United States Department of Labor
Employees' Compensation Appeals Board

K.A., Appellant	)	
and	)	**Docket No. 07-1116**
	)	**Issued: November 16, 2007**
U.S. POSTAL SERVICE, GATEWAY PERFORMANCE CLUSTER, St. Louis, MO, Employer	)	

Appearances:
Francis G. Armeno, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 19, 2007 appellant filed a timely appeal from merit decisions of the Office of Workers' Compensation Programs dated April 21, 2006 and January 10, 2007 denying her schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant has established entitlement to a schedule award for her right arm.

FACTUAL HISTORY

On May 29, 2003 appellant, then a 41-year-old clerk, filed a claim for a right wrist condition which she attributed to lifting sacks and parcels. The Office accepted her claim for a right ganglion cyst and authorized surgery, which she underwent on August 1, 2003. Appellant returned to light duty on August 9, 2003 and full duty on September 9, 2003.

On September 22, 2004 appellant filed a claim for a schedule award. In a letter dated October 1, 2003, the Office apprised appellant's treating physician, Dr. Robert Markenson, a Board-certified orthopedic surgeon, of the information required to make an impairment determination pursuant to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In an October 13, 2004 report, Dr. Markenson noted that appellant had returned to full-duty work and continued to experience pain after about six or seven hours working. Appellant's range of motion revealed that she was missing about 10 to 15 degrees of full forward flexion of her wrist compared to the opposite side. Otherwise, her grip strength appeared adequate. Dorsiflexion and radial and ulnar deviation appeared fine. Dr. Markenson opined that appellant reached maximum medical improvement on October 13, 2003 and could work full duty with out restrictions. He further opined that appellant had a four percent permanent impairment of the right arm.

On October 26, 2003 an Office medical adviser reviewed Dr. Markenson's report and advised that a disability rating could not be derived under the fifth edition of the A.M.A., *Guides*. He explained that Dr. Markenson reported an incomplete range of motion and the range of motion reported, was not measured with a goniometer. The Office medical adviser recommended that appellant be seen by a physician skilled in the use of the fifth edition of the A.M.A., *Guides*.

In a letter dated November 12, 2003, the Office referred appellant, together with her medical record, statement of accepted facts and a list of questions, to Dr. John Gragnani, Board-certified in occupational medicine and physical medicine and rehabilitation, for a second opinion evaluation. In a November 24, 2003 report, Dr. Gragnani noted appellant's history of injury and that she was not currently receiving medical treatment following her release to regular duty on October 13, 2003. He noted her complaints of tenderness at the scar on palpation and that there were no other specific limitations or complaints regarding the wrist. Dr. Gragnani reviewed the medical reports of record and discussed range of motion, pain and sensory change and chronic weakness. He provided an impression of ganglion cyst right wrist, surgically excised and possible early rheumatoid disease by clinical history and examination. Dr. Gragnani opined that appellant had zero percent impairment under the A.M.A., *Guides.* Utilizing Figures 16-28 and 16-31, pages 467 and 469 of the A.M.A., *Guides*, he found that an extension of 66 degrees equaled zero percent impairment; a flexion of 68 degrees equaled zero percent impairment; a radial deviation of 18 degrees equaled zero percent impairment and an ulnar deviation of 34 degrees equaled zero percent impairment. Dr. Gragnani further stated that there were no grip strength or sensory changes. Although appellant had complaints of tenderness and numbness over the scar line, there was no specific nerve level involvement and sensory examination of the fingers showed normal two-point discrimination. Dr. Gragnani opined that Tables 16-10 and 16-11, pages 482 and 484 of the A.M.A., *Guides* did not apply. He further opined that a rating from section 16.7 was also not applicable. In a December 1, 2003 report, the Office medical adviser agreed with Dr. Gragnani that there was no ratable impairment under the A.M.A., *Guides*.

By decision dated December 4, 2003, the Office denied appellant's request for a schedule award as the medical evidence did not show measurable permanent impairment.

On December 11, 2003 appellant disagreed with the Office's decision and requested an oral hearing, which was held on June 23, 2004. By decision dated September 14, 2004, an

Office hearing representative affirmed the December 4, 2003 decision. The Office hearing representative found that the weight of the medical opinion evidence rested with the second opinion physician, Dr. Gragnani.

On May 31, 2005 appellant requested reconsideration. In a May 12, 2005 report, an occupational therapist, noted appellant's range of motion, grip and pinch strength findings. The Office medical adviser reviewed this information and on November 25, 2005, stated that it had no relevance under the A.M.A., *Guides* as section 2.2, page 18 of the A.M.A., *Guides* advised that impairment evaluations were to be performed by a licensed physician.

By decision dated November 29, 2005, the Office denied modification of the September 14, 2004 decision.

On February 6, 2006 appellant requested reconsideration. In a January 27, 2006 report, Dr. Markenson noted seeing appellant on January 23, 2006 and reviewing the May 12, 2005 occupational therapy evaluation with her. He applied the range of motion and grip strength findings contained in the occupational therapy evaluation to the A.M.A., *Guides.* Dr. Markenson advised that he wished to add an additional 10 percent impairment rating to his previous 4 percent impairment rating of October 13, 2003, for a total 14 percent based on grip strength testing contained in the occupational therapy evaluation. He found that appellant lost 10 degrees of wrist extension on the right side, which measured 60 degrees and rated two percent permanent impairment. Additionally, appellant lost 10 percent of the radial deviation on the right side, which measured 15 degrees and represented 2 percent arm impairment. Dr. Markenson also found that appellant had a 41 percent strength loss index of the right side, which measured 107 pounds versus 183 pounds on the left side and which constituted a 20 percent upper extremity impairment under page 509 of the A.M.A., *Guides*.

