United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 06-1700**
	)	**Issued: August 13, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, 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:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 19, 2006 appellant filed a timely appeal from a July 12, 2006 schedule award decision of the Office of Workers' Compensation Programs finding 13 percent impairment to his left upper extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant has more than 13 percent impairment to his left upper extremity, for which he received schedule awards.

FACTUAL HISTORY

On April 15, 1998 appellant, then a 27-year-old part-time flexible clerk, sustained injury to his left wrist while in the performance of duty. His claim was accepted by the Office for an acute avulsion fracture of the left ulnar styloid. Appellant stopped work on April 24, 1998 and returned to light-duty work on September 24, 1998 performing one handed duties. He received appropriate compensation for his disability from work.

Appellant came under the treatment of Dr. Brian J. Sennett, a Board-certified orthopedic surgeon. In a February 25, 1999 chart note, Dr. Sennett stated that appellant had reached maximum medical improvement. He noted some inconsistencies in appellant's functional capacity evaluation and recommended further examination of appellant to define the nature and extent of his residuals. On March 18, 1999 appellant requested a schedule award.

The Office referred appellant to Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a May 17, 1999 report, Dr. Mandel reviewed the history of injury and medical treatment. Appellant noted significant discomfort with grasping, lifting and carrying. On examination, no atrophy of the left upper extremity was noted with no obvious ulnar carpal tunnel instability. Range of motion was found to be full with grip strength slightly diminished on the left as compared to the right. On review of x-rays, Dr. Mandel noted a tiny avulsion fracture from the tip of the ulnar styloid. He diagnosed status post fracture of the tip of the ulnar styloid of the left wrist with minimal residual carpal tendinitis. Dr. Mandel noted that appellant's left hand was callused, which indicated that appellant had been using it for physical activity. He advised that appellant could perform work with his left upper extremity, subject to four hours of pushing, pulling and lifting limited to 10 pounds.

On October 22, 1999 an Office medical adviser reviewed the medical evidence and evaluated appellant's impairment under the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. The medical adviser rated impairment due to constrictive tenosynovitis under Table 29, page 63 and Table 18, page 58. He noted that Dr. Mandel described moderate symptoms for which Table 29 allowed a maximum rating of 40 percent. The medical adviser applied Table 18, which allowed 20 percent impairment as the maximum percentage for the distal radioulnar joint (40 percent x 20 percent) to find a total of 8 percent impairment to the left upper extremity. He noted that pain was already included in the values.

On November 9, 1999 appellant received a schedule award for eight percent impairment to his left upper extremity.

On February 5, 2006, appellant requested an increased schedule award. He submitted a November 23, 2005 treatment note from Dr. Emilio J. Caucci, an osteopath, who described appellant's complaint of pain affecting the left hand and wrist, radiating into the left elbow. Dr. Caucci reported findings on grip strength and diagnosed status, post ulnar styloid fracture with dorsal sensory ulnar neuritis and tendinitis of the left wrist. On April 21, 2006 he repeated his diagnoses. Dr. Caucci recorded appellant's left hand grip strength as 4/5 (good) with some atrophy noted on the left palmar aspect of the left hand.

On May 4, 2006 appellant was examined by Dr. George L. Rodriguez, Board-certified in physical medicine and rehabilitation. Dr. Rodriguez described appellant as a right-hand dominant individual who was working at a modified-duty capacity. He noted appellant's complaint of left wrist pain and dysesthesias and reported a full range of motion of the left wrist with pain on extreme supination and flexion. Palpation revealed a positive Tinel's sign of the left ulnar nerve with moderately decreased sensation along the palmar and dorsal aspects of the left third, fourth and fifth digits and mid-ulnar forearm. Atrophy was reported of the hypothenar eminence of the left hand to a moderate degree. Dr. Rodriguez measured appellant's left hand

