United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 07-1236**
	)	**Issued: February 22, 2008**
U.S. POSTAL SERVICE, RANCHO SANTA FE POST OFFICE, Rancho Santa Fe, CA, Employer	)	

Appearances:
Appellant, 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 April 4, 2007 appellant filed a timely appeal of the May 2 and December 29, 2006 merit decisions of the Office of Workers' Compensation Programs finding that he had no more than a 16 percent impairment of the right upper extremity and a 16 percent impairment of the right lower extremity, for which he received schedule awards. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than a 16 percent impairment to the right upper extremity and a 16 percent impairment to the right lower extremity, for which he received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board. In a May 22, 1998 decision, the Board affirmed an Office hearing representative's November 24, 1995 decision which found that appellant was not entitled to disability compensation for the period August 14 through

November 7, 1993 and February 21 through August 29, 1994.[1] The facts and the history relevant to the present issue are hereafter set forth.

On March 10, 1993 appellant, then a 47-year-old clerk, sustained injury when a rest bar collapsed which caused him to fall to the ground on his right side and hurt his neck, back, right wrist and right elbow. The Office accepted the claim for cervical, thoracic and right wrist sprains, right elbow strain, right shoulder impingement syndrome and right lateral meniscus tear. It authorized open acromioplasty and a Mumford procedure of the right shoulder which were performed on December 13, 1993 and arthroscopic subacromial decompression and another Mumford procedure which were performed on June 5, 2000. Regarding the right knee, the Office authorized a partial posterior horn medial meniscectomy, a partial posterior horn lateral meniscectomy and a plica resection with patella debridement and synovectomy which were performed on November 8, 1993 and January 24, 2001. All of the surgeries were performed by Dr. Robert N. Gould, an attending Board-certified orthopedic surgeon.

By letter dated February 1, 2006, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Thomas J. Sabourin, a Board-certified orthopedic surgeon, for a second opinion medical examination. In a February 9, 2006 medical report, Dr. Sabourin reviewed the history of appellant's March 10, 1993 employment injury and medical background. On physical examination, he reported normal range of motion of the cervical and lumbar spines. Regarding the right shoulder, Dr. Sabourin reported 40 degrees of extension, 170 degrees of flexion, 150 degrees of abduction, 30 degrees of adduction, 90 degrees of external rotation and 80 degrees of internal rotation. He stated that appellant had normal range of motion of both elbows, wrists, hands, hips and feet. There was no pain, swelling, effusion, tenderness, warmth, crepitus or instability. Dr. Sabourin reported 0 degrees of extension and 140 degrees of flexion for the right knee and the same measurements for the left knee. He further reported his normal findings on neurological examination and essentially normal findings on x-ray examination. Dr. Sabourin opined that appellant's work-related neck strain, right wrist sprain, right elbow strain and loose body and thoracic sprain had essentially resolved, noting that minimal residuals continued in these areas. Appellant also had residual symptoms of his right shoulder impingement and right knee problems. Dr. Sabourin stated that all of his problems were permanent and stationary. He diagnosed right shoulder impingement syndrome status post acromioplasty and excision of the distal clavicle and right knee lateral meniscal tear status post two arthroscopic surgeries. Dr. Sabourin opined that the diagnosed conditions were caused by the accepted March 10, 1993 employment injury. He further opined that appellant's preexisting thoracic spine problem was not aggravated by the accepted employment injury. Noting appellant's objective findings and subjective complaints, Dr. Sabourin found that no formal physical therapy was necessary and that a gym membership was sufficient in helping appellant with his chronic injuries. He further found that appellant should continue to perform his limited-duty job as a lobby director at the employing establishment and follow his restrictions which included sitting and standing for two hours with rotation and lifting no more than 15 pounds. In questionnaires dated February 7, 2006, Dr. Sabourin opined that appellant reached maximum medical improvement on that date with regard to his right upper and right lower extremities. He indicated that he experienced moderate

[1] Docket No. 96-1159 (issued May 22, 1998).

pain in the right upper extremity and mild pain in the right lower extremity. Dr. Sabourin concluded that appellant did not have any neurological involvement, weakness or atrophy in either extremity.

