United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
and	)	**Docket No. 08-2487**
	)	**Issued: September 14, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Topeka, KS, Employer	)	

Appearances:
Bruce Alan Brumley, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 17, 2008 appellant filed a timely appeal from a June 19, 2008 decision of the Office of Workers' Compensation Programs adjudicating his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than three percent impairment to his right upper extremity and two percent impairment to his left upper extremity for which he received schedule awards.

On appeal, counsel for appellant contends that the medical evidence establishes that appellant sustained injury to his shoulders which contributes to his impairment.

FACTUAL HISTORY

This is the second appeal in this case.[1] By order dated September 14, 2006, the Board dismissed appellant's appeal at his request so that he could submit a request for reconsideration to the Office.

On April 19, 2002 appellant, then a 61-year-old motor vehicle service driver, sustained a laceration to his forehead near his left eye and a cervical spine strain when his truck overturned due to high wind during a thunderstorm. The Office accepted his claim for a left eyebrow laceration, cervical strain and surgical decompression and fusion at C4-5 and C5-6, performed on September 13, 2002. On October 21, 2003 appellant filed a claim for a schedule award. On November 6, 2003 the Office accepted a lumbar strain and temporary aggravation of degenerative disc disease at L3-4, resolved.

In a December 9, 2003 report, Dr. Kimball Stacey, an internist and an Office referral physician, provided findings on physical examination. He found 15 percent impairment of the left upper extremity based on motor deficit of the left biceps muscle that is innervated by the musculocutaneous nerve, as evidenced by the loss of left biceps deep tendon reflexes. Dr. Stacey rated 12 percent impairment of the right upper extremity based on moderate glenohumeral joint crepitus.[2] On February 29, 2004 Dr. Daniel D. Zimmerman, a Board-certified internist and an Office medical adviser, stated that lack of a reflex does not equate to weakness. Dr. Stacey did not perform an examination validating weakness in the left upper extremity. Dr. Zimmerman stated that impairment due to a cervical spine condition must be based on radicular residuals of a nerve root lesion at the cervical level causing upper extremity sensory or motor deficit. He determined that the impairment rating calculated by Dr. Stacey was not consistent with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (the A.M.A., *Guides*).

In an April 12, 2004 report, Dr. George Varghese, a Board certified physiatrist and an Office referral physician, reviewed appellant's medical history and provided findings on physical examination. Appellant had normal range of motion in both upper extremities. Muscle strength was normal bilaterally. There were no inflammatory changes or deformities detected. Neurological examination revealed subjective hypothesia in the C5 distribution and some hyperesthesia in the C6 distribution. The rest of the dermatomes were normal. In the left upper extremity, appellant had subjective hypothesia in the C5-6 dermatome. The rest of the dermatomes were normal. There was decreased biceps jerk in his left upper extremity but the rest of the reflexes were 2+. Dr. Varghese calculated 3 percent right upper extremity impairment, including 1 percent for pain and sensory deficit in the C5 dermatome, based on Table 15-16 and 15-17 at page 424 (20 percent for Grade 4 sensory deficit multiplied by 5 percent maximum for the C5 nerve root). He calculated 2 percent impairment for pain and sensory deficit at the C6 dermatome based on the same tables and assigning 40 percent for Grade 3 sensory deficit. Dr. Varghese calculated two percent impairment to the left upper

[1] Docket No. 06-1436 (issued September 14, 2006).

[2] Joint crepitus, also called articular crepitus, is the grating sensation caused by the rubbing together of the dry synovial surfaces of the joints. *See* DORLAND'S, *Illustrated Medical Dictionary* (30th ed. 2003) 433.

extremity, including one percent for sensory deficit, each, for the C5 and C6 nerve roots based on Tables 15-15 and 15-17. On April 23, 2004 Dr. Zimmerman agreed with Dr. Varghese's rating of three percent impairment of appellant's right upper extremity and two percent for his left upper extremity.