grip strength, noting 20 pounds on the left out of a normal grip strength of 112.9 pounds. He provided an impairment rating based on sensory and motor loss involving the ulnar nerve under the fifth edition of the A.M.A., *Guides*. For sensory loss, Dr. Rodriguez noted that Table 16-15 provided a maximum of seven percent impairment for the ulnar nerve. Under Table 16-10, he classified appellant's pain as Grade 1, which allows a range of 81 to 99 percent sensory deficit for pain described as deep cutaneous pain sensibility, with abnormal sensations or severe pain which prevents most activity. Dr. Rodriguez allowed a 90 percent sensory deficit (7 percent x 90 percent) to find 6 percent impairment due to sensory loss. He rated the motor loss, again referring to Table 16-15, which provides a maximum of 35 percent impairment for the ulnar nerve below the mid forearm. Under Table 16-11, Dr. Rodriguez graded the extent of motor deficit as Grade 3, or 50 percent (35 percent x 50 percent) to find 18 percent impairment for motor loss. He then allowed three percent impairment under Chapter 18, page 573, for ulnar styloid pain, which he said converted to five percent impairment of the upper extremity under Table 16-3, page 439. Dr. Rodriguez combined the various impairment ratings to find a total 27 percent impairment to appellant's left upper extremity, noting that maximum medical improvement was reached as of February 25, 1999.

On June 23, 2006 an Office medical adviser reviewed the medical evidence, noting that appellant previously received a schedule award for eight percent impairment to the left upper extremity. Upon review of the report from Dr. Rodriguez, the medical adviser noted that the description of appellant's ulnar symptoms did not indicate a Grade 3 motor involvement and Grade 1 sensory deficit, as the degree of severity allowed by Dr. Rodriguez was not documented in his records. The medical adviser noted that, under Table 16-15, the maximum percentages for impairment of the ulnar nerve below the forearm were 7 percent for sensory loss and 35 percent for motor loss. Using Table 16-10, page 482, the Office medical adviser graded the sensory deficit as Grade 3, which allows a deficit of 26 to 60 percent. He allowed a deficit of 60 percent (7 percent x 60 percent) to rate sensory impairment as 4 percent. As to motor loss, the Office medical adviser graded the motor deficit as Grade 4, which allows a motor deficit of 1 to 25 percent. He allowed a deficit of 25 percent (35 percent x 25 percent) to rate motor impairment as 9 percent. The medical adviser noted it was error for Dr. Rodriguez to allow an additional impairment for pain under Chapter 18 as the pain award was reflected in the sensory impairment rating as noted in the A.M.A., *Guides* at page 482. Using the Combined Values Chart to combine the sensory and motor loss, the Office medical adviser concluded that appellant's total left upper extremity impairment was 13 percent.

In a July 12, 2006 decision, the Office found that appellant had 13 percent impairment to his left upper extremity. It granted a schedule award, less the eight percent previously paid.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and the implementing federal regulation[2] set forth the number of weeks of compensation payable to employees who sustain permanent impairment from loss or loss of use of scheduled members or

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

functions of the body.[3] 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 in order that there may be uniform standards applicable to all claimants.[4] The Office has adopted the A.M.A., *Guides* as the uniform standard applicable to rating impairment in claims arising under the Act.[5]

ANALYSIS

The Board finds that appellant has not established that he has greater than 13 percent impairment of his left upper extremity.

