



pisotriquetral arthritis and stated that the condition was aggravated by his work as he described using his wrist to toss mail. He recommended that appellant undergo a pisiform excision of the left wrist. In response to questions by the Office on November 1, 2000, Dr. Bristow indicated that he had not found any record of appellant sustaining a fall or any other kind of injury to the left wrist. He advised that appellant had sent him a letter stating that there was no fall. Dr. Bristow admitted that his July 18, 2000 report was incorrect in reporting that appellant had a fall or injury to the left wrist. He stated that the aggravation of his left wrist condition was aggravated by his work. In a November 22, 2000 letter, the Office accepted appellant's claim for an aggravation of arthritis in the left wrist.

In a March 21, 2001 report, Dr. Caroline Gellrick, a Board-certified family practitioner, stated that an electromyogram (EMG) and nerve conduction studies were consistent with a radial nerve contusion given the nature of the history of injury. She concluded that appellant had a triangular fibrocartilaginous complex tear. Appellant underwent surgery on August 3, 2001 for the left wrist triangular fibrocartilaginous complex tear, left lunotriquetral and scapholunate ligament injuries and left pisotriquetral arthritis. Dr. Tracy M. Wolf, a Board-certified orthopedic surgeon specializing in hand surgery, performed an arthroscopy of the left wrist with debridement of the triangular fibrocartilaginous complex, dermal capsulorrhaphy of the left scapholunate and lunotriquetral ligaments and left pisiform excision.

In subsequent office notes, Dr. Wolf discussed appellant's condition after the surgery. On November 11, 2001 she indicated that he complained of numbness and tingling in the left ring and small fingers on a daily basis. Dr. Wolf noted that he remained tender in the triangular fibrocartilaginous complex region. In a February 2, 2002 note, she stated that appellant had a little pain over the triangular fibrocartilaginous complex region with worse pain over the ulnar region. Dr. Wolf reported that appellant had increased pain with ulnar deviation and ulnar compression tests. On March 1, 2002 appellant reported that he experienced chronic pain and occasional sharp pain in the left wrist, primarily on the dorsoulnar aspect of the wrist. Dr. Wolf stated that the pain was increased with ulnar deviation and forceful supination. She noted that appellant had occasional sharp pain that interfered with gripping and some tool use. Dr. Wolf indicated that he denied having numbness or tingling in the thumb, index and long fingers. She reported that on examination he had full pronation and supination, flexion and extension at the elbow and full flexion and extension and radial and ulnar deviation at the wrist. Dr. Wolf noted some slight tenderness at the proximal aspect the surgical incision without radiation. She indicated that the flexor carpi ulnaris moved smoothly with no subluxation or crepitation across the excised pisiform region. Dr. Wolf stated that there was no tenderness of the volar triangular fibrocartilaginous complex. She reported that the distal radioulnar joint was stable. Dr. Wolf found tenderness over the dorsal aspect of the triquetrum and that the distal triquetral hamate joint. She stated that there was no instability of the triquetrum on ballottement. Dr. Wolf indicated that appellant had mild tenderness over the lunotriquetral joint and slightly proximal to the joint but the tenderness did not seem to be increased with stress. She reported that he had tenderness with full ulnar deviation without crepitation or signs of instability. Dr. Wolf diagnosed mild post-traumatic arthrosis as shown by the torn triangular fibrocartilaginous complex, chronic dorsoulnar pain, intraoperative ligament and synovitis. She commented that appellant did not have significant ulnar impingement or abutment. Dr. Wolf suggested that appellant might need further surgery.

On January 28, 2003 Dr. Wolf performed additional surgery on appellant for a left ulnar-sided wrist pain with extensor carpi ulnaris tendinitis and triangular fibrocartilaginous complex tear. She released the extensor carpi ulnaris sheath in a weak fashion to place it in a different position. Dr. Wolf debrided some tenosynovitis found in the tendon. She excised an accessory slip of the extensor carpi ulnaris tendon and performed an ulnar carpi arthrotomy in the exploration of the triangular fibrocartilaginous complex. In a May 12, 2003 office note, Dr. Wolf stated that appellant was still having a fair amount of pain, most of which seemed to be related to the dorsoulnar nerve branch as he had some minor numbness and tingling, a burning sensation and pain. She stated that his range of motion was good except for some flexion which was the most decreased.