By decision dated April 29, 2004, the Office granted appellant schedule awards for three percent right upper extremity impairment and two percent left upper extremity impairment. The periods of the awards ran from April 6 to July 24, 2004.[3]

Appellant requested an oral hearing that was held on November 4, 2004. He submitted reports dated November 29 and December 3, 2004 from Dr. Peter V. Bieri, an otolaryngologist, who provided findings on physical examination. Appellant had persistent pain in his neck and low back, radiating into both shoulders. He had a persistent tremor at rest involving the dominant right upper extremity. Appellant also had frequent numbness and tingling, depending on activity level and posture. Examination of the shoulders revealed no signs of acute inflammation. Appellant had crepitance bilaterally involving the acromioclavicular joint with active and passive range of motion, which was otherwise full and unrestricted. Shoulder level and overhead use was accompanied by a marked subjective increase in pain. The tremor of the distal right upper extremity was noted at rest, which dissipated upon intention. Grip strength measured by a Jamar dynamometer was 36.5 kilograms (kg) on the dominant right side as opposed to 24.0 kg on the left. Vascular integrity was intact. Sensory examination revealed slight decrease in sensation along the dermatome supplied by C5 and C6. Deep tendon reflexes were slightly decreased at the level of the triceps, bilaterally. Dr. Bieri found 15 percent bilateral upper extremity impairment, including 10 percent for bilateral pain and weakness based on page 510 of the fifth edition of the A.M.A., *Guides* and 5 percent bilaterally for residuals of impingement syndrome of both shoulders based on Table 16-3 at page 439.

By decision dated December 21, 2004, an Office hearing representative vacated the April 29, 2004 decision and remanded the case for further development of the medical evidence because the Office had not reviewed the opinion of Dr. Bieri.

On March 2, 2005 Dr. Zimmerman stated that Dr. Bieri did not provide a medical history or sufficient examination findings from which an impairment rating could be made. He stated that Dr. Bieri provided no examination findings or history regarding upper extremity weakness that could be applied to page 510 of the A.M.A., *Guides*.[4]

By decision dated March 15, 2005, the Office denied appellant's claim for an increased schedule award to his upper extremities.

[3] The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of the upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by three percent and two percent equals 15.60 weeks of compensation.

[4] Table 16-35 at page 510 provides upper extremity impairment ratings due to strength deficit from musculoskeletal disorders based on manual muscle testing of individual units of motion of the shoulder and elbow.

On February 23, 2006 appellant requested that his claim be expanded to include a bilateral shoulder condition. In a February 22, 2006 report, Dr. Bieri stated that appellant had 10 percent bilateral upper extremity impairment due to radicular pain based on page 489 of the A.M.A., *Guides*.[5] He did not explain how he arrived at his impairment calculation. Dr. Bieri also found five percent impairment to each shoulder for impingement impairment due to pain and crepitance according to page 499 of the A.M.A., *Guides*.[6]

On March 17, 2005 appellant requested a telephonic hearing that was held on January 24, 2006. By decision dated March 21, 2006, an Office hearing representative determined that the weight of the evidence, as represented by the opinion of Dr. Varghese, established that appellant had no more than three percent impairment to the right upper extremity and two percent to the left upper extremity.

On March 20, 2007 appellant requested reconsideration. He submitted a copy of Dr. Bieri's December 3, 2004 report with a handwritten note concurring appellant's bilateral hip condition. On a copy of his February 22, 2006 report, Dr. Bieri circled the words "bilateral shoulder impingement impairments" and handwrote "secondary to injury -- no prior symptomatology."

On April 9, 2007 Dr. Zimmerman reiterated that Dr. Bieri did not provide an impairment rating conforming to pages 21 and 22 of the fifth edition of the A.M.A., *Guides*.[7] The reports lacked medical rationale containing a detailed explanation of how appellant's upper extremity impairment related to his accepted cervical conditions or any explanation as to how Dr. Bieri made his impairment ratings.

By decision dated May 4, 2007, the Office denied modification of the March 21, 2006 decision.

On May 1, 2008 appellant requested reconsideration. In an April 30, 2008 report, Dr. Bieri reiterated that appellant had five percent impairment due to bilateral shoulder impingement due to his findings on physical examination on November 29, 2004 and February 22, 2006. This included crepitance (crackling) and subjective complaints of pain from overhead shoulder use. The medical history included complaints of bilateral shoulder pain since shortly after the April 19, 2002 work injury. Dr. Bieri stated that the accident involved appellant's motor vehicle being overturned in high winds and multiple impacts from being tossed in the vehicle. He stated that this mechanism of injury was sufficient to cause the diagnosis of

[5] Page 489 contains Table 16-13 (Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits of Individual Spinal Nerves or to *Combined* 100 percent Deficits) (C5 to T1). (Emphasis in the original.)

[6] Page 499 contains Table 16-18 (Maximum Impairment Values for the Digits, Hand, Wrist, Elbow and Shoulder Due to Disorders of Specific Joints or Units).

