United States Department of Labor
Employees' Compensation Appeals Board

A.T., Appellant	)	
and	)	**Docket No. 06-1204**
	)	**Issued: November 3, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Mill Valley, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 5, 2006 appellant filed a timely appeal from a decision of the Office of Workers' Compensation Programs dated April 6, 2006 which denied her claim for an increased schedule award for the right upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination in this case.

ISSUE

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

FACTUAL HISTORY

On March 5, 2002 appellant, then a 49-year-old general clerk, filed an occupational disease claim, Form CA-2, alleging that factors of her federal employment caused right carpal tunnel syndrome. The Office accepted that appellant sustained right wrist tendinitis and based

on a September 26, 2002 report from her physician, Dr. Vatche Cabayan, Board-certified in orthopedic surgery, on January 10, 2003 the accepted conditions were expanded to include cervical strain, right lateral epicondylitis, carpometacarpal (CMC) joint sprain and right shoulder strain. Magnetic resonance imaging (MRI) scan studies done on April 18, 2003 demonstrated degenerative changes with bulging discs of the cervical spine and no rotator cuff tear but minor tendinopathy of the right shoulder. Upper extremity electromyographic studies done April 18 and October 6, 2003 were interpreted as normal. In a January 29, 2004 report, Dr. Cabayan advised that appellant had reached maximum medical improvement and reiterated the range of motion findings from his 2002 report and noted moderate grip loss. He diagnosed cervical sprain with disc disease and facet dysfunction with no radiculopathy, overuse of the right upper extremity with involvement along the epicondyle, base of the thumb and carpal tunnel tenderness with no findings of entrapment. Dr. Cabayan advised that appellant had a 20 percent right upper extremity impairment for loss of grip strength and a 2 percent impairment for loss of neck range of motion.

On September 30, 2004 appellant filed a schedule award claim. Following recommendation by an Office medical adviser, on January 3, 2005, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Alan B. Kimelman, Board-certified in physiatry, for an impairment rating in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[1] In a January 19, 2005 report, Dr. Kimelman noted the accepted diagnoses and advised that maximum medical improvement had been reached. He found no evidence of right-sided carpal tunnel syndrome or median, ulnar or radial nerve impingement. EMG was reported as normal. Dr. Kimelman provided range of motion findings for the right shoulder, elbow, wrist and thumb and noted neurological involvement with pain and weakness at Grade 4.

By report dated March 9, 2005, an Office medical adviser noted her review of the medical record, including Dr. Kimelman's evaluation. She agreed with his finding regarding maximum medical improvement and that, based on his measurements for range of motion, loss of strength and sensory deficits of appellant's right shoulder and wrist, under the A.M.A., *Guides*, she had a 13 percent right upper extremity impairment. By decision dated March 18, 2005, appellant was granted a schedule award for a 13 percent impairment of the right upper extremity, for a total of 40.56 weeks, to run from January 19 to October 29, 2005.

On February 20, 2006 appellant requested reconsideration and submitted a February 20, 2006 report in which Dr. Cabayan reiterated his diagnoses. He referenced the A.M.A., *Guides* and stated that, based on range of motion deficits of the neck, shoulder and wrist and a grip strength deficit, appellant had whole person impairments of 16 percent for the neck impairment, 23 percent for the right upper extremity and 4 percent for the left upper extremity, to combine for a 38 percent whole person impairment. In a March 26, 2006 report, an Office medical adviser noted her review of Dr. Cabayan's February 20, 2006 report and advised that he did not give actual range of motion measurements for the shoulder, elbow or wrist and the neck was not covered under the A.M.A., *Guides*. She concluded that she found no rationale for an increased impairment rating. By decision dated April 6, 2006, the Office noted that a left upper extremity

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

condition had not been accepted as employment related and found that the medical evidence did not support that appellant was entitled to an increased schedule award.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulations,[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] Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[6] The 1960 amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[7]

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.[8] 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 an opinion concerning the nature and percentage of

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] A.M.A., *Guides*, *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] *Pamela J. Darling*, 49 ECAB 286 (1998).

[7] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

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

impairment and the Office medical adviser should provide rationale for the percentage of impairment specified.[9]

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 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.[10]

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.[11] 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.[12] Grip strength is used to evaluate power weaknesses related to the structures in the hand wrist or forearm. The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* for the most part is based on anatomic impairment. Thus the A.M.A., *Guides* does not assign a large role to such measurements. Only in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately. The A.M.A., *Guides* state that, otherwise, the impairment ratings based on objective anatomic findings take precedence.[13]

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.* In some situations, however, an impairment rating can be increased by up to three percent if pain increases the burden of the employee's condition.[14]

Section 16.7d of the A.M.A., *Guides* provides:

> "Several syndromes involving the upper extremity are variously attributed to tendinitis, fasciitis, or epicondylitis. The most common of these are the stubborn conditions of the origins of the flexor and extensor muscles of the forearm where

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(b-d) (August 2002).

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

[11] A.M.A., *Guides* at 433-521.

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

[13] *Id.* at 508; *see Phillip H. Conte*, 56 ECAB ___ (Docket No. 04-1524, issued December 22, 2004).