In a July 14, 2003 report, Dr. Gellrick stated that appellant still had problems in that he could not lift anything heavy, he could not grip and had pain and tenderness. She reported that his range of motion was markedly decreased on the wrist with 45 degrees of flexion and 42 degrees of extension. Dr. Gellrick indicated that appellant's radial and ulnar deviation had decreased by 50 percent. She found a decreased in grip strength to 3/5. Dr. Gellrick noted that appellant had paresthesias in the left fourth and fifth fingers. In an August 4, 2003 report, she stated that appellant's ranges of motion in the left wrist were 22 degrees flexion, 45 degrees extension, and radial deviation of 10 degrees. Dr. Gellrick noted that the elbow was symmetrical on both sides. She reported that appellant's grip strength was 3/5 on the left compared to 5/5 on the right. Dr. Gellrick indicated that he still had paresthesias of the fourth and fifth fingers of the left hand. She stated that appellant was at maximum medical improvement and maximum therapeutic benefit for work-related injuries to the wrist, status post two surgeries of the left wrist with permanent restrictions recommended of avoidance of any type of heavy lifting.

On November 10, 2003 appellant filed a claim for a schedule award. The Office asked Dr. Gellrick to provide a description of permanent impairment to the left arm. In a January 2, 2004 report, she diagnosed triangular fibrocartilaginous complex tear and debridement, ulnar carpi ligament tendon release and an arthrotomy procedure with residual weakness. Dr. Gellrick listed the date of maximum improvement as August 4, 2003. She stated that appellant had 22 degrees of flexion, 45 degrees of flexion, 10 degrees radial deviation and 30 degrees ulnar deviation. Dr. Gellrick indicated that appellant had a 12 percent impairment of the left arm based on loss of range of wrist motion. She stated that appellant had permanent impairment due to a loss of grip strength in the left hand. Dr. Gellrick calculated that appellant had a 50 percent loss of grip strength which equaled a 20 percent impairment of the left arm. She concluded that appellant had a 30 percent impairment of the left arm.

In a February 25, 2004 memorandum, an Office medical adviser reviewed the medical record. He stated that appellant had a seven percent impairment for loss of flexion in the left wrist, a three percent impairment for loss of extension, a two percent impairment for loss of radial deviation and no impairment for ulnar deviation. The Office medical adviser commented that Dr. Gellrick's rating had included grip strength. He stated that, under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,<sup>1</sup> grip strength could not be applied as an impairable issue in the presence of pain, decreased range of motion, absence of

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<sup>1</sup> A.M.A., 5<sup>th</sup> ed. (2001).

parts or deformities. Rather, he suggested that impairment of the ulnar nerve be calculated under a separate set of tables. The Office medical adviser stated that normally decreased strength was considered in the impairments for range of motion unless there was an associated nerve injury.

In a March 11, 2004 letter, the Office advised Dr. Gellrick of the report of the Office medical adviser and requested that she provide another impairment rating. In a March 15, 2004 report, she stated that the ulnar nerve below the mid forearm motor value, which was shown by loss of grip strength, had a maximum value of 35 percent. Dr. Gellrick indicated that appellant had a 50 percent loss of motor strength. She concluded that he had a 17 percent impairment of the left arm due to loss of strength in the ulnar nerve of the left arm. She concluded that appellant had a 27 percent impairment of the left arm with no apportionment. In an April 7, 2004 memorandum, the Office medical adviser concurred with Dr. Gellrick's impairment rating.

In an April 15, 2004 decision, the Office issued a schedule award for a 27 percent impairment of the left arm.

On April 27, 2004 appellant requested a review of the written record by an Office hearing representative. In an October 18, 2004 decision, the Office hearing representative found that he had 27 percent impairment, for which he received a schedule award. He, therefore, affirmed the Office's April 15, 2004 decision.

