# United States Department of Labor
# Employees' Compensation Appeals Board

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| **JOHN A. VANDERWERKEN, Appellant** | ) | |
| **and** | ) | **Docket No. 04-1990** |
| | ) | **Issued: January 28, 2005** |
| **U.S. POSTAL SERVICE, POST OFFICE, Manlius, NY, Employer** | ) | |

*Appearances:*
*Jeffrey P. Zeelander, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

### ***JURISDICTION***

On August 9, 2004 appellant filed a timely appeal of the June 29, 2004 merit decision of the Office of Workers' Compensation Programs, which found that he had no more than an eight percent permanent impairment of the right upper extremity, for which he received a schedule award. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award claim.[1]

### ***ISSUE***

The issue is whether appellant sustained greater than an eight percent permanent impairment of the right upper extremity, for which he received a schedule award.

[1] The record on appeal indicates that the Office issued a wage-loss decision on August 9, 2004 the same date appellant filed his appeal. However, as there is no indication on appellant's appeal papers that he is contesting the August 9, 2004 decision of the Office, this decision will not be reviewed by the Board at this time.

## ***FACTUAL HISTORY***

On November 20, 2000 appellant, then a 40-year-old rural letter carrier, filed an occupational disease claim alleging that he developed tendinitis in his right arm due to the requirements of his job. The Office accepted the claim for right lateral epicondylitis and authorized surgery for a right ulnar nerve transposition with partial medial epicondylectomy, which appellant underwent on March 14, 2002. Appellant received appropriate compensation for medical benefits and wage loss.

On April 10, 2003 appellant filed a claim for a schedule award. In an August 26, 2003 report, Dr. Stephen P. Bogosian, a Board-certified orthopedic surgeon and appellant's treating physician, noted that appellant reached maximum medical improvement on March 14, 2003. He advised that appellant continued to note persistent aching sensations and dysesthesias in his ulnar nerve distribution. The August 20, 2003 examination revealed point tenderness directly over the medial epicondylar region and no swelling to the elbow. Loss of motion was noted as mild with a loss of extension of 15 degrees, loss of flexion of 10 degrees and loss of supination of 10 degrees. Decreased strength was noted with regard to gripping with no true atrophy present. Pain was experienced in the elbow region with any repetitive activity. In accordance to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*), Dr. Bogosian opined that appellant sustained a 20 percent impairment per Table 13-23 and a 15 percent impairment per Table 13-24.[2] Utilizing the Combined Values Chart, Dr. Bogosian advised that appellant had a 29 percent right upper extremity impairment.

On November 20, 2003 the Office referred Dr. Bogosian's report and the case record to the Office medical adviser. In a report dated December 3, 2003, the Office medical adviser indicated that he did not see how Dr. Bogosian utilized either the tables cited or the Combined Values Chart from the A.M.A., *Guides*.[3] The Office medical adviser applied Dr. Bogosian's findings to the A.M.A., *Guides* and indicated that, under Figures 16-34 and 16-37[4], a 15 degree loss of extension equated to a 2 percent impairment; a 10 degree loss of flexion equated to a 1 percent impairment; and a 10 degree loss of supination equated to a 0 percent impairment. This equaled a total of three percent impairment for loss of motion. The Office medical adviser noted that, although Dr. Bogosian gave no measure of grip strength objectively, he gave appellant five percent impairment for loss of grip strength. Combining the loss of motion with the loss of grip strength impairment ratings, the Office medical adviser found that appellant had an eight percent impairment of the right upper extremity.

By decision dated December 9, 2003, the Office granted appellant a schedule award for an eight percent permanent impairment of the right upper extremity. The period of the schedule award was from March 14 to August 25, 2003.

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[2] Dr. Bogosian did not specify what edition of the A.M.A., *Guides* he used.

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

[4] A.M.A., *Guides*, p. 472, 474, Table 16-34, 16-37.

In a December 19, 2003 letter, appellant requested an oral hearing before an Office hearing representative. In a May 24, 2003 letter, appellant advised that he wished to change his request for an oral hearing to a review of the written record. Appellant submitted medical reports in further consideration of the schedule award.

