United States Department of Labor
Employees' Compensation Appeals Board

A.K., Appellant	)	
and	)	**Docket No. 06-2055**
	)	**Issued: March 28, 2007**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Otisville, NY, 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
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 6, 2006 appellant, through his attorney, filed a timely appeal from an August 24, 2006 merit decision of the Office of Workers' Compensation Programs granting him a schedule award. 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 has more than a six percent permanent impairment of the left upper extremity.

FACTUAL HISTORY

On February 3, 2000 appellant, then a 32-year-old correction officer, filed a claim alleging that he sustained a traumatic injury to his left elbow and shoulder on February 1, 2000 when he picked up a bag from a cart. The Office accepted the claim for an aggravation of epicondylitis of the left elbow.

On August 3, 2000 Dr. Mark Lazarus, an orthopedic surgeon, performed a diagnostic elbow arthroscopy with an excision of chronic lateral epicondylitis and a decompression of the radial tunnel of the left elbow. Appellant received compensation following his surgery until December 18, 2000, when he resumed light duty.

In a decision dated October 19, 2001, the Office denied appellant's claim for a schedule award on the grounds that the medical evidence established that he had no ratable impairment due to his employment injury. The Office based its conclusion on the opinion of Dr. David B. Yanoff, a Board-certified orthopedic surgeon, who performed a second opinion examination on September 26, 2001. He found that appellant had no employment-related upper extremity impairment.

On March 11, 2006 appellant filed a claim for a schedule award. The Office, by letter dated April 17, 2006, requested that he submit an impairment evaluation from his attending physician in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*). Appellant submitted a report dated April 24, 2006 from Dr. Emmanuel E. Jacob, a Board-certified physiatrist, who discussed appellant's complaints of left upper extremity pain and difficulty performing repetitive tasks. He stated:

> "The left elbow flexion is active to 120 degrees, extension 0 degrees and 75 degrees pronation and supination of 70 degrees. Shoulder flexion is 180 degrees, extension of 30 degrees, 40 degrees of abduction, 90 degrees of adduction, 35 degrees of internal rotation and 40 degrees of external rotation. The sensation of the upper limb is diminished along the left radial nerve distribution. No observable muscle atrophy of the upper limb. His hand grip on the left side is 4/5 and the right side is 5/5."

Dr. Jacob diagnosed a left elbow injury, status post decompression of the radial nerve and an excision of chronic lateral epicondylosis. He found that appellant had a 35 percent maximum upper extremity impairment due to a loss of power according to Table 16-32 on page 489, which he multiplied by a 20 percent motor deficit[1] to find a 7 percent upper extremity impairment. Dr. Jacob further found that 140 degrees of elbow flexion and 0 degrees extension yielded no impairment.[2] He determined that 75 degrees forearm supination yielded no impairment and 70 degrees pronation yielded a one percent impairment.[3] Dr. Jacob added the one percent impairment due to loss of range of motion to the seven percent impairment due to motor deficit to find an eight percent upper extremity impairment, which he converted to a three percent whole person impairment. He then added a three percent whole person impairment due to pain under Chapter 18 of the A.M.A., *Guides*, to find a total whole person impairment of six percent.

[1] A.M.A., *Guides* at 484, Table 16-11.

[2] *Id*. at 472, Figure 16-34. The Board notes that early in his report Dr. Jacob indicated that appellant had 120 degrees of elbow flexion.

[3] *Id*. at 474, Figure 16-37.

An Office medical adviser reviewed Dr. Jacob's report on July 12, 2006. He found that Dr. Jacob inappropriately applied Table 16-13 on page 489 of the A.M.A., *Guides* which was utilized for motor and sensory deficits arising from spinal impairments. The Office medical adviser stated:

> "It was a result of muscle weakness that resulted from his surgery of the wrist extensors as part of the lateral epicondylitis operation. In this operation, the extensor carpi radialis longus and brevis are removed from the bone prominence of the medial epicondyles and the muscles are repaired. As a result of this surgery there is weakness of the muscles. There is no involvement of the spinal nerves."