In a report dated February 28, 2006, Dr. Gould stated that subjective factors of appellant's disability included weakness in the right shoulder, right elbow and right knee and sometimes mild pain on an intermittent basis in these joints. Objective factors of his disability included a well-healed anterior shoulder incision and arthroscopic portals of the right elbow. Dr. Gould reported normal range of motion of the right elbow and right knee. Appellant had 30 degrees of abduction and forward flexion of the right shoulder which caused discomfort. On neurosensory examination, Dr. Gould reported that the upper and lower extremities were within normal limits. The knee was stable to varus and valgus stress anteriorly and posteriorly. The elbow was ligamentously stable and intact.

On April 5, 2006 appellant filed a claim (Form CA-7), for a schedule award.

On April 6, 2006 Dr. Leonard A. Simpson, an Office medical adviser, reviewed the medical evidence. Based on Dr. Sabourin's findings, Dr. Simpson determined that appellant's complaints of continuing right shoulder symptoms represented a Grade 3 level of sensory or pain deficit based on Table 16-10 on page 482 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001). He stated that this level of pain or altered sensation may interfere with activities. Sixty percent of the the maximum 5 percent impairment of the axillary nerve constituted a 3 percent impairment for pain factors (A.M.A., *Guides* 492, Table 16-15). Dr. Simpson determined that appellant sustained a 10 percent impairment for his distal clavicle excision (A.M.A., *Guides* 506, Table 16-27). With regard to range of motion of the right shoulder, he determined that 170 degrees of forward flexion constituted a one percent impairment (A.M.A., *Guides* 476, Figure 16-40), 150 degrees of abduction and 30 degrees of adduction each constituted a one percent impairment (A.M.A., *Guides* 477, Figure 16-43), 90 degrees of external rotation and 80 degrees of internal rotation each constituted a zero percent impairment (A.M.A., *Guides* 479, Figure 16-46) and 40 degrees of extension constituted a one percent impairment (A.M.A., *Guides* 476, Figure 16-40), totaling four percent impairment. Dr. Simpson found that appellant had full range of motion of the elbow and wrist which constituted zero percent impairment. He stated that the records did not describe any upper extremity weakness and atrophy. Dr. Simpson combined the 3 percent impairment for pain/sensory deficit, 4 percent impairment for limited range of motion and 10 percent impairment for a distal clavicle excision to rate a total 16 percent impairment to the right upper extremity (A.M.A., *Guides*, 604-6, Combined Values Chart). He concluded that appellant reached maximum medical improvement on June 5, 2002 two years from the date of his last shoulder surgery.

Regarding the right lower extremity, Dr. Simpson determined that appellant's subjective complaints of right knee pain following surgery on November 8, 1993 and January 24, 2001 constituted a Grade 3 level of pain (A.M.A., *Guides*, 482, Table 16-10).[2] He stated that this pain

[2] Table 16-10, page 482 of the fifth edition of the A.M.A., *Guides* is entitled Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Disorders. According to paragraph 17.2l, page 550 of the A.M.A., *Guides*, partial sensory deficits of the lower extremities are calculated as in the upper extremity as set forth in Table 16-10.

