United States Department of Labor
Employees' Compensation Appeals Board

P.Y., Appellant **and** **U.S. POSTAL SERVICE, POST OFFICE, Humble, TX, Employer**	)	**Docket No. 07-1832** **Issued: February 14, 2008**

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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 2, 2007 appellant filed a timely appeal of the Office of Workers' Compensation Programs' March 22, 2007 merit decision granting her a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has greater than seven percent impairment of the left upper extremity.

FACTUAL HISTORY

Appellant, a 49-year-old letter carrier, injured her left wrist and hand on March 29, 2002 when she collided with a door. The Office accepted her claim for left hand contusion and left carpal tunnel syndrome. Appellant underwent left carpal tunnel release surgery on June 27, 2002. On May 22, 2003 she underwent left wrist arthroscopy and debridement and left wrist arthroscopically-assisted scapholunate stabilization. On October 3, 2003 appellant returned to part-time modified duty.

Appellant received a schedule award on May 6, 2004 for five percent impairment of the left upper extremity. The award totaled 15.6 weeks' compensation, covering the period February 11 to May 30, 2004. Appellant returned to full-time limited duty on October 15, 2006.

On May 9, 2006 appellant filed a claim for an additional schedule award. She submitted numerous reports from her treating physician, Dr. Samuel Alianell, a Board-certified physiatrist, reflecting that she continued to experience pain and swelling related to her accepted condition. On May 19, 2006 the Office asked Dr. Alianell to provide an opinion as to the degree of permanent impairment of appellant's left upper extremity. On December 26, 2006 Dr. Alianell informed the Office that he did not perform impairment ratings.

On February 1, 2007 the Office referred appellant, a statement of accepted facts and the entire medical record to Dr. Bernard Albina, a Board-certified orthopedic surgeon, for an evaluation and an opinion as to the degree of permanent impairment of appellant's left upper extremity. In a report dated February 21, 2007, Dr. Albina provided a detailed history of injury and treatment. His examination of the left wrist revealed moderate tenderness and swelling, with discomfort on extension and flexion. Range of motion examination showed dorsiflexion and palmar flexion at 50 percent; radial deviation at 20 percent; and ulnar deviation at 30 percent. Dr. Albina noted no atrophy in the left upper extremity. Sensory examination revealed some diffuse numbness in the volar aspect of the thumb, index and middle fingers, with mildly positive Tinel's and Phalen's signs. Range of motion was normal at the thumb, with flexion at the metatarsophalangeal (MP) and interphalangeal (IP) joints of 60 and 80 degrees respectively. Adduction and opposition were at eight centimeters (cm). Grip strength was six pounds on the left and four pounds on the right. Bicipital and tricipital jerks were normal, and two-point discrimination was positive at six millimeters (mm). Dr. Albina opined that appellant had reached maximum medical improvement (MMI) on March 29, 2004, two years after her injury. Referring to the fifth edition of the A.M.A., *Guides*, Dr. Albina opined that appellant had a seven percent impairment of the left upper extremity. Pursuant to Figure 16-28 at page 467, he found two percent impairment due to loss of extension and two percent impairment due to loss of flexion, for a combined four percent impairment. Referring to Table 16-15 at page 492 and Table 16-10 at page 482, he classified appellant's impairment due to sensory deficit or pain as Grade 4, and selected five percent severity level. Noting that the maximum upper extremity impairment for sensory deficit or pain for the median nerve below the midforearm was 39 percent, he multiplied the grade of severity, 5 percent, by 39 percent to arrive at 2 percent impairment for sensory deficit or pain. Pursuant to Table 16-11 at page 484, he classified impairment due to motor and loss of power as Grade 4, and selected five percent severity level. Noting that the maximum upper extremity impairment for motor and loss of power deficit for the median nerve below the midforearm was 10 percent, he multiplied the grade of severity, 5 percent, by 10 percent to arrive at 1 percent impairment for motor and loss of power deficit. Referring to the Combined Values Chart, Dr. Albina concluded that appellant had seven percent left upper extremity impairment.