He further found that Dr. Jacob should not have used Table 16-11 on page 484 as appellant did not have a peripheral nerve disorder. The Office medical adviser determined that 75 degrees supination of the forearm constituted no impairment and 70 degrees pronation constituted a one percent impairment according to Figure 16-37 on page 474. He found that appellant had full range of motion of the elbow. Applying Table 16-35 on page 510 of the A.M.A., *Guides*, the Office medical adviser stated:

> "[T]he deficit in this case is determined to be based on 4/5 muscle weakness. The muscle that is weak is the elbow extensor and based upon this chart it represents a five percent impairment. This chart is appropriate based upon the description on page 508, 16.8a Principles, where it states, 'An example of this situation would be loss of strength due to a severe muscle tear.' The exact nature of the pathology is a muscle tear of the wrist extensors and this is what was repaired at the time of the surgery."

The Office medical adviser concluded that appellant had a five percent loss of strength which he combined with the one percent impairment due to loss of pronation to find a total left upper extremity impairment of six percent.

By decision dated August 24, 2006, the Office granted appellant a schedule award for a six percent impairment of the left upper extremity. The period of the award ran for 18.72 weeks from April 25 to September 2, 2006.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[4] and its implementing federal regulation,[5] 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 for all

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6]

Regarding loss of strength, the A.M.A., *Guides* states in relevant part:

> "In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the A.M.A., *Guides*, the loss of strength may be rated separately. An example of this situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. If the examiner judges 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.* Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (*e.g.*, thumb amputation) that prevent effective application of maximal force in the region being evaluated."[7] (Emphasis in the original.)

ANALYSIS

The Office accepted that appellant sustained an aggravation of epicondylitis of the left elbow due to a February 3, 2000 employment injury. On August 3, 2000 he underwent a left elbow excision of chronic lateral epicondylitis and a decompression of the radial tunnel. Appellant returned to light-duty employment on December 18, 2000.

On March 11, 2006 he filed a claim for a schedule award.[8] In a report dated April 24, 2006, Dr. Jacob measured range of motion of the left elbow and shoulder. He concluded that appellant had a one percent impairment for loss of pronation. The Board notes, however, that 120 degrees of flexion constitutes a two percent impairment, 0 degrees of extension constitutes no impairment, 75 degrees of pronation constitutes a one percent impairment and 70 degrees supination constitutes no impairment.[9] Additionally, Dr. Jacob measured range of motion of the left shoulder but did not provide an impairment determination for the shoulder. While a shoulder condition has not been accepted as employment related, in determining entitlement to a schedule award, preexisting impairments of the scheduled member of the body are to be included.[10] The scheduled member in this case is the upper extremity, which, under the A.M.A., *Guides*, is to be evaluated as a whole.[11] For the shoulder, Dr. Jacob found 180 degrees of flexion which

[6] 20 C.F.R. § 10.404(a).

[7] A.M.A., *Guides* at 508.

[8] The Office denied appellant's prior claim for a schedule award in a decision dated October 19, 2001.

[9] A.M.A., *Guides* at 472, 474, Figures 16-34, 16-37.

[10] *See Carl J. Cleary*, 57 ECAB ___ (Docket No. 05-1558, issued May 10, 2006); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993).

[11] A.M.A., *Guides* at 515-18.

constitutes no impairment, 30 degrees extension which constitutes a one percent impairment, 40 degrees abduction which constitutes a six percent impairment, 35 degrees internal rotation which constitutes a four percent impairment and 40 degrees which external rotation which constitutes a one percent impairment.[12]

