United States Department of Labor
Employees' Compensation Appeals Board

T.W., Appellant **and** **U.S. POSTAL SERVICE, POST OFFICE, Long Beach, CA, Employer**	))))))))	**Docket No. 07-2021** **Issued: April 17, 2008**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 31, 2007 appellant filed a timely appeal from the Office of Workers' Compensation Programs' July 9, 2007 merit decisions concerning his entitlement to schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than a two percent permanent impairment of his right leg or a seven percent permanent impairment of his left arm, for which he received schedule awards.

FACTUAL HISTORY

On October 12, 2001 appellant, then a 46-year-old clerk, filed an occupational disease claim alleging that his repetitive work duties caused him to experience pain in his neck, back, left hip, shoulders, elbows, right wrist, right knee, ankles and left foot. He did not stop work at the time claimed but began working in a light-duty position.

The findings of October 25, 2001 electromyogram testing revealed mildly abnormal results in the right triceps and right abductor of the fifth finger consistent with a C7-T1 root finding. Magnetic resonance imaging (MRI) scan testing from late 2001 revealed mild disc protrusions at multiple levels between C3 and C7, a mild disc bulge at L2-3, a right knee meniscal tear and a subchondral cyst and edema in the anterior distal femur at the right knee. On January 3, 2002 nerve conduction studies of the extremities found a C6-7 radiculopathy and neurologic changes at the left peroneal/posterior tibial nerve. The medical evidence reveals that appellant had polio since childhood which caused him to have left leg atrophy.

In a June 8, 2003 decision, the Office accepted that appellant sustained employment-related left shoulder tendinitis and mild degenerative meniscal disease of the right knee. The Office paid compensation for periods of disability. On March 18, 2004 appellant underwent a partial medial meniscectomy, synovectomy and chondroplasty of the right knee. The procedure was authorized by the Office. On October 2, 2004 appellant underwent a left anterior subacromial decompression with resection of the coracoacromial ligament. It does not appear that this procedure was authorized by the Office.

On March 2, 2006 Dr. Mark Greenspan, an attending Board-certified orthopedic surgeon, indicated that appellant reported pain in his left shoulder which extended into his entire arm and numbness and tingling in his left hand and fingers. Appellant also reported pain, buckling and giving way in his right knee. Dr. Greenspan indicated with regard to left shoulder motion that appellant had 140 degrees of flexion, 45 degrees of extension, 140 degrees of abduction, 60 degrees of adduction, 45 degrees of external rotation, and 80 degrees of internal rotation. Appellant's right knee showed 105 degrees of flexion and 180 degrees of extension with tenderness of the medial femoral condyle and pes bursa and he was observed walking in a normal fashion. Muscle testing of the lower extremities showed normal strength and sensation. Dr. Greenspan indicated that appellant reached maximum medical improvement with respect to his right leg and left arm. He concluded that, under the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), appellant had a 10 percent permanent impairment of his left arm due to his October 2, 2004 left anterior subacromial decompression with resection of the coracoacromial ligament. Dr. Greenspan also found that appellant had a 2 percent permanent impairment of his right leg due to his March 18, 2004 partial medial meniscectomy and a 10 percent permanent impairment of his right leg due to limited right knee flexion of 105 degrees.

Appellant claimed that he had employment-related injuries other than the accepted left shoulder tendinitis and mild degenerative meniscal disease of the right knee. The Office determined that there was a conflict in the medical opinion between Dr. Fred Hafezi, an attending Board-certified orthopedic surgeon, and Dr. William C. Boeck, a Board-certified orthopedic surgeon who served as an Office referral physician, regarding whether appellant had such additional employment-related injuries. In order to resolve the conflict, the Office referred appellant to Dr. Paul Bouz, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter. On May 2, 2006 Dr. Bouz determined that appellant did not have any additional employment-related injuries. He also indicated with regard to left shoulder motion that appellant had 150 degrees of flexion, 40 degrees of extension, 160 degrees of abduction, 40 degrees of adduction, 70 degrees of external rotation, and 70 degrees of internal rotation. Dr. Bouz stated that appellant had full flexion and extension of his right knee with

minimal tenderness and no instability. He concluded that, under the A.M.A., *Guides*, appellant had a five percent permanent impairment of his left arm due to limited motion and a one percent permanent impairment of his whole person due to his March 18, 2004 partial medial meniscectomy.