The Office referred Dr. Albina's February 21, 2007 report, statement of accepted facts and the entire case record to the district medical adviser for review. In a March 9, 2007 report, the medical adviser found an additional two percent impairment of the left upper extremity, based on Dr. Albina's report. Referring to Figures 16-28 and 16-31 at pages 467-69 of the fifth edition of

the A.M.A., *Guides*, he found that appellant had two percent impairment for flexion and two percent impairment for extension, resulting in four percent impairment for range of motion. Pursuant to Tables 16-15 at 492, 16-10 at page 482, 15-15 and 15-17 at page 424, he classified appellant's sensory deficit as a Grade 4, with five percent level of severity. Noting that the maximum upper extremity impairment for sensory deficit or pain for the median nerve below the midforearm was 39 percent, he multiplied 5 percent by 39 percent to arrive at 2 percent impairment for sensory deficit or pain. Referring to Tables 16-15 at 492, 16-11 at page 484, 15-16 and 15-17 at page 424, he classified appellant's motor deficit as a Grade 4, with five percent level of severity. Noting that the maximum upper extremity impairment for motor deficit for the median nerve below the midforearm was 10 percent, he multiplied 5 percent by 10 percent to arrive at 1 percent impairment for motor deficit. Applying the Combined Values Chart, he concluded that appellant had seven percent permanent impairment of the left upper extremity, which constituted an increased impairment of two percent over the March 29, 2004 schedule award. The medical adviser opined that appellant reached maximum medical improvement on March 29, 2004.

On March 22, 2007 the Office awarded appellant a schedule award for an additional two percent impairment of the left upper extremity. The period of the award was from May 31 to July 13, 2004. The Office found that the date of maximum medical improvement was March 29, 2004.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[1] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, as the appropriate standard for evaluating schedule losses.[2] Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).[3]

A claim for an increased schedule award may be based on new exposure.[4] Absent any new exposure to employment factors, a claim for an increased schedule award may also be based on medical evidence indicating that the progression of an employment-related condition has resulted in a greater permanent impairment than previously calculated.[5]

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[1] For a total, or 100 percent loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1) (2000).

[2] 20 C.F.R. § 10.404.

[3] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[4] *Linda T. Brown*, 51 ECAB 115 (1999).

[5] *Id*.

In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[6] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[7]

It is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. The Board has defined maximum medical improvement as meaning that the physical condition of the injured member of the body has stabilized and will not improve further. The Board has also noted a reluctance to find a date of maximum medical improvement, which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits. The Board, therefore, requires persuasive proof of maximum medical improvement in the selection of a retroactive date of maximum medical improvement.[8] The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[9]

ANALYSIS

On May 6, 2004 the Office granted appellant a schedule award for five percent impairment of her left upper extremity. In response to her May 9, 2006 request for an increased award, the Office granted her an award for an additional two percent impairment. The Board finds that appellant has not established that she has more than seven percent impairment of her left upper extremity.

In his February 21, 2007 report, Dr. Albina provided a detailed history of injury and treatment and a thorough description of findings on examination. His examination of the left wrist revealed moderate tenderness and swelling, with discomfort on extension and flexion. Range of motion examination showed dorsiflexion and palmar flexion at 50 percent; radial deviation at 20 percent; and ulnar deviation at 30 percent. A sensory examination revealed some diffuse numbness in the volar aspect of the thumb, index and middle fingers, with mildly positive Tinel's and Phalen's signs. Range of motion was normal at the thumb, with flexion at the MP and IP joints of 60 and 80 degrees respectively. Adduction and opposition were at eight cm. Grip strength was six pounds on the left and four pounds on the right. Bicipital and tricipital jerks were normal, and two-point discrimination was positive at six mm. Pursuant to Figure 16-28 at page 467, he found a two percent impairment due to loss of extension and a two percent

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[6] *Carol A. Smart*, 57 ECAB __ (Docket No. 05-1873, issued January 24, 2006); *Michael C. Milner*, 53 ECAB 446, 450 (2002).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7(a)(2) (November 1998).

[8] *J.C.*, 58 ECAB ___ (Docket No. 06-1018, issued January 10, 2007); *D.R.*, 57 ECAB ___ (Docket No. 06-668, issued August 22, 2006); *James E. Earle*, 51 ECAB 567 (2000).

