United States Department of Labor
Employees' Compensation Appeals Board

N.N., Appellant	)	
and	)	**Docket No. 08-602**
	)	**Issued: August 6, 2008**
U.S. POSTAL SERVICE, SOUTHEASTERN PENNSYLVANIA P & DC, Southeastern, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
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 December 20, 2007 appellant filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated February 7 and August 1, 2007. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determinations in this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish that she has more than a 13 percent impairment of the right upper extremity for which she received a schedule award.

FACTUAL HISTORY

On March 13, 2002 appellant, then a 37-year-old distribution clerk, filed a Form CA-1, traumatic injury claim, alleging that she injured her right hand and wrist that day. She began working limited duty, and on April 18, 2002, the Office accepted that she sustained an

employment-related right wrist sprain. A May 22, 2002 right wrist magnetic resonance imaging scan (MRI) demonstrated no evidence of a full thickness tear, questionable tendinitis of the extensor carpilunaris tendon and no acute bony abnormality. Appellant came under the care of Dr. Scott M. Fried, a Board-certified osteopath specializing in orthopedic surgery. Under his auspices, an upper extremity functional capacity evaluation was performed, on July 31, 2002. Hand function evaluation using the Jamar dynamometer demonstrated level III strength of 25 on the right. Right wrist extension was 60 degrees, flexion 58 degrees, radial deviation 12 degrees and ulnar deviation 27 degrees. Dr. Fried reviewed the functional capacity evaluation and provided restrictions to appellant's physical activities. In a February 27, 2003 report, he advised that appellant had significant instability of the right wrist and diagnosed an acute right wrist radioulnar joint and capito-hamato-lunato-triquetral ligament injury and recommended arthroscopic exploration. Dr. Fried continued to submit reports, including an April 10, 2003 functional capacity evaluation.

On August 20, 2004 appellant filed a schedule award claim and submitted an April 6, 2004 report in which Dr. David Weiss, an osteopath, noted the history of injury and appellant's complaint of intermittent right wrist pain and stiffness. Dr. Weiss reported that she worked light duty and that her household duties were restricted with difficulty brushing her teeth, grasping, pulling, pushing, driving a motor vehicle and in fine dexterity of her right hand. Appellant's pain level was graded at 0 to 4 in a scale of 10. Physical examination of the right wrist demonstrated dorsiflexion of 75 degrees, palmar flexion of 75 degrees, radial deviation of 20 degrees and ulnar deviation of 35 degrees. Ulnar impingement sign produced pain in the distal radioulnar joint. Other testing including Tinel's, Phalen's and carpal compression was negative. Grip strength testing using the Jamar dynamometer demonstrated 12 kg at level III on the right. Dr. Fried diagnosed post-traumatic distal radioulnar joint injury to the right wrist, triangular fibrocartilage complex injury to the right wrist by clinical impression, and cumulative and repetitive trauma disorder to the right wrist. He opined that in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] under Table 16-34 appellant had a 20 percent right upper extremity impairment arising from a grip strength deficit and, under Table 18-1, a 3 percent pain-related impairment, for a total 23 percent right upper extremity impairment.

On June 30, 2005 the Office referred the medical record, including Dr. Weiss' report, to an Office medical adviser for review. In an undated report, the Office medical adviser noted his review of the medical record including Dr. Weiss' April 6, 2004 report. He advised that maximum medical improvement had been reached on April 6, 2004 and noted that grip strength was very subjective. The Office medical adviser stated that Dr. Weiss' measurements were not in agreement with the measurements found on the July 31, 2002 functional capacity evaluation and based his grip strength impairment rating on the latter, finding a 10 percent impairment under Table 16-34. He agreed that appellant had a 3 percent pain-related impairment, for a total 13 percent right upper extremity impairment rating. Dr. Fried continued to submit reports and functional capacity evaluations.

[1] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

By decision dated February 7, 2007, appellant was granted a schedule award for a 13 percent right upper extremity impairment, to run for 283.92 days from April 6, 2006 to January 14, 2007. On February 15, 2007 appellant, through her attorney, requested a hearing that was held on June 12, 2007. She did not appear at the hearing, and her attorney argued that Dr. Weiss' report should be credited or at the very least, a conflict in medical evidence had been created. In an August 1, 2007 decision, an Office hearing representative affirmed the February 7, 2007 schedule award decision.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulation,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[4] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[6] Office procedures provide that to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement"), describes the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment, and the percentage of impairment should be computed in accordance with the fifth edition of the A.M.A., *Guides*. The procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for opinion concerning the nature and percentage of impairment, and the Office medical adviser should provide rationale for the percentage of impairment specified.[7]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Supra* note 1.

