United States Department of Labor
Employees' Compensation Appeals Board

RANDALL R. DEATHERAGE, Appellant	)	
and	)	**Docket No. 05-12**
	)	**Issued: May 3, 2005**
DEPARTMENT OF THE AIR FORCE, TINKER AIR FORCE BASE, OK, Employer	)	

Appearances:
Randall R. Deatherage, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On September 23, 2004 appellant filed a timely appeal from merit decisions of the Office of Workers' Compensation Programs dated August 9 and 19 and September 9, 2004, regarding a schedule award decision.[1] Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has sustained more than a 14 percent impairment of his left upper extremity, for which he received a schedule award.

FACTUAL HISTORY

On January 31, 2000 appellant, then a 52-year-old aircraft electrician, filed a traumatic injury claim alleging that he was loading electrical equipment onto a trailer when something

[1] The record contains a November 6, 2003 decision denying modification of appellant's recurrence claim. However, appellant is not appealing this decision.

popped in his left elbow.[2] The Office accepted the claim for left elbow strain and fracture of the left elbow. Appellant returned to work on limited duty and underwent a left elbow lateral epicondylectomy on July 21, 2000. He also underwent exploration of the left elbow with repair of the extensor carpi radialis brevis and advancement as well as a revision of the lateral epicondylectomy and exploration of the elbow joint and excision of the radial head on June 28, 2002. Appellant was placed on the periodic rolls on July 31, 2002.

Appellant's treating physician, Dr. George M. Matook, a Board-certified orthopedic surgeon, saw him on July 19, 2002 and advised that his elbow pain was completely resolved, that appellant was out of his cast with his wound showing progress towards healing. On August 7, 2002 Dr. Matook advised that he could return to work with restrictions comprised of no lifting over 10 pounds on the left arm.[3]

On December 19, 2002 Dr. Matook advised that appellant could return to work with one arm duty.

In a February 10, 2003 report, Dr. David Brent Tipton, Board-certified in physical medicine and rehabilitation, noted appellant's history of injury and treatment, which included a functional capacity evaluation on January 9, 2003, advising that he was unable to return to full duty as an aircraft electrician. He advised that appellant was post left elbow surgery with excision of the radial head with soft tissue implant arthroscopy and revision of the lateral epicondylectomy, arthrotomy with synovectomy and tendon repair and advancement. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001), Dr. Tipton determined that appellant was at maximum medical improvement and had a 22 percent upper extremity impairment. He referred to Table 16-27, page 506,[4] for the radial head resection arthroplasty and determined that this equated to 10 percent, he determined that loss of range of motion equated to 4 percent and appellant's grip strength was equivalent to a 17 percent strength loss index, which equated to a 10 percent impairment. Dr. Tipton used the Combined Values Table and determined that the 10 percent for the surgery, plus the 4 percent for the loss of range of motion and the 10 percent for loss of grip strength equated to a 22 percent upper extremity impairment. He also concurred with the light-duty restrictions for appellant's left upper extremity.[5]

Appellant filed a claim for a schedule award on April 7, 2003.

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[2] The record reflects that appellant was receiving regular medical care for the right elbow and a prior left elbow nonwork injury on May 20, 1997 for which he sought periodic care.

[3] The record reflects that appellant returned to work on August 21, 2002.

[4] A.M.A., *Guides* 506, Table 16-27.

[5] The Office subsequently advised appellant by letter dated October 7, 2003, that his claim could not be considered as he had not reached maximum medical improvement. However, the determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to the date of the evaluation by the attending physician which is accepted as definitive by the Office. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a) (June 2003); *See* Mark A. Holloway, 55 ECAB ___ (Docket No. 03-2144, issued February 13, 2004).

In a report dated April 13, 2003, Dr. Avinash C. Vyas, Board-certified in internal medicine, noted that appellant had a functional evaluation performed by Christian Dillinger, a physical therapist, who indicated that he had a 33 percent impairment of the left upper extremity and a 20 percent impairment of the whole person. Dr. Vyas advised that appellant had restrictions which included lifting of no more than 18 to 27 pounds, with pushing or pulling of this weight for no more than two hours a day and only four hours of tolerating vibrating equipment. Dr. Vyas opined that appellant was not able to return to full unrestricted duty and that his restrictions were permanent.

By letter dated April 21, 2003, the Office requested information from appellant's treating physician regarding an assessment for permanent impairment.