### **LEGAL PRECEDENT**

The schedule award provision of the Federal Employees' Compensation Act<sup>2</sup> and its implementing regulation<sup>3</sup> 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.<sup>4</sup>

### **ANALYSIS**

Dr. Gellrick reported that appellant had 22 degrees of flexion, 45 degrees of extension and 10 degrees of ulnar deviation. Under the A.M.A., *Guides*, 22 degrees of flexion of the wrist represents a 7 percent impairment of the arm and 45 degrees of extension is a 3 percent impairment of the arm.<sup>5</sup> A 10 degree radial deviation of the wrist is a 2 percent impairment of the arm.<sup>6</sup> By adding the impairments figures due to the loss of motion in the wrist, Dr. Gellrick

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<sup>2</sup> 5 U.S.C. § 8107.

<sup>3</sup> 20 C.F.R. § 10.404 (1999).

<sup>4</sup> *Id.*

<sup>5</sup> A.M.A., *Guides*, page 467, Figure 18-28.

<sup>6</sup> *Id.* at page 469, Figure 16-31.

and the Office medical adviser properly found that appellant had a 12 percent impairment due to loss of range of motion.

In evaluating appellant's loss of strength, Dr. Gellrick initially used grip strength to determine impairment. However, the A.M.A., *Guides* provide that a large role is not assigned to measurements of grip strength because such measurements are functional tests influenced by subjective factors, including fatigue, handedness, time of day, age, nutritional state, pain and the claimant's cooperation. The A.M.A., *Guides* state that voluntary muscle strength testing remains somewhat subjective until a precise method of measuring muscle contraction is generally available. Under the A.M.A., *Guides*, loss of strength by grip or pinch strength may be used in rare cases as an impairing factor if the loss of strength has not been considered adequately by other methods in the A.M.A., *Guides*.<sup>7</sup> Therefore, measurement of grip strength can only be used to determine impairment as a last resort after all other methods of determining impairment due loss of strength under the A.M.A., *Guides* have been found to be inadequate. The Office medical adviser properly recommended that Dr. Gillreck use another method to determine appellant's impairment due to loss of strength.

Dr. Gillreck indicated that the maximum impairment of the arm for loss of motor strength in the ulnar nerve below the midforearm is 35 percent.<sup>8</sup> She classified appellant as having a 50 percent loss of strength, Grade 3 in this region.<sup>9</sup> Dr. Gillreck multiplied the 50 percent Grade by the maximum 35 percent impairment for loss of motor function of the ulnar nerve below the midforearm to find a 17 percent impairment of the left arm. She and the Office medical adviser used the Combined Values Chart of the A.M.A., *Guides*<sup>10</sup> to calculate that appellant had a 27 percent impairment of the left arm.

The Board notes that in multiplying 50 percent by 35 percent, the actual sum is 17.5 percent. In schedule award determinations under the Act, the percentage is rounded up.<sup>11</sup> Therefore, the actual impairment of the left arm due to loss of strength should be 18 percent, not 17 percent. Under the Combined Values Chart, combining 18 percent for loss of motor strength with 12 percent for loss of motion equals a 28 percent impairment. The Board will modify the schedule award for an additional one percent of impairment.

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<sup>7</sup> *Id.* at 507-08.

<sup>8</sup> *Id.* at page 493, Table 16-15.

<sup>9</sup> *Id.* at page 484, Table 16-11.

<sup>10</sup> *Id.* at pages 604-06.

<sup>11</sup> FECA Program Memorandum No. 49 (issued May 1, 1967). According to this memorandum, half is rounded up to the nearest whole number. See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(b) (November 1998).

**CONCLUSION**

The Board finds that appellant has a 28 percent impairment of the left arm.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated October 18, 2004 be affirmed, as modified, to find a 28 percent impairment of the left arm.

Issued: December 28, 2005  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge  
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge  
Employees' Compensation Appeals Board