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

> they attach to the medial and lateral epicondyles of the humerus. Although these conditions may be persistent for some time, they are not given a permanent impairment rating unless there is some other factor that must be considered. If an individual has had a tendon rupture or has undergone surgical release of the flexor or extensor origins or medial or lateral epicondylitis, or has had excision of the epicondyle, there may be some permanent weakness of grip as a result of the tendon rupture or the surgery. In this case, impairment can be given on the basis of weakness of grip strength according to section 16.8b."[15]

ANALYSIS

The Board finds that this case is not in posture for decision. Dr. Cabayan's September 26, 2002 report is of diminished probative value regarding an impairment because he did not find that appellant had reached maximum medical improvement, and entitlement to a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury.[16] While in his January 29, 2004 report Dr. Cabayan advised that maximum medical improvement had been reached and provided an impairment rating for appellant's neck and loss of grip strength on the right, as stated above, schedule awards are not payable for injuries to the spine.[17] Likewise, the A.M.A., *Guides* specifically provides that strength deficits measured by functional tests should only rarely be included in the calculation of an upper extremity impairment.[18] In his February 20, 2006 report, Dr. Cabayan provided no range of motion measurements which could be used in determining a degree of impairment for appellant's right shoulder, elbow or wrist. Furthermore, it would not be appropriate to rate appellant's accepted epicondylitis under section 16.7d of the A.M.A., *Guides* as she did not meet either of the required criteria, *i.e.*, she had not had a tendon rupture or undergone surgical release.[19] For these reasons, Dr. Cabayan's reports are insufficient to establish that appellant is entitled to an increased schedule award.

Dr. Kimelman did not reference specific figures under the A.M.A., *Guides*. He, however, provided sufficient examination findings on Office form reports that are based on the A.M.A., *Guides* requirements for appellant's right shoulder, elbow, wrist and thumb and for right upper extremity sensory and motor deficit. It was, therefore, proper for the Office medical adviser to apply the A.M.A., *Guides* to Dr. Kimelman's reported findings. Regarding appellant's right shoulder, under Figures 16-40 and 16-46, her measured extension and external rotation were normal.[20] Shoulder abduction of 150 degrees would yield a 1 percent impairment and adduction

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[15] A.M.A., *Guides* at 507.

[16] *See Mark A. Holloway*, 55 ECAB ____ (Docket No. 03-2144, issued February 13, 2004); *see* A.M.A., *Guides* at 19.

[17] *Pamela J. Darling*, *supra* note 6.

[18] *Supra* note 13.

[19] A.M.A., *Guides* at 507.

[20] *Id.* at 476, 479.

of 30 degrees would yield a 1 percent impairment under Figure 16-43.[21] Under Figure 16-46, shoulder internal rotation of 70 degrees would yield an additional 1 percent[22] and under Figure 16-40, flexion of 160 degrees would yield an additional 1 percent,[23] for a total shoulder impairment due to loss of range of motion of 4 percent.

Regarding appellant's right elbow, the Office medical adviser properly reported that Dr. Kimelman's range of motion measurements were normal.[24] Regarding the right wrist, as noted by the Office medical adviser, Dr. Kimelman's range of motion measurements for palmar, radial and ulnar deviation were normal, but under Figure 16-28, dorsiflexion of 50 percent yielded a 2 percent impairment.[25]

The Office medical adviser also included an impairment rating in accordance with Dr. Kimelman's findings of weakness and pain that interfered with gripping and reaching, which he rated as Grade 4 or 25 percent. Pursuant to Tables 16-10 and 16-11,[26] when multiplied by the maximum of 40 percent for the C5, C6 nerves identified by Dr. Kimelman, under Table 16-13, appellant was entitled to an additional 10 percent impairment for pain and weakness.[27]

The Board, however, finds that appellant has established an additional impairment rating for her right thumb. A right CMC joint sprain was accepted as employment related, and Dr. Kimelman's provided range of motion measurements for appellant's right thumb. The Office medical adviser, however, did not consider these measurements in making her impairment determination. The case must therefore be remanded to the Office to determine if appellant has established an additional right upper extremity impairment based on loss of range of motion of her right thumb such that she would be entitled to an increased schedule award.

The A.M.A., *Guides* provide that regional range of motion deficits are to be combined.[28] Therefore, on remand appellant's shoulder, wrist and thumb abnormal motion impairments should be combined with her impairment for loss of strength and sensory deficit utilizing the Combined Values Chart of the A.M.A., *Guides*[29] to determine if she is entitled to an impairment rating greater than the 13 percent awarded.

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[21] *Id.* at 477. The Board notes that the Office medical adviser reported appellant's shoulder adduction at 40 degrees. Dr. Kimelman's report contains two findings for right shoulder adduction: 30 degrees, as found on the first page of his report and 40 degrees as found on the form report for the shoulder.

[22] *Id.* at 479.

[23] *Id.* at 476.

[24] *Id.* at 472, 474, Figures 16-34 and 16-37.

[25] *Id.* at 467.

[26] *Id.* at 482, 484.

[27] *Id.* at 489.

[28] *Id.* at 517.

[29] *Id.* at 604.

CONCLUSION

The Board finds that this case is not in posture for decision regarding whether appellant is entitled to an increased schedule award for her right upper extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 6, 2006 be vacated and the case remanded to the Office for proceedings consistent with this opinion.

Issued: November 3, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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