[7] *See* Chapter 2, Practical Application of the A.M.A., *Guides*, section 2.6, Preparing Reports, 21-22. This section provides that an impairment rating must include a clinical evaluation with a medical history, current clinical status, diagnostic study results, a discussion of whether the individual had reached maximum medical improvement, diagnoses, causation and a discussion of impairment rating criteria. It must contain a calculation of the impairment with reference to how specific physical findings relate to criteria in the applicable sections of the A.M.A, *Guides*.

bilateral shoulder impingement syndrome and related disorders of the shoulder joint. Dr. Bieri's impairment ratings were based on pages 498 to 499 of the fifth edition of the A.M.A., *Guides* and Table 16-18 at page 499. He stated that the five percent impairment for each shoulder was based on the five percent upper extremity impairment provided in Table 16-18 for the sternoclavicular shoulder joint. Dr. Bieri indicated that the finding of crepitance and related impingement in appellant's physical examinations best fit section 16.7, Table 16-18.

Dr. Zimmerman noted a shoulder condition that was not accepted by the Office. He reviewed the medical evidence contemporaneous with the accepted motor vehicle accident regarding shoulder problems. A May 13, 2002 office note from Dr. K.N. Arjunan, a Board-certified neurosurgeon, indicated that appellant had pain in the left shoulder but there were no physical examination findings regarding either shoulder. A June 24, 2002 note indicated that a magnetic resonance imaging (MRI) scan of the left shoulder was negative. In October 23, 2002 notes, Dr. Arjunan noted that appellant still had right shoulder pain, especially with abduction of the right arm and his right shoulder "crackled." There were no physical examination findings for either shoulder in the October 23, 2002 note. A December 3, 2002 note provided no history regarding either shoulder except that appellant had discomfort and tightness. Dr. Zimmerman noted that the December 3, 2002 office note discussed appellant's condition following cervical spine surgery, decompression and fusion at C4-5 and C5-6, performed on September 13, 2002. He stated that a valid diagnosis of impingement syndrome required symptoms, signs and diagnostic studies. There was no clear, unequivocal documentation in the first eight to ten months post injury that appellant had any specific diagnosis at the shoulder level, based on a thorough history, physical examination and diagnostic studies. The contemporaneous reports of Dr. Arjunan indicated cervical spine complaints, not shoulder complaints.

By decision dated June 19, 2008, the Office denied modification of the May 4, 2007 decision.[8]

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[9] 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*.[10]

Neither the Act nor the implementing regulations provide for a schedule award for loss of use of the back or to the body as a whole.[11] However, the schedule award provisions of the Act

[8] Subsequent to the June 19, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[11] *See Guiseppe Aversa*, 55 ECAB 164 (2003).

include the extremities and a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of such impairment originates in the spine.[12]

In a claim for permanent impairment under the Act, the employee has the burden of proving that the condition for which a schedule award is sought is causally related to his or her federal employment.[13]

ANALYSIS

Appellant's upper extremity schedule awards were based on the April 12, 2004 report from Dr. Varghese, who reviewed the medical history and provided findings on physical examination. Dr. Varghese found a normal range of motion in both upper extremities. Muscle strength was normal bilaterally. There were no inflammatory changes or deformities detected. Neurological examination revealed subjective hypothesia in the C5 distribution and probably some hyperesthesia in the C6 distribution. The rest of the dermatomes were normal. In the left upper extremity, appellant had subjective hypothesia in the C5-6 dermatome. The rest of the dermatomes were normal. There was decreased biceps jerk in his left upper extremity but the rest of the reflexes were 2+. Dr. Varghese found three percent right upper extremity impairment, including 1 percent for pain and sensory deficit, in the C5 dermatome based on Table 15-16 and 15-17 at page 424 (20 percent for Grade 4 sensory deficit multiplied by five percent maximum for the C5 nerve root). He calculated 2 percent impairment for pain and sensory deficit at the C6 dermatome based on the same tables and assigning 40 percent for Grade 3 sensory deficit. Dr. Varghese multiplied the 40 percent for Grade 3 sensory deficit by the 5 percent maximum allowed for the C6 nerve root. However, Table 15-17 provides eight percent maximum for sensory deficit of the C6 nerve root, not five percent. Multiplying 40 percent by 8 percent equals 3 percent impairment, not 2 percent. The Board notes that the total right upper extremity impairment should be four percent, not three percent.[14] Dr. Varghese found two percent impairment to the left upper extremity, including one percent for sensory deficit, each, for the C5 and C6 nerve roots based on Tables 15-15 and 15-17. However, as noted, Table 15-17 provides eight percent maximum sensory loss for the C6 nerve root. Multiplying 20 percent for Grade 4 sensory deficit by eight percent maximum for the C6 nerve root equals 1.6, rounded to two percent. Accordingly, appellant has two percent left upper extremity impairment for the C6 nerve root sensory deficit, which, combined with one percent for the C5 nerve root sensory deficit, equals three percent left upper extremity impairment. The Board finds that appellant has four percent right upper extremity impairment and three percent left upper extremity impairment.

