United States Department of Labor
Employees' Compensation Appeals Board

W.S., Appellant	)	
and	)	**Docket No. 06-989**
	)	**Issued: September 19, 2006**
U.S. POSTAL SERVICE, Pittsburg, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On March 29, 2006 appellant, through his representative, filed a timely appeal of the Office of Workers' Compensation Programs' schedule award decision dated March 21, 2006. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 11 percent impairment of his left upper extremity for which he received a schedule award.

FACTUAL HISTORY

On August 3, 2004 appellant, then a 51-year-old letter carrier, filed a traumatic injury claim alleging that he sustained a laceration to his left forearm in the performance of duty.

Dr. Stephanie Sweet, a Board-certified orthopedic surgeon, performed surgery on August 9, 2004 to repair a complete laceration of the extensor digitorum communis of the left long and right fingers and a partial laceration of approximately 50 percent to the small finger

extensor digitorum communis. The surgical repair took place at the level of the mid forearm. Dr. Sweet noted that the posterior interosseous nerve was functioning.

On November 15, 2004 the Office accepted appellant's claim for laceration of the left forearm with tendon involvement.

Dr. Sweet examined appellant on January 7, 2005 and noted that he had returned to full duty. She noted that he reported occasional discomfort in cold weather, but good function overall. On examination appellant demonstrated intact extensors of the long, ring and small fingers with no extensor lag. Dr. Sweet stated, "He can flex the index three centimeters, long four centimeters, ring four centimeters and the small three and one-half centimeters of the distal palmar crease actively, but he improves with passively and when he reaches up he can actually do more."

By letter dated August 17, 2005, the Office requested appellant's impairment rating for schedule award purposes. In a report dated December 22, 2005, Dr. George L. Rodriguez, a physician Board-certified in physical medicine and rehabilitation, described his history of injury. He noted that appellant reported continuous stiffness in the extensor tendons of the left hand as well as numbness and bluing of the five fingers along the dorsal aspect after exposure to cold. Appellant also described limited pronation and supination resulting in difficulty opening jars and doorknobs with his left hand. On examination Dr. Rodriguez found that appellant's left wrist had 50 degrees of supination, normal pronation, palmar flexion of 70 degrees and normal dorsiflexion. He noted, "Evaluation of the left forearm reveals that there is irregularity underlying the dermis in the area where there is reanastomsis of the tendons." Dr. Rodriguez found that appellant had a normal sensory examination and that his grip strength was 95 pounds on the right and 75 pounds of the left. He diagnosed multiple lacerations of the extensor tendons of the left forearm, a small finger extensor digtorum communis laceration, postsurgical cutaneous sensory nerve transient neuropraxia of the left ulnar dorsal and palmar cutaneous, radial superficial and dorsal digitals and median palmar cutaneous and palmar digitals nerves as well as stenosing flexor tenosynovitis. Dr. Rodriguez concluded that appellant was suffering significantly from left upper extremity pain and dysfunction, that he reached maximum medical improvement on February 10, 2005.

Dr. Rodriguez provided appellant's impairment rating for schedule award purposes based on sensory nerve impairment of the distal median superficial nerve of 10 percent, 2 percent impairment of the distal ulnar superficial palmar nerve, 2 percent impairment of the distal ulnar superficial dorsal nerve and 4 percent impairment of the distal radial superficial nerve for a total of 18 percent sensory deficit. He awarded him 1 percent impairment for loss of supination as well as 10 percent impairment for loss of grip strength. Dr. Rodriguez found that appellant had a total impairment of the left upper extremity of 27 percent.

The Office referred appellant's medical records to the Office medical adviser on January 24, 2006. Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, reviewed the reports of Dr. Sweet and Dr. Rodriguez and concluded that Dr. Sweet did not provide any evidence of injury to the sensory nerves as was found by Dr. Rodriguez. He further stated, "The injury was not in the area of the medial and ulnar nerve, therefore, this would not be even in consideration to have medial and ulnar nerve injury as noted in Dr. Rodriguez's report."

However, Dr. Berman concluded that appellant was entitled to 1 percent impairment due to 50 degrees of supination and that he was also entitled to 10 percent upper extremity impairment due to loss of grip strength for a combined value of 11 percent impairment of the left upper extremity. He found that he had reached maximum medical improvement on December 25, 2005.