[5] *See Joseph Lawrence, Jr., supra* note 1; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

[6] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6(b-d) (August 2002).

of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the figures and tables found in the A.M.A., *Guides*. However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.[8]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[9] Section 16.8a provides that, in a rare case, if the examiner believes the individual's loss of strength represents an impairment factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. 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.[10] Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts, and these should be added to obtain the total motion impairment.[11]

Section 18.3b provides that pain-related impairment should not be used if the condition can be adequately rated under another section of the A.M.A., *Guides*. Office procedures provide that, if the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is determined by the appropriate section of the A.M.A., *Guides*. Section 18.3d provides guidance on how a pain-related impairment should be rated, noting that an award of up to three percent whole person impairment may be granted if pain increases the burden of the employee's condition.[12] While the A.M.A., *Guides*, provides for impairment to the individual member and to the whole person, the Act does not provide for permanent impairment for the whole person.[13]

ANALYSIS

The Board finds this case is not in posture for decision as none of the medical reports used to determine the schedule awards comports with the A.M.A., *Guides*. As stated above, section 16.8 of the A.M.A., *Guides*, provides that strength measurements are functional tests influenced by subjective factors that are difficult to control. The A.M.A., *Guides* does not assign a large role to strength measurements. Impairment ratings based on objective anatomic findings take precedence and the A.M.A., *Guides* gives examples such as a severe muscle tear that healed leaving "a palpable muscle defect.[14] The A.M.A., *Guides* also provides that decreased strength

[8] *Robert V. Disalvatore*, 54 ECAB 351 (2003).

[9] *Supra* note 1 at 433-521.

[10] *Id*. at 508; *see Cerita J. Slusher*, 56 ECAB 532 (2005).

[11] *Id.* at 451-52.

[12] *Id*. at 573, 588; *see Richard B. Myles*, 54 ECAB 379 (2003).

[13] *See Janae J. Triplette*, 54 ECAB 792 (2003).

[14] *Supra* note 1 at 508; *see Mary L. Henninger*, 52 ECAB 408 (2001).

cannot be rated where other medical conditions or factors prevent effective application of maximum force,[15] and that the results of strength testing should be reproducible on different occasions or by two or more trained observers.[16]

The Office medical adviser found the date of maximum medical improvement to be April 6, 2004, the date of Dr. Weiss' report. Yet he relied on grip strength measurements taken in July 2002, almost two years previously. The Office medical adviser did not explain why he relied on the July 2002 report other than to state that grip strength measurements were subjective.[17] While Dr. Weiss opined that under Table 16-34 appellant had a 20 percent grip strength deficit, he did not explain why this would qualify as a rare exception under section 16.8a exception or how appellant's loss of strength was based on etiologic or pathomechanical causes unrelated to other impairments.[18] There is no evidence of record to show that grip strength testing was repeated and verified in any subsequent examinations. Furthermore, the medical evidence in this case does not qualify as an unusual case under section 16.8a of the A.M.A., *Guides.*

In section 18.3d(c), the A.M.A., *Guides* provides that an additional three percent impairment may be granted for pain that slightly increases the burden of a condition.[19] Based on the conclusions of Dr. Weiss and the Office medical adviser, appellant might receive an additional three percent impairment for pain.[20] The A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the body and organ impairment rating systems given in other chapters.[21]

The presence of pain alone does not justify a pain-related impairment. Dr. Weiss advised that appellant's wrist condition caused intermittent right wrist pain and stiffness and that her household duties were restricted, noting difficulty grasping, pulling, pushing and with fine dexterity in her right hand. He graded her pain as between 0 and 4 on a scale of 10. Dr. Weiss did not adequately explain why appellant's right wrist condition could not be rated in other chapters of the A.M.A., *Guides* or how her condition falls within one of the several exceptions in Chapter 18.3a.[22] The Office medical adviser merely adopted Dr. Weiss' conclusion without comment or explanation as there is no medical opinion evidence of record that follows the

[15] *Id.; see Cerita J. Slusher, supra* note 10.

[16] *Supra* note 1 at 509.

[17] *See generally Keith Hanselman*, 42 ECAB 680 (1991).

[18] *See K.W.*, 59 ECAB ____ (Docket No. 07-1547, issued December 19, 2007).

[19] *Supra* note 1 at 573.

[20] *See Richard B. Myles*, 54 ECAB 379 (2003).

[21] *Id*. at 571.

[22] Section 18.3a of the A.M.A., *Guides* provides that a pain-related impairment can be rated when there is excess pain in the context of a verifiable medical condition that causes pain, when there are well established pain syndromes without significant identifiable organ dysfunction to explain the pain, and when there are other associated pain syndromes. *Id*. at 570.

A.M.A., *Guides.* Therefore, the case is not in posture for decision and must be remanded to the Office

On remand, the Office should further develop the medical evidence and obtain an opinion on appellant's right upper extremity impairment that conforms with Office procedures and the A.M.A., *Guides.* Following this and any other development deemed necessary, the Office shall issue an appropriate decision on the merits of appellant's schedule award claim.[23]

CONCLUSION

The Board finds that this case is not in posture for decision because further development of the medical evidence is warranted to determine the permanent impairment of appellant's right upper extremity resulting from her accepted right wrist sprain.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 1, 2007 be vacated and case remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: August 6, 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

[23] *See Beatrice L. High*, 57 ECAB 329 (2006).