In a May 10, 2006 decision, the Office denied appellant's claim that he had employment-related injuries other than the accepted left shoulder tendinitis and mild degenerative meniscal disease of the right knee.

On May 11, 2006 Dr. Grant Orlin, an attending Board-certified orthopedic surgeon, indicated that appellant had slight tenderness over the supraspinatus tendon of his left shoulder and that with regard to left shoulder motion that he had 120 degrees of flexion, 40 degrees of extension, 130 degrees of abduction, 60 degrees of adduction, 5 degrees of external rotation, and 80 degrees of internal rotation. He stated that appellant had slight right patellar crepitation and exhibited full range of motion of his right knee with slight pain on full extension.

On February 21, 2007 Dr. Albert Jenkins, an attending Board-certified orthopedic surgeon, stated that appellant had a sensory loss on the left arm in the C5 and C6 nerve root distributions but that the lower extremities showed no sensory loss. Appellant had right knee motion and right mediolateral joint line tenderness. Dr. Jenkins stated with regard to left shoulder motion that appellant had 142 degrees of flexion, 26 degrees of extension, 65 degrees of abduction, 33 degrees of adduction, 67 degrees of external rotation, and 55 degrees of internal rotation. Appellant's right knee showed 79 degrees of flexion and 5 degrees of extension. Dr. Jenkins concluded that, under the A.M.A., *Guides*, appellant had a 13 percent permanent impairment of his left arm due to limited left shoulder motion which was comprised of a 3 percent rating for flexion, 1 percent for extension, 6 percent for abduction, 1 percent for adduction, and 2 percent for internal rotation. He found that appellant had a 20 percent permanent impairment of his right leg due to limited right knee flexion of 79 degrees.[1]

In a February 27, 2007 decision, the Board affirmed the Office's May 10, 2006 decision regarding appellant's accepted employment conditions.

On April 28, 2007 appellant requested entitlement to schedule award compensation. On May 23, 2007 Dr. Arthur S. Harris, a Board-certified orthopedic surgeon who served as an Office medical adviser, stated that Dr. Greenspan felt that appellant had reached maximum medical improvement when he performed his examination on March 2, 2006. Dr. Harris stated that appellant's condition "did not appear to be significantly changed from that of March 2, 2006" when Dr. Orlin examined him on May 11, 2006 and Dr. Simpkins examined him on February 21, 2007. Dr. Harris concluded, based on the findings of Dr. Greenspan, that appellant had a seven percent permanent impairment of his left arm due to limited left shoulder motion which was comprised of a three percent rating for flexion, one percent for extension, two percent for abduction, and one percent for external rotation. He found that appellant had a two percent permanent impairment of his right leg due to his March 18, 2004 partial medial meniscectomy.

[1] Dr. Jenkins indicated that appellant's range of motion limitations provided a more accurate basis for his right leg impairment rating than a two percent rating for his partial medial meniscectomy or a five percent rating for his right knee arthritis.

In a July 9, 2007 decision, the Office granted appellant a schedule award for a seven percent permanent impairment of his left arm. The award ran for 21.84 weeks from March 2 to August 1, 2006. In another July 9, 2007 decision, the Office granted appellant a schedule award for a two percent permanent impairment of his right leg. The award ran for 5.76 weeks from August 2 to September 11, 2006.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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.[4] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[5]

Proceedings under the Act are not adversary in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[6] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[7]

ANALYSIS

The Office accepted that appellant sustained employment-related left shoulder tendinitis and mild degenerative meniscal disease of the right knee. In a July 9, 2007 decision, the Office granted appellant a schedule award for a seven percent permanent impairment of his left arm. In another July 9, 2007 decision, the Office granted him a schedule award for a two percent permanent impairment of his right leg.

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id*.