On May 5, 2003 the Office received an undated response from appellant advising that his physician, Dr. Tipton, had performed a final evaluation on February 10, 2003.

An August 26, 2003 magnetic resonance image (MRI) scan of the left elbow, read by Dr. Michael A. Pollack, a Board-certified diagnostic radiologist, revealed that appellant was post surgery at the common extensor tendon and lateral humeral condyle with resection of the radial head, had moderate elbow degenerative joint disease and minimal effusion.

In a September 2, 2003 report, Dr. Daniel J. Jones, a Board-certified orthopedic surgeon, diagnosed bilateral elbow arthrosis and advised several options for treatment, which included cortisone injections and exploratory debridement of his elbow.

In an undated letter from appellant received by the Office on September 12, 2003, he advised that he had not stopped working, that he had seen his physician and was forwarding the information shortly.[6]

On October 7, 2003 the Office advised appellant that his claim for a schedule award could not be considered at this time because he was not at maximum medical improvement.

On December 2, 2003 appellant advised the Office that he was submitting an additional statement from Dr. Jones and that he retired on disability effective August 22, 2003. In a report dated November 18, 2003, Dr. Jones diagnosed bilateral elbow arthritis and advised that appellant continue his full-duty status, while continuing his at home exercise program emphasizing elbow range of motion.

Dr. Matook continued to submit treatment notes, including a January 14, 2004 report in which he indicated that appellant's only option appeared to be an elbow fusion or a new orthosis.

On March 25, 2004 the Office requested that the Office medical adviser provide an impairment rating.

[6] The record reflects that appellant's application for disability retirement was approved on August 4, 2003.

In an April 21, 2004 report, the Office medical adviser explained that the reports of Dr. Tipton, were not sufficient to permit a calculation of the left upper extremity. He advised that Dr. Tipton should be contacted for specific information regarding his impairment estimate and for an explanation as to how it was derived.

By letter dated May 13, 2004, the Office requested additional information from Dr. Tipton regarding an assessment of permanent impairment for a schedule award. The Office did not receive a response from Dr. Tipton.

On June 15, 2004 the Office denied appellant's claim for a schedule award, because no additional information was received from Dr. Tipton. However, this decision was subsequently vacated on June 16, 2004. Appellant was advised by the Office, that, as his two surgical procedures were authorized, he was entitled to an impairment rating and he was being referred for a second opinion. By letter dated June 23, 2004, the Office referred appellant to Dr. Archana Barve, a physician Board-certified in physical medicine and rehabilitation, for a second opinion examination.

In a report dated July 7, 2004, Dr. Barve noted appellant's history of injury and treatment, which included a functional evaluation. On physical examination he noted that the incision was healed and that appellant had some dysesthetic sensation over the mid-aspect of the scar; however, he was able to tolerate wearing a brace that locked his elbow in flexion. Dr. Barve noted some atrophy of the extensor mass, with grip testing on the right at 50/46/46; and on the left 34/28/30. He indicated that manual muscle testing revealed some weakness on the left and that left supination was 3+ and left pronation was -4, with the left biceps at 4+. Regarding range of motion deficits he advised that right flexion was at 144 and the left was 123 and that range of motion deficits of the elbow, equated to right, flexion 144 and left at 123. Dr. Barve noted that right extension was -6 and the left was -12. Further, he indicated that right pronation was 90 and the left was 82. He advised that right supination was 78 and the left was 56 degrees. Dr. Barve also indicated that sensory examination revealed an intact sensation to fine touch and pinprick despite subjective complaints of numbness over the fourth and fifth digits of the left hand. He also noted that the Tinel's was negative at the wrist and at the elbow. Dr. Barve advised that appellant was entitled to an impairment rating based on the following: Range of motion deficit, strength deficit, two percent for pain. He advised that, based on Table 16-27,[7] page 506, impairment of the upper extremity after arthroplasty, in particular a soft tissue implant arthroplasty of the radial head, this was equivalent to an eight percent upper extremity rating for the arthroplasty. Regarding range of motion, Dr. Barve advised that appellant was entitled to two percent for flexion, one percent for extension, zero percent for pronation and one percent for supination, for a total of four percent combined with two percent for pain, which equated to six percent. He combined the 6 percent with the 8 percent for the arthroplasty and using the Combined Values Chart, equated to a 14 percent impairment. Dr. Barve noted that an upper extremity range of motion deficit pursuant to Table 16-35[8] equated to five percent for supination, four percent for pronation, for a total of nine percent. He also indicated that this 9

[7] *See supra* note 3.