Appellant requested a schedule award on March 5, 2006. By decision dated March 21, 2006, the Office granted him a schedule award for 11 percent impairment of his left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulation[2] 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

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. The A.M.A., *Guides* for the most part are based on anatomic impairment. 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.[3] The A.M.A., *Guides* state, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence.*" (Emphasis in the original.)[4] The A.M.A., *Guides* also provide a protocol for performing grip strength evaluations in which the measurements are repeated three times and the results averaged.[5]

It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[6] The A.M.A., *Guides* provide that

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] *Mary L. Henninger*, 52 ECAB 408, 409 (2001).

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

[5] A.M.A., *Guides* 508. The A.M.A., *Guides* recommend that grip strength tests are repeated three times with each hand at different times during the examination and then the values are recorded and later compared. The Board adopted this method in *Henniger*, *supra* note 3.

[6] *Tara L. Hein*, 56 ECAB ___ (Docket No. 05-91, issued April 4, 2005).

decreased strength cannot be rated in the presence of decreased motion or painful conditions unless based on an unrelated etiology or pathomechanical causes.[7]

ANALYSIS

The schedule award issued in this case was based on the December 22, 2005 report of Dr. Rodriguez, a physician Board-certified in physical medicine and rehabilitation. It was reviewed by the Office medical adviser, Dr. Berman, a Board-certified orthopedic surgeon. There are, however, deficiencies in these reports that diminish their probative value for a proper schedule award determination.[8]

Dr. Rodriguez based his impairment rating for schedule award purposes on loss of range of motion, grip strength deficits and sensory nerve impairment of the distal median superficial nerve, the distal ulnar superficial palmar nerve, the distal ulnar superficial dorsal nerve and the distal radial superficial nerve. Dr. Berman reviewed this report and concluded that appellant had no sensory nerve impairment. However, he also provided appellant with impairment ratings for both loss of range of motion and grip strength.

As noted above, the A.M.A., *Guides* do not favor an impairment rating based on grip strength unless it represents an impairing factor that has not been otherwise considered adequately.[9] The A.M.A., *Guides* also provide a protocol for performing grip strength evaluations which requires repeating the measurements three times and averaging the results.[10] Dr. Rodriguez does not address the issue of whether grip strength was the only appropriate measurement of impairment, nor does he indicate whether he repeated the tests performed in accordance with the A.M.A., *Guides*. He only provided one measurement of appellant's grip strength which does not comport with the recommendations of the A.M.A., *Guides*. Neither physician in this case has offered an explanation for the use of grip strength in evaluating appellant's impairment and both reports are of diminished probative value.

The A.M.A., *Guides* also provide that impairments for loss of range of motion and loss of strength may not be combined unless there is a separate etiology for the conditions and the Board has held that it is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[11] In this case, neither physician explained a separate etiology for appellant's loss of range of motion and loss of grip strength or why the combination of these methods was appropriate due to appellant's impairments. Therefore, these reports are of diminished probative value to the issues presented.

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[7] A.M.A., *Guides* 508 and 526, Table 17-2; *Patricia J. Horney*, 56 ECAB __ (Docket No. 04-2013, issued January 14, 2005).

[8] *Belinda H. Wilson*, 57 ECAB ___ (Docket No. 05-1426, issued October 19, 2005).

[9] *Henninger*, *supra* note 3.

[10] A.M.A., *Guides* 508. The A.M.A., *Guides* recommend that grip strength tests are repeated three times with each hand at different times during the examination and then the values are recorded and later compared. The Board adopted this method in *Henninger*, *supra* note 3.

[11] *Hein*, *supra* note 6.

The case will be remanded to the Office for development of the medical evidence on the degree of permanent impairment to appellant's left upper extremity under the A.M.A., *Guides*. After such further development as the Office deems necessary, it should issue an appropriate decision.

CONCLUSION

The medical evidence is not sufficient to establish that a schedule award for 11 percent impairment of the left upper extremity was appropriate under the A.M.A., *Guides.* The case will be remanded for further development.

ORDER

IT IS HEREBY ORDERED THAT the March 21, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: September 19, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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