

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of CHARLES L. CLINTON and U.S. POSTAL SERVICE,  
DALLAS BULK MAIL CENTER, Dallas, Tex.

*Docket No. 97-505; Submitted on the Record;  
Issued March 2, 1999*

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DECISION and ORDER

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

The issues are: (1) whether the Office of Workers' Compensation Programs properly reduced appellant's wage-loss compensation to zero effective August 11, 1995 based on his actual earnings as a modified casual mailhandler; and (2) whether appellant sustained greater than an 11 percent permanent impairment of his left upper extremity, for which he received a schedule award.

The Office accepted that on September 30, 1994, appellant, then a 39-year-old casual mailhandler,<sup>1</sup> sustained left elbow lateral epicondylitis when a metal guard rail came loose and struck him on the left elbow. Appellant was treated by Dr. William M. Osborne, an attending orthopedic surgeon, beginning in October 1994. Appellant stopped work on December 14, 1994 and on December 15, 1994 underwent a modified Bosworth procedure of the lateral epicondyle performed by Dr. Osborne, with a postoperative diagnosis of lateral epicondylitis of the left elbow and synovitis of the radiohumeral joint.

Dr. Osborne submitted progress notes dated January to May 1995,<sup>2</sup> describing continued left elbow pain,<sup>3</sup> weakness, restricted motion, the need for continued medication and a transcutaneous electrical nerve stimulator unit.<sup>4</sup> In a May 25, 1995 report, Dr. Osborne restricted appellant from lifting more than 40 pounds or repetitive activity with the left arm,<sup>5</sup>

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<sup>1</sup> Effective July 16, 1994, the employing establishment appointed appellant to a noncareer position of modified casual mailhandler.

<sup>2</sup> Appellant received physical therapy in March 1995 to address strength and mobility issues.

<sup>3</sup> In a May 8, 1995 report, Dr. William Skinner, a psychiatrist and pain management specialist, to whom appellant was referred by Dr. Osborne, diagnosed chronic pain syndrome of the left elbow, arm and hand, with possible reflex sympathetic dystrophy.

<sup>4</sup> A June 23, 1995 radiographic study of the left elbow showed post-traumatic or soft tissue injury at the site of the left lateral epicondyle.

<sup>5</sup> Appellant received wage-loss compensation from January 7 to July 8, 1995, when he returned to work for four

renewing these restrictions through December 1995 due to appellant's continued left elbow symptoms.

Appellant returned to light-duty work for four hours per day on July 8, 1995, increasing to eight hours per day on August 14, 1995, with wages of \$240.00 per week. His July 16, 1994 noncareer appointment was extended to July 21, 1995 and set to expire on July 13, 1996.<sup>6</sup> An August 23, 1995 Office worksheet indicates that as of that date, the current pay rate for appellant's date-of-injury position was \$252.00 per week.

On September 20, 1995 appellant claimed a schedule award.

By decision dated December 12, 1995, the Office found that appellant had no loss of wage-earning capacity effective August 11, 1995, when he was reemployed as a modified casual mailhandler at the employing establishment, with wages of \$240.00 per week. The Office then reduced appellant's wage-loss compensation to zero under section 8115 of the Federal Employees' Compensation Act,<sup>7</sup> finding that his actual wages met or exceeded the wages of his date-of-injury position. The Office noted that appellant had been working successfully in the modified position for over 60 days and, therefore, the position fairly and reasonably represented his wage-earning capacity.

Appellant worked light duty through January 1996, stopped work on January 24, 1996, and on that day Dr. Osborne performed an excision of the radial head, with a postoperative diagnosis of traumatic radiohumeral arthritis of the left elbow.<sup>8</sup>

By decision dated January 30, 1996, the Office awarded appellant a schedule award for a three percent permanent impairment of the left arm according to the tables and grading schemes of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fourth edition (hereinafter, the A.M.A., *Guides*). The award covered the period December 6, 1995 to February 9, 1996, equivalent to 9.36 weeks of compensation.<sup>9</sup>

Appellant received compensation from February 10 to March 8, 1996 when he returned to work 8 hours per day light duty. A March 12, 1996 Office computer case data record indicates that as of that date, the current pay rate for appellant's date-of-injury position was \$252.00 per week.