[8] A.M.A., *Guides* 510, Table 16-35.

percent combined with the flexion, which was 6 percent, was equal to 14 percent. Dr. Barve combined the 14 percent with the other 14 percent to equate to a 26 percent impairment of the left upper extremity.[9] He opined that appellant was at maximum medical improvement on April 13, 2003.

On July 26, 2004 the Office medical adviser reviewed Dr. Barve's July 7, 2004 report and advised that the date of maximum medical improvement would be July 7, 2004, which was the date of the evaluation. Regarding appellant's elbow range of motion, he referred to Figure 16-34[10] and advised that flexion of 123 degrees was equal to a 2 percent impairment and extension of -12 degrees was equal to a 1 percent impairment. The Office medical adviser referred to Figure 16-37[11] and determined that appellant was entitled to an impairment of 0 percent for left pronation of 82 degrees and 1 percent for supination of 56 degrees. The Office medical adviser determined that this was equal to four percent and combined this figure with an eight percent impairment for the arthroplasty[12] and advised that pursuant to the Combined Values Chart[13] equated to 12 percent. He also gave appellant an additional two percent for pain pursuant to Chapter 18.3(d)(c) of the A.M.A., *Guides*[14] and determined that he was entitled to an impairment of 14 percent to the left upper extremity. Regarding appellant's strength loss, the Office medical adviser explained that he could not be given an impairment for loss of strength in addition to the range of motion deficits.[15]

Accordingly, on August 9, 2004 the Office granted appellant a schedule award for 14 percent impairment of the left upper extremity. The award covered a period of 43.68 weeks from July 7, 2004 to May 8, 2005.

On August 16, 2004 the Office received an undated request for reconsideration by appellant of his schedule award. He specifically advised that he was not sending new evidence as his physician had already provided a rating which was 22 percent.

In an August 19, 2004 decision, the Office denied modification of the August 16, 2004 decision. The Office found that the evidence was insufficient to warrant modification as appellant did not advance a point of law or fact not previously considered, nor did he address the deficiency of the medical evidence.

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[9] *Id*. at 604.

[10] *Id*. at 472, Figure 16-34.

[11] *Id*. at 472, Figure 16-37.

[12] *Id*. at 506, Table 16-27.

[13] *Id*. at 604.

[14] *Id*. at 573.

[15] *Id*. at 508.

On August 23, 2004 appellant requested reconsideration. In his request, he advised that he was sending a copy of his functional capability examination dated January 9, 2003.

By decision dated September 9, 2004, the Office found that the medical evidence was insufficient to modify the August 9, 2004 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[16] 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.[17] 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 for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[18] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[19]

ANALYSIS

In support of his claim for a schedule award, appellant referred to the February 10, 2003 report of Dr. Tipton, who advised that he had a 22 percent impairment to the left upper extremity and was at maximum medical improvement. However, the Board notes that there is no explanation as to how he determined that appellant sustained a 22 percent impairment of the left upper extremity as he did not reveal how his figures were obtained or explain how he determined his calculations pursuant to the A.M.A., *Guides*, with the exception of noting that appellant was entitled to 10 percent for the radial head resection pursuant to Table 16-27.[20] The Office medical adviser attempted to utilize Dr. Tipton's findings; however, he explained that his report was insufficient to permit a calculation of the upper extremity and advised that additional information was needed from him, which included specific information regarding an impairment estimate and an explanation as to how it was derived. When the Office contacted Dr. Tipton for additional information regarding a schedule award on May 13, 2004 he did not provide a response.

The record also contains an April 13, 2003 report from Dr. Vyas, a treating physician, who advised that appellant had a 33 percent impairment of the left upper extremity. However, this report was also insufficient as there was no discussion or explanation to reveal how his figures were obtained or how he determined his calculations pursuant to the A.M.A, *Guides* and, thus, this report was also insufficient.

[16] 5 U.S.C. §§ 8101-8193.

[17] 5 U.S.C. § 8107.

[18] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[19] A.M.A., *Guides* (5th ed. 2001); 20 C.F.R. § 10.404.

[20] A.M.A., *Guides*, 506.