In an April 7, 2004 report, Dr. Daniel L. Carr, a Board-certified orthopedic surgeon, noted his physical findings and stated that appellant had some ongoing sensory disturbance as well as subjective complaints of pain and subjective loss of strength without objective evidence of atrophy. He stated that appellant's motion deficits were five percent in flexion and five percent in extension. Under Table 16-34 of the A.M.A., *Guides*,[5] Dr. Carr stated that, as a flexion deficit of 10 percent and an extension deficit of 10 percent each equaled 1 percent loss of use, a 5 percent loss of each would total a 1 percent loss of use combined. Based on Table 16-10, Dr. Carr stated that appellant had a Class 3 disturbance of the ulnar nerve, as he had some diminished light touch in a 2-point discrimination testing which interferes with some activities and opined that he had a 40 percent sensory deficit.[6] Under Table 16-15, Dr. Carr noted that the maximum sensory deficit of the ulnar nerve was 7 percent[7] and multiplied this figure by the 40 percent sensory deficit to equal a total sensory deficit of 3 percent. Combining the one percent motion deficit with the three percent sensory deficit, Dr. Carr opined that appellant had a total right upper extremity impairment of four percent.

In a June 11, 2004 report, Dr. George L. Rodriquez, a physiatrist, reviewed appellant's medical records and opined that appellant's impairment rating should be 23 percent. Dr. Rodriquez stated that he disagreed with the Office medical adviser's report wherein appellant was found to have a five percent rating because of grip strength deficit as it was an estimate without adequate foundation. He opined that Dr. Carr performed a good impairment rating evaluation, but noted that Dr. Carr had rounded the flexion and extension impairments down by one percent too much. He indicated, however, that although Dr. Carr had discounted a significant measured grip strength deficit in the right hand on the assumption that the presence of pain rendered the measurement useless, the A.M.A., *Guides* clearly states on page 484 that, if there is questionable motor activity based on either pain or suspected anatomic variations, the use of a local anesthetic to block either the pain point or competing innervation may assist the examiner in evaluating function. Dr. Rodriquez thus opined that it was entirely possible that the grip strength measurements recorded by Dr. Carr were reliable and that his impairment rating could have been increased by 20 percent more, for a combined total of 23 percent. He rationalized that, as appellant's own surgeon felt that he had objective grip strength loss, unrelated to pain, one year after surgery, supports the probability that grip strength loss measured at a later date would also be independent of pain. Dr. Carr further opined that any remeasuring of appellant's grip strength (controlled for any pain) would result in Dr. Carr's reading and, thus, Dr. Carr's right grip strength of 28.6 kg was a true measurement of actual function.

[5] *Id*. at p. 472, Table 16-34.

[6] *Id*. at p. 482, Table 16-10.

[7] *Id*. at p. 492, Table 16-15.

By decision dated June 29, 2004, the Office hearing representative affirmed the Office decision of December 9, 2003.

## ***LEGAL PRECEDENT***

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulation[9] sets 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.[10]

## ***ANALYSIS***

The Board has carefully reviewed Dr. Bogosian's August 26, 2003 report and notes that, while the physician determined that appellant sustained a 29 percent right upper extremity impairment, it is not clear how he arrived at this conclusion. Although Dr. Bogosian noted that appellant had a 20 percent impairment per Table 13-23 and a 15 percent impairment per Table 13-24, he failed to identify and grade the nerve involved in the evaluation of the sensory deficit and in the evaluation of the muscles and motor nerves involved in the loss of muscles power and motor function resulting from a peripheral nerve disorder as set forth in the A.M.A., *Guides.*[11] He also subsequently failed to properly explain how he calculated such impairment ratings under the respective tables as set forth in the A.M.A., *Guides.*[12] As such, Dr. Bogosian's impairment rating does not conform to the A.M.A., *Guides*. It is well established that, when the attending physician fails to provide an estimate of impairment conforming with the protocols of the A.M.A., *Guides,* his opinion is of diminished probative value in establishing the degree of any permanent impairment. In such cases, the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[13]

Based on Dr. Bogosian's examination findings and Figures 16-34 and 16-37 of the A.M.A., *Guides,*[14] the Office medical adviser properly determined that appellant had a 3 percent impairment for loss of motion. The Office medical adviser also accessed a five percent loss of grip strength, although Dr. Bogosian gave no measure of objective grip strength. The Board

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404 (1999).

[10] *See id.*; *Jacqueline S. Harris*, 54 ECAB ___ (Docket No. 02-203, issued October 4, 2002).

[11] A.M.A., *Guides*, p. 346, 348, Table 13-23, 13-24.

[12] *Id.*

[13] *See John L. McClanic*, 48 ECAB 552 (1997); *see also Paul R. Evans*, 44 ECAB 646, 651 (1993).