Appellant submitted a report from Dr. Rodriguez in support of his claim for an additional schedule award. Dr. Rodriguez rated appellant's impairment to the ulnar nerve below the forearm as a total of 27 percent due to sensory and motor loss. However, the Board finds that the impairment rating by Dr. Rodriguez is of diminished probative value as the physician did not properly apply the A.M.A., *Guides* in estimating the extent of impairment. Dr. Rodriguez noted that Table 16-15, page 492, provided maximum upper extremity impairment of 7 percent for sensory loss and 35 percent for motor loss of the ulnar nerve below the forearm. The medical adviser agreed that this was a proper basis on which to rate impairment due to pain and loss of strength due to peripheral nerve compression neuropathy. In grading the extent of appellant's sensory deficit, Dr. Rodriguez stated that Grade 1, which allows a deficit of 81 to 99 percent, was appropriate. However, he did not adequately explain the basis for this determination. As noted at page 482, Dr. Rodriguez should address how the sensory deficit or pain interferes with the individual's performance of daily activities. Grade 1 under Table 16-10 is for deep cutaneous pain; absent superficial pain and tactile sensibility with abnormal sensation or severe pain that prevents most activity. Dr. Rodriguez did not adequately address the clinical findings supporting this grade.[6] Moreover, he duplicated the impairment rating for pain by applying Chapter 18, page 573, and allowed an additional five percent impairment. The A.M.A., *Guides* provide that Chapter 18 should not be used to rate pain-related impairment for conditions that are adequately rated under the other chapters.[7] Dr. Rodriguez did not explain why he departed from the standards and protocols of the A.M.A., *Guides* to allow an additional pain rating under Chapter 18 when he had already provided a rating for sensory loss (pain) under Chapter 16. The Board has noted that the application of certain impairment rating mechanisms, such as those under Chapter 18, may be incompatible with the simultaneous application of other impairment tables where this would result in duplicative measurements and artificially high impairment

[3] *See Robert B. Myles*, 54 ECAB 379 (2003).

[4] *See Harry D. Butler*, 43 ECAB 859, 866-868 (1992) and cases cited therein.

[5] *See Jesse Mendoza*, 54 ECAB 802 (2003) (Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001).

[6] The period covered by a schedule award commences on the date the employee reaches maximum medical improvement from residuals of the employment injury. Maximum improvement means that the physical condition of the injured member has stabilized and will not improve further. *Joseph R. Waples*, 44 ECAB 936 (1993).

[7] A.M.A., *Guides* 571, section 18.3b.

percentages.[8] As to the motor loss rating, Dr. Rodriquez graded the impairment under Table 16-11 as Grade 3, allowing 50 percent deficit for motor loss described as complete active range of motion against gravity only, without resistance. Again, the clinical basis supporting this grading determination is not fully explained in the physician's report. The grading allowed by Dr. Rodriguez varies significantly with the contemporaneous findings of appellant's left upper extremity strength as noted by Dr. Caucci. Dr. Rodriguez stated there was moderate atrophy and significant grip strength loss to the left hand, findings that diverge from those recorded by Dr. Caucci two weeks prior. He indicated that left hand grip strength loss was 4/5 (good) as opposed to only 20 pounds out of 112.9 pounds as recorded by Dr. Rodriguez.[9] For these reasons, the Board finds that the impairment rating provided by Dr. Rodriguez is of diminished probative value.[10]

The Office properly referred the medical evidence for review by an Office medical adviser. He rated the extent of appellant's permanent impairment according to sensory and motor loss under Chapter 16. Applying Table 16-15, page 492, the medical adviser noted that the A.M.A., *Guides*, provide maximum impairment values of 7 percent for sensory loss and 35 percent for motor loss of the ulnar nerve below the midforearm. He graded the sensory loss with reference to Table 16-10, page 482, as Grade 3 and allowed 60 percent sensory deficit (7 percent x 60 percent) to find a total 4 percent impairment due to pain. As for motor loss, the medical adviser applied Table 16-11, page 484, to grade the motor deficit as Grade 4, allowing 25 percent for complete range of motion against gravity with some resistance (35 percent x 25 percent) to find a total 9 percent impairment for loss of strength. The Combined Values Chart was properly applied to find 13 percent total impairment of appellant's left upper extremity.

CONCLUSION

The Board finds that appellant does not have more than 13 percent impairment to his left upper extremity.

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

[9] 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* do not assign a large role to such measurements, noting that only in rare cases should grip strength be used and only when it represents an impairing factor that has not otherwise been considered adequately. *See Mary L. Henninger*, 52 ECAB 408 (2001).

[10] *See Fritz A. Klein*, 53 ECAB 642 (2002). The description of a given impairment must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its restrictions and limitations. *N.M.*, 58 ECAB ___ (Docket No. 06-2054, issued January 12, 2007).

ORDER

IT IS HEREBY ORDERED THAT the July 12, 2006 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: August 13, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

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

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