or altered sensation may interfere with activities. Sixty percent of the maximum 7 percent impairment of the femoral nerve constituted a 4.2 or 4 percent impairment for pain (A.M.A., *Guides* 552, Table 17-37). Dr. Simpson stated that, although appellant had reduced range of motion of the right knee from 0 to 140 degrees, he sustained 0 percent impairment (A.M.A., *Guides* 537, Table 17-10). Since the records did not indicate atrophy or weakness, he determined that appellant did not have any impairment for these conditions. Dr. Simpson concluded that appellant sustained a four percent impairment of the right lower extremity. He also calculated appellant's right lower extremity impairment utilizing the diagnosis-based estimates of the A.M.A., *Guides*. Dr. Simpson found that appellant's partial medial and partial lateral meniscectomies constituted a 10 percent impairment (A.M.A., *Guides* 546, Table 17-33). He determined that the finding of some mild narrowing of the medial compartment constituted a seven percent impairment of the joint space narrowing (A.M.A., *Guides* 544, Table 17-31). Dr. Simpson combined the 10 percent impairment for partial medial and lateral meniscectomies and 7 percent impairment for mild medial joint compartment narrowing to calculate a 16 percent impairment of the right lower extremity (A.M.A., *Guides*, 604-6, Combined Values Chart). Dr. Simpson concluded that appellant reached maximum medical improvement on January 24, 2002, one year after his knee surgery on January 24, 2001.

On April 25, 2006 appellant filed another CA-7 claim for a schedule award.

By decisions dated May 2, 2006, the Office granted appellant a schedule award for a 16 percent impairment of the right upper extremity and a 16 percent impairment of the right lower extremity based on Dr. Simpson's April 6, 2006 opinion.

In a letter dated May 30, 2006, appellant requested an oral hearing before an Office hearing representative.

By decision dated December 29, 2006, an Office hearing representative affirmed the May 2, 2006 decisions based on a review of the written record.[3] He found that appellant did not have more than a 16 percent impairment to the right upper extremity and a 16 percent impairment of the right lower extremity previously awarded. The hearing representative determined that the weight of the evidence rested with the Office medical adviser.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] set forth the number of weeks of compensation to be paid for

[3] In his May 30, 2006 request for a hearing, appellant indicated with a checkmark that he was open to a teleconference if this was deemed suitable by the Office. By letter dated September 7, 2006, the Office advised him that a telephone hearing was scheduled for October 5, 2006 at 11:15 a.m. Eastern Standard time. Appellant advised the Office at the approximate time of the hearing that he was unable to participate in the telephone conference. The hearing representative attempted to contact him on the next day, but was unable to do so. Since appellant failed to participate in the telephone hearing, the hearing representative conducted a review of the written record.

[4] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[5] 20 C.F.R. § 10.404.

permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[6] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[7]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be reviewed by an Office medical adviser for an opinion concerning the nature and percentage of any impairment.[8]

ANALYSIS

The Board finds that appellant has not established that he has more than a 16 percent impairment of the right upper extremity. However, the medical evidence establishes a 19 percent impairment of the right lower extremity. Regarding the right shoulder, appellant underwent an open acromioplasty and a Mumford procedure which were performed on December 13, 1993 and arthroscopic subacromial decompression and another Mumford procedure which were performed on June 5, 2000. Regarding the right knee, he underwent a partial posterior horn medial meniscectomy, a partial posterior horn lateral meniscectomy and a plica resection with patella debridement and synovectomy which were performed on November 8, 1993 and January 24, 2001.

In a February 28, 2006 report, Dr. Gould, an attending physician, found that subjective factors of appellant's disability included weakness in the right shoulder, right elbow and right knee and sometimes mild pain on an intermittent basis in these joints. Objective factors of his disability included a well-healed anterior shoulder incision and arthroscopic portals of the right elbow. Dr. Gould reported normal range of motion of the right elbow and right knee, 30 degrees of abduction and forward flexion of the right shoulder which caused discomfort. He reported that the upper and lower extremities were within normal limits on neurosensory examination. The knee was stable to varus and valgus stress anteriorly and posteriorly. The elbow was ligamentously stable and intact. Dr. Sabourin, an Office referral physician, provided in a February 9, 2006 report that appellant had 40 degrees of extension, 170 degrees of flexion, 150 degrees of abduction, 30 degrees of adduction, 90 degrees of external rotation and 80 degrees of internal rotation of the right shoulder. With regard to the right knee, he reported 0 degrees of extension and 140 degrees of flexion. However, neither Dr. Gould nor Dr. Sabourin provided an impairment rating based on the tables and figures of the A.M.A., *Guides*. Therefore, the Board finds that their reports are insufficient to establish that appellant has more than a 16 percent impairment to the right shoulder and a 16 percent impairment to the right knee.