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hours per day light duty as a modified casual mailhandler. Additional compensation was paid for four hours per day leave without pay through August 14, 1995, when appellant returned to work eight hours per day.

<sup>6</sup> In a December 12, 1995 letter, the employing establishment explained that casual mailhandlers may be hired "indefinitely for 359 days with a 6-day break between appointments." Appellant was "appointed to a noncareer 359-day [m]ail [h]andler [c]asual position effective July 16, 1994 which was extended to July 14, 1995. He was again appointed to another 359-day appointment effective July 21, 1995 which expires July 13, 1996."

<sup>7</sup> 5 U.S.C. § 8115.

<sup>8</sup> Dr. Osborne submitted periodic progress reports through May 1996.

<sup>9</sup> The award was based in part on a January 17, 1996 report from an Office medical adviser who reviewed Dr. Osborne's reports, and found a three percent impairment for loss of range of motion.

In a March 14, 1996 report, Dr. Osborne diagnosed radial humeral arthritis, tendinitis, and lateral epicondylitis of the left elbow and held appellant off work. He released appellant to work up to 6 days a week, 8 hours per day as of April 9, 1996.

In a May 1, 1996 report, Dr. Osborne noted that appellant had reached maximum medical improvement. He found full range of motion of the left elbow and forearm, with some pain and weakness with resisted extension and flexion of the left wrist and weakness with lifting. Dr. Osborne noted a grip strength of 38 pounds in the left hand compared to 75 pounds on the right. Referring to the A.M.A., *Guides*, Dr. Osborne found a 25 percent loss of strength of the left forearm secondary to median nerve impairment affecting innervation of the anterior interosseous muscle," equaling a 4 percent permanent impairment of the left upper extremity. He provided work restrictions limiting twisting, pulling, pushing, grasping, fine manipulation and reaching above the shoulder with the left arm to 4 hours per day.<sup>10</sup>

In a May 8, 1996 closure report, a vocational rehabilitation counselor noted that appellant was working at the employing establishment and was adjusting well to his duties and work restrictions.<sup>11</sup>

On May 13, 1996 appellant claimed an additional schedule award for permanent impairment of the left upper extremity.

In a June 4, 1996 report, an Office medical adviser calculated that according to the A.M.A., *Guides*, Table 27, page 61, appellant had an 8 percent permanent impairment of the left upper extremity due to arthroplasty of the radial head, and a 3 percent impairment due to loss of strength due to impairment of the median nerve, according to Table 12, page 49. The maximum percentage of impairment attributable to median nerve pathology was 10 percent, multiplied by Dr. Osborne's figure of 25 percent, equaled 3 percent. The medical adviser then combined the 8 and 3 percent impairments to equal an 11 percent permanent impairment of the left upper extremity.

By decision dated June 14, 1996, the Office awarded appellant a schedule award for an additional 8 percent permanent impairment of the left upper extremity, totaling an 11 percent permanent impairment. The period of the award, equivalent to 24.96 weeks of compensation, ran from May 1 to October 22, 1996.

Regarding the first issue, the Board finds that the Office improperly found that appellant had no loss of wage-earning capacity effective August 11, 1995.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.<sup>12</sup> The Office, in its December 12, 1995 decision, reduced appellant's compensation for loss of

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<sup>10</sup> In a May 24, 1996 report, Dr. Osborne diagnosed radial humeral arthritis of the left upper extremity, with anticipated permanent effects of left elbow pain and weakness. He indicated that appellant was not able to resume regular work.

<sup>11</sup> Appellant received vocational rehabilitation services from February 1995 to May 1996.

<sup>12</sup> *David W. Green*, 43 ECAB 883 (1992); *Bettye F. Wade*, 37 ECAB 556 (1986).

wage-earning capacity to zero under 5 U.S.C. § 8115 based on his actual earnings as a modified casual mail handler. The Board finds that the Office improperly reduced appellant's compensation.