The Office subsequently referred appellant for a second opinion examination with Dr. Barve, Board-certified in physical medicine and rehabilitation. He utilized the measurements from his calculations and explained that, for range of motion, according to Figure 16-34,[21] flexion on the left of 123 degrees, was equal to 2 percent and extension on the left of 12 degrees was equal to 1 percent. Dr. Barve also referred to Figure 16-37[22] and indicated that pronation of 82 degrees on the left would entitle appellant to 0 percent and that supination of 56 degrees on the left equated to 1 percent. He added these figures for a total of four percent. Dr. Barve also referred to Table 16-27[23] and noted that appellant was entitled to an impairment of the upper extremity for his soft tissue implant arthroplasty of the radial head, which was equivalent to an eight percent upper extremity rating for the arthroplasty. He also advised that appellant was entitled to an additional two percent for pain; however, he did not explain how his determination was calculated in accordance with the relevant standards of the A.M.A., Guides.[24] In addition, Dr. Barve determined that appellant was entitled to an impairment rating based on his strength deficit. He noted that an upper extremity range of motion deficit pursuant to Table 16-35[25] equated to five percent for supination, four percent for pronation, for a total of nine percent. Dr. Barve also indicated that this 9 percent combined with the flexion, which was 6 percent, was equal to 14 percent. He combined the 14 percent with the above mentioned 14 percent to equate to a 26 percent impairment of the left upper extremity.[26] Dr. Barve opined that appellant was at maximum medical improvement on April 13, 2003.

The Office medical adviser, in a July 26, 2004 report, utilized Dr. Barve's findings and concurred with his findings regarding appellant's elbow range of motion. His findings utilizing Figure 16-34,[27] were the same with regard to flexion of 123 degrees, which he determined was equal to a 2 percent impairment and that extension of 12 degrees was equal to a 1 percent impairment and a 1 percent impairment for supination of 56 degrees. Dr. Barve did not find any impairment for pronation. The Office medical adviser determined that this was equal to 4 percent and combined this figure with an 8 percent impairment for the arthroplasty according to Table 16-27[28] and advised that pursuant to the Combined Values Chart[29] this equated to 12 percent. He also gave appellant an additional two percent for pain pursuant to Chapter 18 of the

[21] *Id*. at 472.

[22] *Id*. at 474.

[23] *Id*. at 506, Table 16-27.

[24] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[25] A.M.A., *Guides* 510, Table 16-35.

[26] *Id*. at 604.

[27] *Id*. at 472, Figure 16-34.

[28] *Id*. at 506, Table 16-27.

[29] *Id*. at 604.

A.M.A., *Guides*[30] and determined that he was entitled to an impairment of 14 percent to the left upper extremity. However, according to section 18.3(b) of the A.M.A., *Guides*, "examiners should not use this chapter to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*."[31] Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).[32] Regarding the additional impairment provided by Dr. Barve for appellant's strength loss, the Office medical adviser explained that pursuant to the A.M.A., *Guides* appellant could not be given an impairment for loss of strength in addition to the range of motion deficits.[33] The Board notes that the A.M.A., *Guides* specifically provide that strength deficits measured in functional tests should only rarely be included in the calculation of upper extremity impairment and the facts do not support the inclusion of this form of strength impairment rating in the present case.[34] There is no medical report in the record explaining why any strength deficit should be included despite the language of the A.M.A., *Guides*.

For the above noted reasons, the evidence does not reflect that appellant is entitled to more than the 14 percent impairment for which he already received.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a 14 percent permanent impairment of his left upper extremity, for which he received a schedule award.

[30] *Id*. at 573.

[31] Section 18.3b, page 571, A.M.A., *Guides* (5th edition, 2001).

[32] *See* FECA Bulletin 01-05 (issued January 31, 2001): Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[33] A.M.A., *Guides* 508.

[34] The A.M.A., *Guides* provides that loss of strength may be rated separately if such a deficit has not been considered adequately by other rating methods. An example of this situation would be loss of strength caused by a severe muscle tear that healed leaving "a palpable muscle defect." If the rating physician determines that loss of strength should be rated separately in an extremity that presents other impairments, "the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence*." (emphasis in original) The A.M.A., *Guides* further provides that decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximum force. A.M.A., *Guides* 508, section 16.8a.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated September 9, August 19 and 9, 2004 are hereby affirmed.

Issued: May 3, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member