Dr. Stacey calculated 15 percent impairment of the left upper extremity based on motor deficit of appellant's left biceps muscle, noting a loss of left biceps deep tendon reflexes. He calculated 12 percent impairment of the right upper extremity based on moderate glenohumeral

[12] *See Vanessa Young*, 55 ECAB 575 (2004).

[13] *See Veronica Williams*, 56 ECAB 367 (2005).

[14] *See also* A.M.A., *Guides*, Table 16-13 at page 489 regarding maximum upper extremity impairment due to sensory or motor deficits of individual spinal nerves.

joint crepitus. However, Dr. Stacey did not reference any portions of the A.M.A., *Guides* in making his rating nor did he explain how he calculated impairment. Dr. Zimmerman noted that lack of a reflex, alone, did not establish weakness and Dr. Stacey did not provide any other findings on examination to validate weakness in the left upper extremity. The Board finds that the impairment rating of Dr. Stacey is not based on the fifth edition of the A.M.A., *Guides* or sufficient to establish that appellant has more than four percent right arm impairment or three percent left arm impairment.

Dr. Bieri stated that he found 15 percent bilateral upper extremity impairment, including 10 percent for bilateral pain and weakness based on page 510 of the fifth edition of the A.M.A., *Guides* and 5 percent bilaterally for residuals of impingement syndrome of both shoulders based on Table 16-3 at page 439.[15] He noted pain in appellant's neck radiating into both shoulders and a persistent tremor at rest involving the dominant right upper extremity. Shoulder level and overhead use was accompanied by a marked subjective increase in pain. However, physical examination of the shoulders revealed no signs of acute inflammation. Vascular integrity was intact. Sensory examination revealed slight decrease in sensation along the dermatome supplied by C5 and C6. Deep tendon reflexes were slightly decreased at the level of the triceps, bilaterally. On February 22, 2006 Dr. Bieri reiterated his opinion that appellant had 10 percent bilateral upper extremity due to radicular pain based on page 489 of the A.M.A., *Guides*. However, he did not explain how he arrived at his impairment calculation. Dr. Bieri calculated five percent impairment to each shoulder for impingement impairment due to pain and crepitance according to page 499 of the A.M.A., *Guides.* He did not explain his impairment calculation or provide medical rationale regarding causal relationship. In March 2007, Dr. Bieri circled the words "bilateral shoulder impingement impairments" on a copy of his February 22, 2006 report and handwrote "secondary to injury -- no prior symptomatology." However, Dr. Bieri provided no additional medical history, findings on physical examination or medical rationale supporting his impairment rating.[16] He provided no examination findings or history regarding upper extremity weakness that could be applied to page 510 of the A.M.A., *Guides.*[17] Dr. Bieri's subsequent report addressed appellant's hip condition which is not relevant to the issue on appeal. His 2004 through 2007 reports do not meet the requirements for an impairment rating as provided on pages 21 and 22 of the fifth edition of the A.M.A., *Guides.*[18] Due to these

[15] Table 16-3 at page 439 of the A.M.A., *Guides* involves the conversion of upper extremity impairment to impairment of the whole person. The Board notes that neither the Act nor the implementing regulations provide for a schedule award for loss of use of the back or to the body as a whole. *See Guiseppe Aversa*, 55 ECAB 164 (2003). However, the schedule award provisions of the Act include the extremities and a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of such impairment originates in the spine. *See Vanessa Young*, *supra* note 12.

[16] *See George Randolph Taylor*, 6 ECAB 986 (1954) (a medical opinion not fortified by medical rationale is of little probative value).

[17] As noted, Table 16-35 at page 510 provides upper extremity impairment ratings due to strength deficit from musculoskeletal disorders based on manual muscle testing of individuals units of motion of the shoulder and elbow.

[18] *See* Chapter 2, Practical Application of the A.M.A., *Guides*, section 2.6, Preparing Reports, 21-22. This section provides that an impairment rating must include a clinical evaluation with a medical history, current clinical status, diagnostic study results, a discussion of whether the individual had reached maximum medical improvement, diagnoses, causation and a discussion of impairment rating criteria. It must contain a calculation of the impairment with reference to how specific physical findings relate to criteria in the applicable sections of the A.M.A., *Guides*.

deficiencies, Dr. Bieri's opinion on appellant's upper extremity impairment is of diminished probative value.