[5] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of Office procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

[6] *Russell F. Polhemus,* 32 ECAB 1066 (1981).

[7] *See Robert F. Hart,* 36 ECAB 186 (1984).

The Office based its schedule award determination on the May 23, 2007 assessment of Dr. Arthur S. Harris, a Board-certified orthopedic surgeon who served as an Office medical adviser.[8] Dr. Harris concluded, based on the findings of Dr. Greenspan, that appellant had a seven percent permanent impairment of his left arm due to limited left shoulder motion which was comprised of a three percent rating for flexion, one percent for extension, two percent for abduction, and one percent for external rotation.[9] He found that appellant had a two percent permanent impairment of his right leg due to his March 18, 2004 partial medial meniscectomy.

The Board finds that Dr. Harris did not adequately explain why he chose to only use the findings of Dr. Greenspan to evaluate appellant's left arm impairment. The record contains three other impairment evaluations that occurred after Dr. Greenspan's evaluation, including the May 2, 2006 evaluation of Dr. Bouz, a Board-certified orthopedic surgeon,[10] the May 11, 2006 evaluation of Dr. Orlin, an attending Board-certified orthopedic surgeon, and the February 21, 2007 evaluation of Dr. Simpkins, an attending Board-certified orthopedic surgeon. The reports of Dr. Orlin and Dr. Simpkins both contain findings for left shoulder motion which would produce greater impairment ratings for motion limitations than the findings of Dr. Greenspan. The findings of Dr. Orlin would produce a 9 percent impairment rating and the findings of Dr. Simpkins would produce a 13 percent rating.[11]

In addition, Dr. Harris did not adequately explain why he concluded that appellant only had a two percent permanent impairment of his right leg due to his March 18, 2004 partial medial meniscectomy. He did not explain why it would not be more appropriate to base appellant's right leg impairment rating on range of motion deficits for the right knee. The Board notes that the 105 degrees of right knee flexion found by Dr. Greenspan would produce a 10 percent permanent impairment rating for appellant's right leg and the 79 degrees of right knee flexion found by Dr. Simpkins would produce a 20 percent rating for appellant's right leg.[12]

As noted above, the Office shares responsibility in the development of the evidence particularly when it undertakes to develop the medical evidence.[13] Therefore, the Office should

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[8] Dr. Harris did not examine appellant but rather reviewed the medical evidence of record.

[9] The Board notes that applying the findings of Dr. Greenspan to the relevant standards of the A.M.A., *Guides* would produce such impairment ratings. *See* A.M.A., *Guides* 476-78, 479, Figures 16-40, 16-43 and 16-46.

[10] Dr. Bouz served as an impartial medical specialist regarding appellant's claim that he sustained additional employment-related conditions, but did not serve as an impartial medical specialist with respect to his claim for schedule award compensation.

[11] Dr. Greenspan indicated that appellant had a 10 percent permanent impairment of his left arm due to his October 2, 2004 left anterior subacromial decompression with resection of the coracoacromial ligament. *See* A.M.A., *Guides* 506, Figures 16-27. However, the record does not support that this surgery was authorized by the Office or that the condition which necessitated this surgery was employment related. Moreover, the record does not show that appellant had a preexisting condition which necessitated this surgery. *See supra* note 5 and accompanying text.

[12] *See* A.M.A., *Guides* 537, Figure 17-10. The Board notes that the A.M.A., *Guides* does not allow combination of impairment based on limited motion with a diagnosis-based impairment such as impairment based on knee surgery. *Id.* at 526, Table 17-2.

[13] *See supra* notes 6 and 7 and accompanying text.

further develop the medical evidence to address the matters discussed above and to ensure that there is a full and accurate assessment of appellant's right leg and left arm impairments under the standards of the A.M.A., *Guides*. After such development as it deems necessary, the Office should issue an appropriate merit decision regarding appellant's entitlement to schedule award compensation.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant met his burden of proof to establish that he has more than a two percent permanent impairment of his right leg or a seven percent permanent impairment of his left arm, for which he received schedule awards. The case is remanded to the Office for further development.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' July 9, 2007 decisions are set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: April 17, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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