Dr. Jacob further found that appellant had grip strength of 4/5 on the left and 5/5 on the right with a loss of sensation along the radial nerve distribution. He determined that appellant had a seven percent impairment of the upper extremity due to loss of power pursuant to Tables 16-32 and 16-11 on pages 489 and 484 of the A.M.A., *Guides*, respectively. He added the one percent impairment for loss of range of motion to the impairment due to motor deficit to find an eight percent total upper extremity impairment. Dr. Jacob converted the eight percent upper extremity impairment to a three percent whole person impairment and added an additional three percent whole person impairment due to pain to find a whole person impairment of six percent. The Act, however, does not provide for permanent impairment for the whole person.[13] Further, Dr. Jacob applied Table 16-32 on pages 489, which is relevant to determining impairments due to spinal nerve deficits, in calculating the impairment due to loss of strength. Appellant did not have a cervical spine injury and thus the use of Table 16-32 is inappropriate in determining the extent of his impairment. Dr. Jacob also added an additional award for pain pursuant to Chapter 18 of the A.M.A., *Guides*. Examiners should not use Chapter 18 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*.[14] As Dr. Jacob's report does not conform to the A.M.A., *Guides*, it is of diminished probative value.[15]

On July 12, 2006 an Office medical adviser reviewed Dr. Jacob's report and applied the tables and pages of the A.M.A., *Guides* to his findings. He determined that appellant reached maximum medical improvement on April 24, 2006. The Office medical adviser opined that 75 degrees supination of the forearm constituted no impairment and 70 degrees pronation constituted a one percent impairment according to Figure 16-37 on page 474. He further found that appellant had no loss of elbow motion. As previously discussed, however, appellant has an additional impairment due to loss of elbow flexion and may also be entitled to an additional award due to loss of range of motion of the left shoulder. The Office medical adviser's opinion is thus insufficient to establish the extent of appellant's left upper extremity impairment.

The Office medical adviser determined that appellant had 4/5 muscle weakness of the elbow extensor which he found constituted a 5 percent impairment according to Table 16-35 on page 510 of the A.M.A., *Guides*. Table 16-35 on page 510 of the A.M.A., *Guides* is used to estimate impairment for strength deficits based on manual muscle testing. The A.M.A., *Guides*

[12] *Id*. at 476, 477, 479, Figures 16-40, 16-43, 16-46. It appears that Dr. Jacob may have listed the wrong measurements for abduction and adduction as an impairment percentage for 90 degrees measured adduction is not depicted in Figure 16-43 on pages 477.

[13] *Robert Romano*, 53 ECAB 649 (2002).

[14] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* at 18.3(b); *see also Philip Norulak*, 55 ECAB 690 (2004).

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

indicates that the use of such a table is appropriate only in a rare case where the loss of strength represents an impairing factor that has not been considered adequately by other methods.[16] The A.M.A., *Guides* provides that the table can be used for an individual who experienced a "severe muscle tear that healed leaving a palpable muscle defect."[17] The Office medical adviser explained that the use of the table was proper because appellant had muscle weakness resulting from a muscle tear of the wrist extensors. The muscle tear was surgically repaired but the weakness remained. The Office medical adviser properly found that appellant was entitled to a separate rating for loss of strength under Table 16-35. He then combined the five percent impairment due to loss of strength with the one percent impairment he found for loss of pronation. The Board notes, however, that decreased strength cannot be rated in the presence of decreased motion that prevents effective application of maximal force in the evaluated region.[18] Appellant, consequently, is not entitled to an additional award due to loss of range of motion of the elbow. The A.M.A., *Guides* further provides that an impairment due to loss of strength cannot be combined with any other impairment unless based on unrelated etiologic or pathomechanical causes. It is unclear whether the loss of range of motion of appellant's shoulder is due to an unrelated etiologic or pathomechanical cause or whether the decreased motion in the shoulder prevents application of maximal force in the evaluated region such that it could not be combined with an impairment for loss of strength. The case will be remanded for the Office to seek clarification from the Office medical adviser on the extent of appellant's permanent impairment.

CONCLUSION

The Board finds that the case is not in posture for decision and will be remanded for further development of the medical evidence. After such further development as the Office deems necessary, it should issue an appropriate merit decision.

[16] A.M.A., *Guides* at 508.

[17] *Id*.

[18] *Id*.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 24, 2006 is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: March 28, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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