By decision dated October 1, 2001, the Office denied appellant's claim for recurrence with respect to appellant's back and neck strain. Appellant requested reconsideration on October 28, 2001 and enclosed additional medical evidence.

By decision dated June 16, 2002, the Office denied modification of the October 1, 2001 decision.

On July 26, 2002 appellant completed a Form CA-7 for compensation for a schedule award.

The record reflects that appellant had previously submitted a report from her physician, Dr. William W. Bohn, a Board-certified orthopedic surgeon, regarding a schedule award. However, appellant withdrew her claim for a schedule award as she had not reached maximum medical improvement and because her doctor was recommending surgery, which was authorized and performed on April 5, 2002.

By letter dated December 11, 2002, the Office advised appellant that they were unable to process her claim for a schedule award as additional information was needed, including verification from her physician that she had reached maximum medical improvement. The Office further advised appellant to submit medical evidence in support of her claim based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In a separate letter dated January 30, 2003, the Office advised appellant that they had not received the requested medical evidence and that no further action would be taken on her schedule award claim until the necessary documents were received.

In a February 11, 2003 report, Dr. Bohn noted appellant's history of injury and treatment, which included a diagnosis of severe glenoid labrum tear which was resected with arthroscopic shoulder surgery. He indicated that appellant returned with a new problem that occurred when her left shoulder was reinjured in the year 2000, at work and opined that appellant suffered a permanent partial impairment related to her original June 9, 1998 injury. He advised that he would like an opportunity to visit with appellant to review the final outcome of shoulder surgery.

[1] The record reflects two other claims for appellant; a July 14, 2000 elbow strain (No. 110181039) and a January 7, 2002 lumbar strain (No. 112006791). Additionally, the record reflects preexisting left shoulder chronic impingement syndrome with a subacromial decompression and acromioplasty, resection of the coracoacromial ligament and removal of impingement area bursa of the subacromial space on August 18, 1993.

[2] The Office determined that the recurrence occurred on or about July 12, 2000.

By memorandum dated April 28, 2003, an Office medical adviser indicated that appellant was eligible for an impairment rating.

By letters dated May 1 and 5, 2003, the Office referred appellant to Dr. George Varghese, Board-certified in physical medicine and rehabilitation, to evaluate the extent of permanent impairment based on her employment injuries.

In a June 4, 2003 report, Dr. Varghese noted appellant's history of injury and treatment and utilized the fifth edition of the A.M.A., *Guides*. He indicated that inspection of the left shoulder, revealed no muscular atrophy and a well-healed scar over her anterior lateral aspect of her shoulder. Regarding range of motion, Dr. Varghese indicated that shoulder flexion was 120 degrees and extension was 50 degrees, abduction was 120 degrees, adduction 50 degrees, external rotation was 40 degrees, internal rotation 70 degrees and sensation was slightly decreased to light touch over her left lateral shoulder in a nondermatomal pattern. He noted that motor strength testing was 5/5 with left shoulder abduction, adduction, forward flexion, extension, internal rotation, elbow flexion, elbow extension and hand grasp. Dr. Varghese indicated that motor strength was 4/5 with left external rotation and deep tendon reflexes were +2 and symmetrical. For range of motion, Dr. Varghese referred to Figure 16-40[3] and explained that flexion of 120 degrees would entitle appellant to an impairment rating of 4 percent and that shoulder extension of 50 degrees, did not qualify for any rating. He also referred to Figure 16-43[4] and advised that abduction of 120 degrees would warrant a 3 percent rating, however, he noted that adduction of 50 degrees did not warrant any rating. Dr. Varghese referred to Figure 16-46[5] and noted that external rotation of 40 degrees warranted a 1 percent rating. The physician also referred to Figure 16-46[6] and noted that internal rotation of 70 degrees warranted a 1 percent rating. He advised that, when these figures were added, they were equal to a nine percent rating for decreased range of motion of the left shoulder. Regarding motor strength, Dr. Varghese indicated that, based on Table 16-35, a grade of 4/5 with motor strength with external rotation would warrant a one percent rating and explained that appellant did not have any atrophy. Dr. Varghese added the impairment of 9 percent for decreased range of motion and the 1 percent for decrease in motor strength and found that appellant had a left upper extremity impairment of 10 percent. He advised that appellant had reached maximum medical improvement on June 3, 2003.

