U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CARL LEONARD BOUCHARD and DEPARTMENT OF JUSTICE, DEVANS FEDERAL MEDICAL CENTER, Ayer, MA

Docket No. 03-238; Submitted on the Record;
Issued September 2, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, COLLEEN DUFFY KIKO,
DAVID S. GERSON

The issue is whether appellant is entitled to greater than a 10 percent permanent impairment of the right upper extremity for which he received a schedule award.

On October 7, 1999 appellant, then a 35-year-old corrections officer, sustained an injury to his right elbow during training practice in the performance of duty. The Office of Workers' Compensation Programs accepted the claim for right lateral epicondylitis and subsequent surgeries. Appellant was paid appropriate compensation and benefits. He returned to full duty on December 20, 2001.

On January 12, 2002 appellant filed a claim for a schedule award.

In reports dated February 19, 2002, Dr. Kelton Burbank, a family practitioner and appellant's treating physician, described the results of his physical examination of appellant's right upper extremity. He indicated that he had treated appellant for an injury sustained while appellant was training at a federal prison academy in October 1999. Dr. Burbank indicated that, at the time, appellant had symptoms consistent with lateral epicondylitis and an avu1sion of his extensor mass, which was confirmed by a magnetic resonance imaging (MRI) scan. He indicated that appellant received conservative treatment for six months. In July 2001, appellant underwent a right elbow lateral epicondylectomy with debridement of his ECRB and common extensor mass with an attempt to repair the extensor mass back to the lateral epicondyle. Dr. Burbank noted that postoperatively, appellant did well and his chronic pain was gone. Appellant was able to do, after a prolonged rehabilitation, his activities of daily living; however, he continues to have difficulty with resistance-type activities, particularly with his elbow extended. Dr. Burbank notes that carrying groceries can be painful. Appellant cannot bench press as much weight as he used to. He cannot do as many curls or curl as much weight as he used to. Turning multiple locks at work hurts. Dr. Burbank notices that appellant's endurance is decreased as well. He was returned to full duty on December 20, 2001. This was the time of his maximal medical benefit. Dr. Burbank has no restriction in his range of motion. Appellant has

full supination pronation and flexion extension of the elbow. It is symmetric with the opposite side. He does not have any pain to palpation around the elbow. Appellant does have some decreased strength in the forearm. It appears to be with wrist extension and his grip strength appears to be equal. Appellant's biceps strength appears to be equal. Subjectively, however, he feels that there is a difference. Appellant has pain with heavy weights and repeated activities against resistance. Cold weather also seems to cause pain in the area. I believe that all these are attributable to his original injury in October 1999. Appellant is currently at his maximal medical benefit. I believe he is at 80 percent of his preinjury state in his right elbow. Appellant has no other injuries or impairment attributable to his accident.

In a report dated April 30, 2002, Dr. Burbank, filled out the chart provided by the Office in accordance with the American Medical Association*, Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001).[1] He indicated that appellant was at maximum medical improvement as of December 20, 2001. Dr. Burbank stated that with respect to loss of function, appellant had loss of function due to pain, discomfort, sensory alteration, muscle atrophy and weakness. Regarding appellant's range of motion, he opined that appellant had 140 degrees of flexion, 0 degrees of extension,[2] 80 degrees of forearm pronation[3] and supination of negative 80 degrees.[4] Dr. Burbank opined that there was no ankylosis at the elbow or forearm. He added that the intensity of the pain fluctuated from no pain to moderate pain and it was made worse by cold weather and heavy activity involving the elbow. Dr. Burbank stated it was located along the lateral border of the distal humerus and was not in any nerve distribution but might involve the posterior interosseous nerve. He noted that there was no numbness but pain interfered in some degree with lifting, turning keys and grip strength at work. Dr. Burbank opined that appellant had right arm weakness which was localized at the common extensor of the arm, but also affected other muscles because of inhibition due to pain, noting that this was especially true of elbow flexion/extension strength with no measurable atrophy. He indicated that, the estimated weakness based on preinjury and post injury weights, was 10 percent. Dr. Burbank also indicated that grip strength was affected but was not officially measured. Further, he added that appellant had some scarring on the lateral elbow at seven cetermeters, with a metal tack/screw in the lateral epicondyle which affected his elbow function. Dr. Burbank opined that appellant had an overall disability that decreased the function in his right elbow/forearm by 20 percent.

On July 5, 2002 the Office medical adviser indicated that appellant sustained a hyperextension injury to his right elbow on October 7, 1999 and that he had persistent elbow pain, which was diagnosed as lateral epicondylitis and avulsion of the extensor muscles. He stated that, when appellant failed to show improvement with conservative treatment, appellant underwent a right lateral epicondylectomy with debridement of the ECRB tendon and an attempt to "repair the extensor mass back to the lateral epicondyle" on July 10, 2001. The Office medical adviser noted that appellant returned to full duty on December 20, 2001 and that there

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[1] A.M.A., *Guides.*

[2] Normal extension was zero.