[6] 5 U.S.C. § 8107(c)(19).

[7] 20 C.F.R. § 10.404.

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

Dr. Simpson, an Office medical adviser, reviewed Dr. Sabourin's findings. He determined that appellant's complaints of continuing right shoulder symptoms constituted a maximal Grade 3 level of pain or sensory deficit which may interfere with activities or 60 percent grade of the maximum 5 percent impairment allowed for the axillary nerve which constituted a 3 percent impairment for pain factors (A.M.A., *Guides* 482, 492, Tables 16-10, 16-15). Dr. Simpson further determined that appellant sustained a 10 percent impairment for his distal clavicle excision (A.M.A., *Guides* 506, Table 16-27). He found that 170 degrees of forward flexion constituted a one percent impairment (A.M.A., *Guides* 476, Figure 16-40), 150 degrees of abduction and 30 degrees of adduction each constituted a one percent impairment (A.M.A., *Guides* 477, Figure 16-43), 90 degrees of external rotation and 80 degrees of internal rotation each constituted a zero percent impairment (A.M.A., *Guides* 479, Figure 16-46) and 40 degrees of extension constituted a one percent impairment (A.M.A., *Guides*, 476, Figure 16-40), totaling a four percent impairment. Dr. Simpson found that appellant had full range of motion of the elbow and wrist and there was no evidence of upper extremity weakness and atrophy which constituted zero percent. He combined the 3 percent impairment for pain, 4 percent impairment for limited range of motion and 10 percent impairment for a distal clavicle excision to calculate a 16 percent impairment of the right upper extremity (A.M.A., *Guides*, 604-6, Combined Values Chart).

Regarding the right lower extremity, Dr. Simpson determined that appellant's subjective complaints of right knee pain following surgery on November 8, 1993 and January 24, 2001 constituted a Grade 3 level of pain which may interfere with activities or 60 percent of the maximum 7 percent impairment allowed for the femoral nerve, representing a 4 percent impairment for pain and sensory loss (A.M.A., *Guides*, 552, Table 17-37). He stated that, although appellant had reduced range of motion of the right knee from 0 to 140 degrees, he sustained a zero percent impairment (A.M.A., *Guides* 537, Table 17-10). Dr. Simpson found that appellant had no atrophy or weakness and, thus, he had zero percent impairment. He concluded that appellant sustained a four percent impairment of the right lower extremity based on sensory loss. Dr. Simpson also calculated appellant's impairment utilizing diagnosis-based estimates of the A.M.A., *Guides*. He determined that his partial medial and partial lateral meniscectomies constituted a 10 percent impairment (A.M.A., *Guides* 546, Table 17-33). Dr. Simpson further determined that the finding of some mild narrowing of the medial compartment constituted a seven percent impairment of the joint space narrowing (A.M.A., *Guides* 544, Table 17-31). He combined the 10 percent impairment for partial medial and lateral meniscectomies and 7 percent impairment for mild medial joint compartment narrowing to calculate a 16 percent impairment of the right lower extremity (A.M.A., *Guides*, 604-6, Combined Values Chart). The Board notes, however, that Table 17-2, the cross usage chart, does not preclude combining the sensory (pain) impairment with the loss due to arthritis and the diagnosed based estimates. Combining the 4 percent sensory loss with 16 percent results in a total 19 percent loss to the right lower extremity.

Dr. Simpson applied the A.M.A., *Guides* and provided rationale for rating 16 percent impairment of the right upper extremity. The Board finds 19 percent impairment of the right lower extremity.

CONCLUSION

The Board finds that appellant has no more than a 16 percent impairment to the right upper extremity and a 19 percent impairment to the right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the December 29 and May 2, 2006 decisions of the Office of Workers' Compensation Programs are affirmed, as modified.

Issued: February 22, 2008
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