In a June 15, 2003 report, an Office medical adviser reviewed Dr. Varghese's June 4, 2003 report and determined that appellant was entitled to a 10 percent impairment of her left upper extremity.[7] He explained that Dr. Varghese referred to appellant's range of motion, her

[3] A.M.A., *Guides*, 476, Figure 16-40.

[4] *Id*. at 477, Figure 16-43.

[5] *Id*. at 479, Figure 16-46.

[6] *Id.* at 479.

[7] The June 15, 2003 report actually indicated right upper extremity, however, this was corrected and determined to be a typographical error.

chronic pain and sensory changes and chronic weakness and advised that his rating was acceptable based on the A.M.A., *Guides.*

By decision dated September 23, 2003, the Office awarded appellant compensation for 31.2 weeks from June 3 to September 6, 2003 based upon a 10 percent permanent impairment of the right upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulation[9] 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 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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[10]

ANALYSIS

In this case, both Dr. Varghese and the Office medical adviser reported that appellant had a 10 percent impairment to her left upper extremity. The Office medical adviser concurred with the findings of Dr. Varghese, who applied fifth edition of the A.M.A., *Guides* to find that appellant had a total impairment of 10 percent to her left upper extremity.

In a June 4, 2003 report, Dr. Varghese utilized the fifth edition of the A.M.A., *Guides,* and referred to the appropriate tables and figures in the A.M.A., *Guides.* The Office's medical adviser subsequently concurred with Dr. Varghese's findings. Dr. Varghese referred to Figure 16-40[11] for range of motion, noting that appellant had flexion of 120 degrees and determined that appellant was entitled to an impairment rating of 4 percent and no rating was warranted for shoulder extension of 50 degrees. Regarding abduction, he referred to Figure 16-43[12] and advised that abduction of 120 degrees would warrant a 3 percent rating and no rating was warranted for adduction of 50 degrees. Dr. Varghese also referred to Figures 16-44[13] and 16-46[14] and explained that external rotation of 40 degrees warranted a 1 percent rating and that internal rotation of 70 degrees warranted a 1 percent rating. He added the figures which resulted

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] A.M.A., *Guides* (5th ed. 2001).

[11] *Id*. at 476, Figure 16-40.

[12] *Id.* at 477, Figure 16-43.

[13] *Id*. at 478, Figure 16-44.

[14] *Id*. at 479, Figure 16-46.

in a 9 percent rating for decreased range of motion of the left shoulder. Regarding motor strength, Dr. Varghese indicated that based on Table 16-35, at page 510, a grade of 4/5 with motor strength with external rotation would warrant a 1 percent rating. However, the A.M.A., *Guides*, specifically provides that strength deficits measured by manual muscle testing should only rarely be included in the calculation of an upper extremity impairment.[15] The medical evidence in this case does not explain why such impairment should be considered in light of the language of the A.M.A., *Guides.* Thus, it was improper for Dr. Varghese and the Office medical adviser to combine one percent for a strength deficit based on manual muscle testing, under Table 16-35, with nine percent for decreased range of motion.

The Board finds that there is no other medical evidence of record, based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than a 10 percent permanent impairment of the left upper extremity for which she received a schedule award. Although appellant submitted a report from her physician, Dr. Bohn, he did not purport to rate any impairment for schedule award purposes. Accordingly, the Board finds that appellant has no more than a 10 percent permanent impairment of the left upper extremity.

On appeal, appellant alleged that she felt she was entitled to greater than the 10 percent she was awarded and that her physician should have been given an opportunity to examine her. The record reflects that appellant was advised by letter dated December 11, 2003 of the requirements for submitting an impairment rating. However, this does not preclude appellant from submitting relevant medical evidence to the Office in support of a request for an additional schedule award.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained more than a 10 percent permanent impairment of her left upper extremity, for which she received a schedule award.

[15] The A.M.A., *Guides* provides that loss of strength may be rated separately if such a deficit has not been considered adequately by other rating methods. An example of this situation would be loss of strength caused by a severe muscle tear that healed leaving "a palpable muscle defect." If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, "the impairment due to loss of strength could be combined with the other impairments, only if based on unrelated etiologic or pathomechanical causes. Otherwise, the impairment ratings based on objective anatomic findings take precedence." The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 23, 2003 is affirmed, as modified.

Issued: May 10, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member