United States Department of Labor
Employees' Compensation Appeals Board

LAURA A. BOOTH, Appellant	)	
and	)	**Docket No. 05-958**
	)	**Issued: September 1, 2005**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, San Diego, CA, Employer	)	

Appearances:
Laura A. Booth, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 18, 2005 appellant timely filed an appeal from a December 9, 2004 decision by the Office of Workers' Compensation Programs which found that she had a three percent impairment of the right arm for which she received a schedule award. The Board has jurisdiction over the merits of this case pursuant to 20 C.F.R. §§ 501.2(c) and 501.3.[1]

ISSUE

The issue is whether appellant had more than a three percent impairment of the right arm.

[1] In a November 17, 2004 decision, the Office found that appellant had received an $849.82 overpayment of compensation. She did not seek review of this decision

FACTUAL HISTORY

On April 24, 2002 appellant, then a 37-year-old registered nurse, filed a claim for a traumatic injury which occurred on April 14, 2002 when she was turning a patient by herself. She claimed that she sustained a cervical thoracic strain.

In an April 14, 2002 report, Dr. Arnold Markman, Board-certified in family practice and occupational medicine, diagnosed a chronic cervical thoracic strain. He noted that x-rays showed minimal degenerative joint disease of the cervical and thoracic regions of the spine. In an April 23, 2002 report, Dr. Lindy O'Leary, Board-certified in occupational medicine, stated that appellant had persistent pain in the right side of the neck which radiated down into the right shoulder. She indicated that appellant could not move her neck due to the pain. Dr. O'Leary commented that she was not able to drive safely. She found that appellant had pain to palpation and palpable muscle tightness in the right paracervical area, in the superior of the trapezius on the right side and in the rhomboid area. Dr. O'Leary indicated that her range of motion of the neck was severely restricted due to pain and guarding. She commented that the range of motion in the shoulders was full and symmetrical bilaterally with pain in the right shoulder with full motion.

On July 3, 2002 appellant underwent a magnetic resonance imaging (MRI) scan. Dr. Linda Lewis, a Board-certified radiologist, stated that appellant had a moderate reversal of the normal cervical lordosis consistent with muscle spasms. She stated that at the C4-5 level she had mild spinal stenosis, a posterior cervical disc protrusion, right neural foraminal narrowing with possible impingement of the right exiting C5 nerve root. At the C5-6 level appellant had a central disc protrusion which was impinging on the cervical cord with borderline low normal overall size of the central canal. At the C6-7 level, Dr. Lewis indicated that she had a posterior left preforaminal disc protrusion with possible impingement of the crossing and exiting the left C7 nerve root. In a July 23, 2002 report, Dr. O'Leary diagnosed cervical thoracic strain with multilevel herniated nucleus pulposus as shown by the MRI scan. In a September 17, 2002 report, she indicated that the herniated nucleus pulposus was causing spinal stenosis and stenosis of the exiting C5 nerve root.

In a September 9, 2002 medical report, Dr. Michael McBeth, a Board-certified anesthesiologist, diagnosed radiculopathy of the right arm. In an October 16, 2002 report, Dr. Jeffrey Lee, a neurosurgeon, indicated that appellant had a long history of neck pain on the right side and had developed pain in the right arm in the C5 nerve root distribution. He indicated that she did not show any true signs of radiculopathy or myelopathy in his neurological examination.

In a January 2, 2003 report, Dr. Howard J. Noack, a Board-certified neurologist, stated that electrodiagnostic studies showed no evidence for a significant C5-7 neuropathy. He commented that appellant might have radiculopathy without a significant motor component. Dr. Noack indicated that she had significant pain.

The Office referred appellant to Dr. William Curran, a Board-certified orthopedic surgeon, for an examination and second opinion. In a March 10, 2003 report, he noted that she complained of constant cervical spine pain, constant thoracic spine pain and constant right

shoulder pain. Dr. Curran indicated that appellant had palpable tenderness without spasm in the cervical spine, upper thoracic spine, the right trapezius and the right shoulder. He found no atrophy or deformity of either shoulder. Dr. Curran reported appellant's range of motion in the right shoulder as 110 degrees in flexion, 90 degrees in abduction, 30 in adduction, 10 degrees in extension, 90 degrees in external rotation and 60 degrees in internal rotation. He noted that all motions of the right shoulder were painful. Dr. Curran indicated that sensory examination revealed diminished sensation in the entire left arm. He commented that there was no atrophy of either hand. Dr. Curran stated that the muscle power in both arms was normal and all reflexes were intact and equal. He diagnosed multilevel cervical disc stenosis and facet disease. Dr. Curran, in answer to the Office's questions, stated that appellant's April 2002 work-related accident aggravated preexisting symptomatic cervical and thoracic spine complaints. He indicated that the aggravation was temporary but he could not state when the aggravation would cease. Dr. Curran commented that the nonindustrial preexisting disability included degenerative joint and disc disease of the cervical spine and central and foraminal stenosis of the cervical spine.

In a May 23, 2003 report, Dr. O'Leary diagnosed chronic myofascial pain with questionable C5 radiculopathy and multilevel degenerative disc disease as shown on an MRI scan. She indicated that a computerized tomography (CT) myelogram showed at C5-6 effacement of the anterior aspect of the thecal sac with soft tissue density protruding posteriorly from the disc space, more prominently on the left than the right. Dr. O'Leary noted contact in the axial root sheaths bilaterally and symmetrically. She stated that at C6-7 the spinal canal was adequate in size with no lateral recess stenosis. Dr. O'Leary found no disc protrusion or herniation. She noted a slight bony prominence on the left causing effacement of the thecal sac. Dr. O'Leary stated that the findings were consistent with a small herniated nucleus pulposus at C5-6 more on the left than the right and spurring of the C6 vertebral body impinging on the anterior aspect of the spinal canal at the C5-6 level on the left.