[9] *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

impairment due to loss of flexion, for a combined four percent impairment. Referring to Table 16-15 at page 492 and Table 16-10 at page 482, he classified appellant's impairment due to sensory deficit or pain as Grade 4, and selected five percent severity level. Noting that the maximum upper extremity impairment for sensory deficit or pain for the median nerve below the midforearm was 39 percent, he multiplied the grade of severity, 5 percent, by 39 percent, to arrive at 2 percent impairment for sensory deficit or pain. Pursuant to Table 16-11 at page 484, he classified impairment due to motor and loss of power as Grade 4, and selected five percent severity level. Noting that the maximum upper extremity impairment for motor and loss of power deficit for the median nerve below the midforearm was 10 percent, he multiplied the grade of severity, 5 percent, by 10 percent, to arrive at 1 percent impairment for motor and loss of power deficit. Referring to the Combined Values Chart, Dr. Albina concluded that appellant had a seven percent left upper extremity impairment.

Based on the findings contained in Dr. Albina's report, the district medical adviser found an additional 2 percent impairment of the left upper extremity. Properly referring to Figures 16-28 and 16-31 at pages 467-69 of the fifth edition of the A.M.A., *Guides*, he found that appellant had two percent impairment for flexion and two percent impairment for extension, resulting in four percent impairment for range of motion. Pursuant to Tables 16-15 at 492, 16-10 at page 482, 15-15 and 15-17 at page 424, he classified appellant's sensory deficit as a Grade 4, with five percent level of severity. Noting that the maximum upper extremity impairment for sensory deficit or pain for the median nerve below the midforearm was 39 percent, he multiplied 5 percent by 39 percent to arrive at 2 percent impairment for sensory deficit or pain. Referring to Tables 16-15 at 492, 16-11 at page 484, 15-16 and 15-17 at page 424, he classified appellant's motor deficit as a Grade 4, with five percent level of severity. Noting that the maximum upper extremity impairment for motor deficit for the median nerve below the midforearm was 10 percent, he multiplied 5 percent by 10 percent, to arrive at 1 percent impairment for motor deficit. Applying the Combined Values Chart, he concluded that appellant had seven percent permanent impairment of the left upper extremity, which constituted an increased impairment of two percent over the May 6, 2004 schedule award. After reviewing Dr. Albina's report, the medical adviser referred to, and properly applied, the appropriate tables and figures of the A.M.A., *Guides*, and determined that appellant had seven percent impairment rating for the left upper extremity. There is no evidence of record supporting appellant's contention that she sustained greater than seven percent impairment to her left upper extremity.

As appellant previously received a schedule award for a five percent impairment of the left upper extremity, the Office correctly subtracted that amount from the total percentage of impairment.[10] Accordingly, the Board finds that the Office properly granted appellant a schedule award for an additional two percent left lower extremity impairment.

The Office medical adviser found that appellant reached MMI on March 29, 2004, two years after her injury. The Office specified that the period of the schedule award ran from May 31 to July 13, 2004. It is well established that the period of a schedule award commences on the date that the employee reaches MMI from the residuals of the accepted employment

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[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7(a)(2) (November 1998).

injury. The determination of whether MMI has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[11] The Board has noted a reluctance to find a date of MMI which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits.[12] The Board, therefore, requires persuasive evidence of MMI for selection of a retroactive date of MMI.[13] In this case, Dr. Albina found that the date of MMI was March 29, 2004, and the Office medical adviser agreed. However, their opinions, without explanation, do not constitute the persuasive proof necessary to support a retroactive date of MMI. Moreover, since the evidence establishes that appellant is entitled to an increased schedule award, it appears that the date the condition stabilized was subsequent to the Office's original schedule award decision, which was issued on May 6, 2004. The Board, therefore, finds that the period of the schedule award should commence on February 21, 2007, the date of Dr. Albina's evaluation, which was accepted as definitive by the Office. The case will be remanded for the Office to determine whether the change in the date of commencement of the schedule award changes the pay rate applicable to the schedule award.

CONCLUSION

Appellant has not demonstrated that she has greater than a seven percent impairment of the left upper extremity.

[11] *See Mark A. Holloway, supra* note 9.

[12] *James E. Earle,* 51 ECAB 567 (2000).

[13] *D.R., supra* note 8. *See also id.*

ORDER

IT IS HEREBY ORDERED THAT the March 22, 2007 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part and remanded for further proceedings consistent with this decision of the Board.

Issued: February 14, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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