On April 30, 2008 Dr. Bieri stated that he based his calculation of five percent impairment due to bilateral shoulder impingement on appellant's November 29, 2004 and February 22, 2006 findings on physical examination and on the medical evidence. The physical findings included crepitance and subjective complaints of pain from overhead shoulder use. Dr. Bieri stated that the 2002 medical reports included subjective complaints of bilateral shoulder pain. He noted that appellant's accident involved his motor vehicle being overturned in high winds and his multiple impacts from being tossed in the vehicle. Dr. Bieri stated that this mechanism of injury was sufficient to cause the diagnosis of bilateral shoulder impingement syndrome and related disorders of the shoulder joint and the bilateral shoulder impairment rating. However, the contemporaneous 2002 medical reports do not provide objective physical examination findings or any diagnosis regarding appellant's shoulders. The Board has held that contemporaneous evidence is entitled to greater probative value than later evidence.[19] Dr. Arjunan's May 13, 2002 note indicated that appellant had left shoulder pain but there were no physical examination findings regarding either shoulder. A June 24, 2002 note indicated that an MRI scan of the left shoulder was negative. There were no physical findings in this note. On October 23, 2002 Dr. Arjunan noted that appellant "still" had right shoulder pain, especially with abduction of the right arm and his right shoulder crackled. There were no physical examination findings for either shoulder in the October 23, 2002 note. A December 3, 2002 note provided no history or physical findings regarding either shoulder and noted only subjective shoulder discomfort. There is no clear documentation in the contemporaneous 2002 medical reports that appellant had any diagnosis, specifically at the shoulder level, based on a thorough history, physical examination and diagnostic studies. Due to these deficiencies, Dr. Bieri's April 30, 2008 report is not sufficient to establish that appellant is entitled to a schedule award for shoulder impairment.

The Board finds that the weight of the medical evidence establishes that appellant has four percent impairment to his right upper extremity and three percent impairment to his left upper extremity.

On appeal, appellant argues that his shoulder conditions should be accepted as causally related to the April 19, 2002 accepted cervical and lumbar spine conditions. He states that his testimony at the November 4, 2004 hearing was described in the December 21, 2004 hearing representative's decision. Appellant asserts that the hearing representative found his testimony credible. However, the hearing representative merely related appellant's description of the April 19, 2002 incident. The case was remanded because the Office had not reviewed the November 29 and December 3, 2004 reports of Dr. Bieri which were submitted after the April 29, 2004 schedule award decision. The hearing representative did not find that appellant's shoulder conditions should be accepted by the Office. Therefore, this argument is without merit.

Appellant argues that his shoulder conditions should be accepted because the shoulder symptoms manifested after the 2002 employment injury as reflected in the 2002 reports of Dr. Arjunan. Dr. Bieri also opined that the shoulder conditions were causally related to the

[19] *See Conard Hightower*, 54 ECAB 796 (2003).

accepted employment injury. The Board addressed the 2002 medical reports and the 2004 through 2008 reports of Dr. Bieri regarding the issue of causal relationship between appellant's shoulder conditions and his accepted conditions. Therefore, this argument has been considered and found to be without merit. Appellant argues that a May 7, 2007 (sic) report of Dr. Michael Smith supports causal relationship between his shoulder conditions and his employment injury. However, Dr. Smith did not diagnosis a shoulder condition in his May 7, 2002 report. He noted appellant's left shoulder pain and a positive impingement sign and stated, "There has been some question brought up regarding potential shoulder injury." Dr. Smith ordered an MRI scan of the left shoulder which revealed moderate degenerative arthritic changes involving the acromioclavicular joint resulting in a mild degree of impingement. However, Dr. Smith provided no medical rationale explaining how the left shoulder impingement was causally related to the April 19, 2002 employment injury. Therefore, this argument is without merit. Appellant argues that Dr. Zimmerman did not properly consider the shoulder symptoms described in the 2002 reports. As noted, in a claim for permanent impairment under the Act, the employee has the burden of proving that the condition for which a schedule award is sought is causally related to his or her federal employment. Appellant did not submit sufficient medical evidence establishing that his shoulder conditions were causally related to his 2002 employment injury.

CONCLUSION

The Board finds that appellant has four percent impairment to his right upper extremity and three percent impairment to his left upper extremity. On return of the case record, the Office should modify its June 19, 2008 decision to reflect appellant's increased right and left upper extremity impairment and calculate the additional compensation to which he is entitled.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 19, 2008 is affirmed, as modified.

Issued: September 14, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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