In a December 31, 2003 report, Dr. O'Leary diagnosed cervicothoracic strain with myofascial pain and questionable C5 and C8 radiculopathy and multilevel degenerative disc disease, confirmed on MRI and CT scans. She related that, appellant stated that her neck pain was much better. Dr. O'Leary noted she had a fairly constant tingling vibration sensation in her right fourth and fifth fingers which was frequently worse in the morning. She indicated that appellant was performing her regular duties without difficulty. Dr. O'Leary found discomfort to palpation in the superior portion of the trapezius on the right and the right thoracic upper back. She indicated that appellant's shoulders had a full range of motion. Dr. O'Leary stated that she had decreased sensation in the fourth and the fifth fingers in her right hand.

In a January 8, 2004 report, Dr. Noack stated that an electrophysiological study was normal with no evidence for a right carpal tunnel syndrome, right arm neuropathy or significant right C5-T1 radiculopathy. He noted that appellant's chief complaints were intermittent fourth and fifth right finger numbness, an odd sensation of the posterior lateral right arm and intermittent neck pain and spasm. Dr. Noack commented, however, that she had a less significant cervical radiculopathy given her pain, spasm and radicular symptoms in the right arm. He indicated that the condition was mostly resolved after therapy, time and epidural steroid injections. Dr. Noack stated that the likely etiology of the fourth and fifth digit numbness was intermittent irritation of the right ulnar nerve probably at the elbow.

In an April 21, 2004 report, Dr. O'Leary stated that appellant had discomfort to palpation in the paracervical area, greatest on the right and in the right thoracic region along the scapular and the rhomboid area. She reported that her range of motion in both shoulders was flexion to 160 degrees, lateral flexion to 30 degrees, abduction to 160 degrees, extension to 50 degrees and external rotation to 90 degrees. Dr. Oleary indicated that appellant had internal rotation to 70 degrees in the right arm and 90 degrees in the left arm. She reported that an impingement test on the right was positive. Dr. O'Leary noted that appellant had good muscle strength with no sensory or motor deficits. She indicated that she complained of decreased sensation, a vibratory numbness of the tip of the right fourth and fifth fingers. Dr. O'Leary diagnosed cervicothoracic strain with chronic myofascial pain with right C5 and C8 radiculopathy. She stated that appellant's April 14, 2002 employment injury contributed to her chronic cervicothoracic strain and C5 plus C8 radiculopathy.

In a July 6, 2004 memorandum, Dr. Arthur S. Harris, an Office consultant, stated that a review of appellant's medical records established diagnoses of cervical and thoracic spine strain and cervical disc protrusion at C4-5, C5-6 and C6-7, with associated right cervical radiculopathy. He commented that, for schedule award purposes, she had a Grade 3 pain/decreased sensation that interfered with some activity which equaled 60 percent of the right C7 nerve root. Dr. Harris concluded that appellant had a three percent impairment of the right arm. He stated that the sole impairment in the right arm arose from the employment injury. Dr. Harris gave the date of maximum improvement as March 24, 2004.

In a December 9, 2004 decision, the Office issued a schedule award for a three percent impairment of the right arm.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[4]

ANALYSIS

Dr. Harris properly determined that appellant had a Grade 3 level of pain or sensory loss which equaled 60 percent. He multiplied that 60 percent by the 5 percent maximum impairment

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id*.

for total sensory loss in the right ulnar nerve and calculated that she had a 3 percent impairment of the right arm.

Dr. Harris, however, did not indicate in his July 6, 2004 report that he had reviewed the most recent range of motion measurements given by Dr. O'Leary in her April 21, 2004 report. To determine any impairment under the Act, the measurements of range of motion are compared to the range of motion given in the A.M.A., *Guides* and not in comparison to the range of motion of a noninjured member.[5] The A.M.A., *Guides* show that 160 degrees of flexion equal a 1 percent impairment of the arm, abduction to 160 degrees equals a 1 percent impairment of the arm, lateral flexion or adduction to 30 degrees equals a 1 percent impairment of the arm and 70 degrees of internal rotation equals a 1 percent impairment of the arm. Dr. O'Leary's measurements suggest that appellant has additional rating due to loss of motion. She also noted a positive impingement sign on the right which would suggest further problems in her right shoulder. The evidence of record, therefore, suggests that appellant's impairment of the right arm is greater than the three percent that was properly awarded. The Office medical adviser, Dr. Harris, however, did not review this evidence prior to his July 6, 2004 report. His opinion, which was the basis of the schedule award, was based upon an incomplete review of the record. This case must, therefore, be remanded to the Office for a supplemental opinion from Dr. Harris.

CONCLUSION

The case is not in posture for decision and must be remanded to determine whether appellant has an impairment greater than three percent in the right arm. After further development as it may find necessary, the Office should issue a *de novo* decision.

[5] *Frank Vara, Jr.*, 38 ECAB 434, 437 (1987).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 9, 2004 is hereby set aside and the case remanded for further development as set forth in this decision.

Issued: September 1, 2005
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