[3] Normal pronation was 80 degrees.

[4] Normal supination was negative 80 degrees.

was no restriction of right elbow motion. He indicated that there was right elbow pain with the use of heavy weights and certain repeated activities against resistance. Grip strength and biceps strength were normal. There was reduced right forearm strength. Using the A.M.A., *Guides,*[5] he referred to Table 16-15, page 492 and found that the maximum upper extremity impairment due to elbow pain was five percent. The Office medical adviser found that at Tab1e 16-10, Grade 3, page 482, appellant was allowed 60 percent for pain that interfered with some activities. He explained that 60 percent of 5 percent resulted in a 3 percent impairment of the right upper extremity. Further, using Table 16-15, the maximum upper extremity impairment due to forearm weakness was 35 percent and Table 16-11, Grade 4, page 484 allowed for 20 percent loss of strength and 20 percent of 35 percent results in 7 percent impairment of the right upper extremity. The Office medical adviser then used the Combined Values Chart, at page 604 and determined that 3 percent impairment due to elbow pain combined with 7 percent for weakness resulted in 10 percent impairment of the right upper extremity. He concluded that the date of maximum medical improvement was December 20, 2001 when appellant returned to full duty.

By decision dated September 19, 2002, the Office awarded appellant compensation for 31.2 weeks from December 20, 2001 to July 26, 2002 based upon a 10 percent permanent impairment of the right upper extremity.

The Board finds that appellant has no more than a 10 percent impairment of the right upper extremity for which he received a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act[6] and its implementing regulation[7] set 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.[8]

Appellant's attending physician, Dr. Burbank, determined that appellant had a decrease in function of 20 percent of the left lower extremity. He did not reference any figures or tables or explain how he set forth his calculations of impairment or explain how he applied the A.M.A., *Guides*[9] to produce his figure of 20 percent.[10] Therefore, the Board finds that his report is of diminished probative value.

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[5] *See supra* note 1.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404 (1999).

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

[9] *See* footnote 1.

[10] Board precedent is well settled, that when an attending physician's report gives an estimate of permanent

The Office medical adviser determined that appellant had a 10 impairment of the right lower extremity.

The Office medical adviser applied the A.M.A., *Guides* to Dr. Burbank's findings. He referred to Table 16-15, page 492 and found that the maximum upper extremity impairment for elbow pain was 5 percent and Table 16-10 on page 482 allowed 60 percent for pain that interfered with some activities. The Office medical adviser explained how 60 percent of 5 percent resulted in a 3 percent impairment of the right upper extremity, that the maximum upper extremity impairment due to forearm weakness was 35 percent and that using Table 16-15 the maximum upper extremity impairment due to forearm weakness was 35 percent. He went on to calculate that Table 16-11 on page 484 allowed for 20 percent loss of strength. The Office medical adviser explained his calculations showing that 20 percent of 35 percent equated to a 7 percent impairment of the right upper extremity. He then referred to the Combined Values Chart on page 604 and determined that a three percent impairment for elbow pain would be combined with a seven percent impairment for weakness not to exceed a ten percent impairment of the right upper extremity and opined the date of maximum medical improvement was December 20, 2001, the date appellant returned to full duty. He properly applied the A.M.A., *Guides*[11] to calculate a 10 percent impairment of the right upper extremity for which he received a schedule award. It is appellant's burden to submit evidence sufficient to establish his claim.[12] While Dr. Burbank indicated that appellant had a 20 percent impairment of the right upper extremity, he did not indicate what tables and/or figures he utilized to reach this conclusion. There is, therefore, no evidence of record that appellant has more than a 10 percent impairment of the right upper extremity for which appellant received a schedule award. The report of the Office medical adviser is the only medical report, which evaluated appellant's permanent impairment properly utilizing the A.M.A., *Guides*[13] and thus constitutes the weight of the medical evidence.[14]

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impairment and mentions the A.M.A., *Guides*, but does not base that estimate upon correct application of specifically identifiable sections, grading schemes, tables or figures, the Office is correct to follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides; see Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980). Board cases are clear that if the attending physician does not properly utilize the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of any permanent impairment; *see Thomas P. Gauthier*, 34 ECAB 1060 (1983); *Raymond Montanez*, 31 ECAB 1475 (1980). *See Tonya D. Bell,* 43 ECAB 845 (1992).

[11] A.M.A., *Guides* (5th ed. 2000).

[12] *See Annette M. Dent,* 44 ECAB 403 (1993).

[13] *Id.*

[14] *Joseph Santaniello*, 42 ECAB 710 (1991).

The September 19, 2002 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
September 2, 2003

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member