[14] *See supra* note 4.

notes, however, that the A.M.A., *Guides* clearly states that "in compression neuropathies, additional impairment values are not given for decreased grip strength."[15] The A.M.A., *Guides* state that impairment ratings based on objective anatomic findings take precedence and, in a rare case, the loss of strength may be rated separately only if it is based on an unrelated cause or mechanism. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts that prevent effective application of maximal force in the region being evaluated.[16] The Board notes, however, that the A.M.A., *Guides* allow for motor weakness associated with disorders of the peripheral nervous system and various degenerative neuromuscular conditions, which are evaluated according to section 16.5 and Chapter 13.[17] Thus, while the Office medical adviser found a five percent loss of grip strength, he did not adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides.*[18] Moreover, he failed to address Dr. Bogosian's assertion that appellant's strength loss appeared to be a subjective loss due to pain as no true atrophy was present. Thus, it does not appear that the Office medical adviser based his impairment rating for loss of grip strength on a proper application of the A.M.A., *Guides*.[19] Although the Office medical adviser had combined the three percent loss of motion and the five percent loss of grip strength impairment values to find an eight percent impairment of the right upper extremity, the Board finds that the Office medical adviser's report only reflects a minimum entitlement to a three percent right upper extremity impairment based on loss of motion.

Appellant also submitted an April 7, 2004 report from Dr. Carr, who examined appellant and opined that he had a four percent right upper extremity impairment resulting from a one percent motion deficit and a three percent sensory deficit. As the A.M.A., *Guides* p. 470 allow for the impairment values to be adjusted or interpolated proportionally in the corresponding interval when the motion measurements fall between those shown on the pie chart, Dr. Carr's calculation that appellant had a total of a 1 percent loss of use for motion deficit under Table 16-34 for a 5 percent loss in motion for flexion and a 5 percent loss in motion for extension was proper. Dr. Carr also properly utilized Tables 16-10 and 16-15 of the A.M.A., *Guides* in finding a total sensory deficit of 3 percent. As such, Dr. Carr based his four percent upper extremity impairment rating on a proper application of the A.M.A., *Guides.* Although Dr. Carr discounted the measured grip strength deficit in appellant's right hand, the Board finds that Dr. Carr's four percent impairment rating based on loss of motion and sensory deficit results in a greater impairment than the Office medical adviser's rating based on loss of motion alone.

The record also contains a June 11, 2004 report from Dr. Rodriquez, who opined that appellant had 23 percent impairment to his right upper extremity. His opinion is based on a review of the records, his general agreement with Dr. Carr's impairment evaluation and his opinion that it was "entirely possible" the grip strength measurements recorded by Dr. Carr were

[15] A.M.A., *Guides*, p. 494; FECA Bulletin No. 01-01 (issued January 29, 2001).

[16] *Id*. at p. 508. *See also id.* at p. 526, Table 17-2.

[17] *Id.*; *see also* FECA Bulletin No. 01-01 (issued January 29, 2001).

[18] *See Tonya R. Bell*, 43 ECAB 845 (1992).

[19] *See Patricia J. Penny-Guzman*, 55 ECAB ___ (September 30, 2004).

reliable and that appellant's impairment "could have been increased by 20 percent or more." While Dr. Rodriquez properly points out that page 484 of the A.M.A., *Guides* allow for the use of a local anesthetic to block either the pain point or competing innervation to assist the examiner in evaluating muscle strength,[20] he did not examine appellant and Dr. Carr did not measure appellant's grip strength with a local anesthetic or performed a Jamar dynamometer series. To opine that any measuring of appellant's grip strength by such tests would result in the same readings obtained by Dr. Carr is purely speculative. Moreover, Dr. Rodriquez failed to address Dr. Carr's assertion that, based on his physical examination and testing, appellant's strength loss was a subjective loss due to pain. Due to the speculative nature of his opinion that appellant's impairment "could have been increased by 20 percent or more" and the fact that Dr. Rodriquez did not examine appellant, Dr. Rodriquez' report is of little probative value.[21] Additionally, Dr. Rodriquez' opinion that appellant has a total impairment rating of 23 percent based on his general agreement with Dr. Carr's range of motion deficits and appellant's grip strength of at least 20 percent, is not based on a proper application of the A.M.A., *Guides.* As previously noted, the A.M.A., *Guides* do not allow range of motion ratings to be combined with muscle atrophy or muscle strength methodologies.[22]

Accordingly, a review of the evidence of record reflects that appellant is not entitled to a greater schedule award than he has already received.

## ***CONCLUSION***

The Board finds that the evidence in this case reflects that appellant is not entitled to more than the eight percent permanent impairment of the right upper extremity for which he received a schedule award.

[20] A.M.A., *Guides*, at 484.

[21] *See Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history or which are speculative or equivocal in character have little probative value).

[22] A.M.A., *Guides*, p. 526 Table 17-2.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the June 29, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 28, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member