Effective August 11, 1995, appellant was re-employed as a modified causal mail handler, with wages of \$240.00 per week. However, an August 23, 1995 and March 12, 1996 Office worksheets state that the current pay rate for appellant's date-of-injury position was \$252.00 per week for that time period. Thus, appellant had a loss of wage-earning capacity of \$12.00 per week, the difference between the \$252.00 current date-of-injury pay rate and his actual earnings of \$240.00 per week. Therefore, it was in error for the Office to find that appellant had no loss of wage-earning capacity as of August 11, 1995, and the December 12, 1995 decision must be reversed.

Regarding the second issue, the Board finds that appellant has not established that he sustained greater than an 11 percent permanent impairment of the left upper extremity to the September 30, 1994, left elbow injury.

Section 8107 of the Act<sup>13</sup> and section 10.304 of the implementing regulations<sup>14</sup> provide that schedule awards are payable for permanent impairment of specified body members, functions or organs, but do not specify how to determine the percentage of impairment. Therefore, the Office has adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoptions.<sup>15</sup> Proper use of the A.M.A., *Guides* ensures consistent results and equal justice for all claimants.

The A.M.A., *Guides* lists specific procedures for determining impairment of affected body parts. A physician must first determine the effect of the medical condition on life activities and determine the date of maximum medical improvement.<sup>16</sup> When the effect of impairment is pain or loss of sensation, the physician must identify the area of involvement and the nerve or nerves that enervate the area of involvement.<sup>17</sup> The physician then finds the value for maximum loss of function of the nerve or nerves due to pain or loss of sensation, using the appropriate table.<sup>18</sup> The physician next grades the degree of decreased sensation or pain according to a six-level grading scheme ranging from level one, "[n]o loss of sensation or no spontaneous abnormal sensations" equal to 0 percent degree of decreased sensation or pain, to level 6, "[d]ecreased sensation with pain, which may prevent all activity" equal to between 96 and 100 percent degree of decreased sensation or pain.<sup>19</sup> Finally, a physician multiplies the value of the nerve, gleaned from the appropriate table, by the degree of decreased sensation or pain to reach the percentage

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<sup>13</sup> 5 U.S.C. § 8107.

<sup>14</sup> 20 C.F.R. § 10.304.

<sup>15</sup> *Leisa D. Vassar*, 40 ECAB 1287, 1290 (1989); *Francis John Kilcoyne*, 38 ECAB 168, 170 (1986).

<sup>16</sup> A.M.A., *Guides*, 9.

<sup>17</sup> A.M.A., *Guides*, 40, Table 10.

<sup>18</sup> A.M.A., *Guides*, 40, 70, Tables 10 and 47.

<sup>19</sup> *Id.*, *supra* note 18.

of impairment due to pain or loss of sensation.<sup>20</sup> Similar guidelines exist for evaluating impairment due to loss of motion or impairment due to motor deficits.

In this case, Dr. William Osborne, an attending orthopedic surgeon, submitted a May 1, 1996 report, finding that appellant had reached maximum medical improvement following the January 24, 1996 excision of the radial head, and calculated a 4 percent permanent impairment of the left upper extremity according to the A.M.A., *Guides* due to a 25 percent loss of strength of the left forearm secondary to median nerve impairment. An Office medical adviser reviewed Dr. Osborne's report, and in a June 4, 1996 report, calculated that appellant had an 11 percent impairment of the left upper extremity according to the appropriate tables and grading schemes of the A.M.A., *Guides*, 8 percent due to arthroplasty and 3 percent due to median nerve impairment. His opinion is based on a statement of accepted facts and a review of the medical record.

Appellant has not submitted medical evidence to support his contention that he sustained greater than an 11 percent impairment of the left upper extremity, or presented persuasive argument or evidence that the Office medical adviser's calculations were in error.

Consequently, appellant has not established that he sustained greater than an 11 percent impairment of the left upper extremity due to work factors.

The decision of the Office of Workers' Compensation Programs dated June 14, 1996 is hereby affirmed; the decision dated December 12, 1995 is hereby reversed.

Dated, Washington, D.C.  
March 2, 1999

David S. Gerson  
Member

Willie T.C. Thomas  
Alternate Member

Michael E. Groom  
Alternate Member

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<sup>20</sup> *Id.*, *supra* note 19; *see* A.M.A., *Guides*, 70.