In a March 20, 2006 report, the Office medical adviser stated that Dr. Markenson could not provide an increased impairment rating to account for grip strength differences as the grip strength was evaluated by an occupational therapist.

By decision dated April 21, 2006, the Office denied modification of the November 21, 2005 decision.

On November 22, 2006 appellant requested reconsideration. In a November 10, 2006 report, Dr. Bruce Schlafly, a Board-certified orthopedic surgeon, noted the history of injury and appellant's medical care. He stated that appellant's primary complaint was pain with use and that she did not have normal strength and endurance in her right wrist. Dr. Schlafly reported his examination findings, which included range of motion findings, pinch strength and grip strength. He opined that appellant did not have any impairment of her right arm based on loss of range of motion or nerve damage and stated that the dorsal wrist numbness was insignificant. However, that appellant had seven percent permanent impairment of the right upper extremity based on pain and weakness for which she reached maximum medical improvement on August 1, 2004. Dr. Schlafly noted that appellant had average grip strength of 62 pounds in the right hand and 65 pounds in the left hand which resulted in a 10 percent strength loss index which resulted, under Table 16-34 of page 509 of the A.M.A., *Guides* in a 10 percent impairment of the right arm. He noted that Table 16-18 on page 499 of the A.M.A., *Guides* provided a 40 percent

maximum impairment value, which he then multiplied by the 10 percent impairment to find that appellant had a 4 percent permanent impairment of the right upper extremity. Based on the nature of the surgery performed and appellant's description of residual pain, Dr. Schlafly additionally opined that appellant had an additional impairment based on pain. Using the information provided on page 573 of Chapter 18 of the A.M.A., *Guides*, he provided an additional three percent impairment due to pain.

In a December 18, 2006 report, an Office medical adviser reviewed Dr. Schlafly's report. He noted that Dr. Schlafly did not measure range of motion abnormalities, provide a sensory assessment or perform any examination except for grip strength testing, range of motion measurements and noted a patch of numbness. The medical adviser stated that the use of the grip strength index was precluded in that appellant's condition was reported by Dr. Schlafly to be manifested by pain. He also stated that Dr. Schlafly's use of Table 16-18 was incorrect as the maximum percentage for the radiocarpal joint was multiplied by the conditions described in Tables 16-19 through 24 of the A.M.A., *Guides.* The Office medical adviser stated that Dr. Schlafly's report contained no medical documentation to allow for consideration of the rating process using Table 16-18 in conjunction with Tables 16-19 through 24. Furthermore, the multiplication of the rating for the radiocarpal joint from Table 16-18 by the rating for weakness, incorrectly processed from section 16.8b, pages 508-09, was not acceptable under the A.M.A., *Guides*. The medical adviser stated that Dr. Schlafly incorrectly used Chapter 18 as a detailed history was not provided and appellant did not have chronic pain syndrome. He concluded that no weighing for pain under Chapter 18 of the A.M.A., *Guides* was warranted.

By decision dated January 10, 2007, the Office denied modification of its previous decisions.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implement regulations[2] 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. The Act, however, does not specify the manner in which the percentage loss of a member 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 A.M.A., *Guides* (5th ed. 2001) has been adopted by the Office for evaluating schedule losses.[3]

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

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] *See* 20 C.F.R. § 10.404; *see also David W. Ferrall*, 56 ECAB ___ (Docket No. 04-2142, issued February 23, 2005).

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.[4] The A.M.A., *Guides* state, otherwise, the impairment ratings based on objective anatomic findings take precedence. (Emphasis in the original.)[5] 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.[6]

It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[7] The A.M.A., *Guides* provide that decreased strength cannot be rated in the presence of decreased motion or painful conditions unless based on an unrelated etiology or pathomechanical causes.[8]

ANALYSIS

In an October 13, 2004 medical report, Dr. Markenson opined that appellant reached maximum medical improvement on October 13, 2003 and had a four percent permanent impairment of the right wrist. However, no physical examination findings accompanied his report and he failed to explain how his impairment calculations were derived or conformed with the A.M.A., *Guides.* Thus, this report is of diminished probative value.

In a January 27, 2006 report, Dr. Markenson advised that he wished to amend his previous 4 percent impairment rating to find a total impairment rating of 14 percent for the right arm. He provided impairment ratings for both loss of range of motion and grip strength as contained in a May 12, 2005 occupational therapy evaluation.[9] As noted, however, the A.M.A., *Guides* do not favor an impairment rating based on loss of grip strength unless it represents an impairing factor that has not been otherwise considered adequately.[10] The A.M.A., *Guides* also provide a protocol for performing grip strength evaluations which requires repeating the

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

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

[6] *Id.* 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 4.

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

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

[9] The Board notes that, while the May 12, 2005 evaluation was conducted by an occupational therapist and cannot be used by itself to perform an impairment rating, a licensed physician, such as Dr. Markenson may incorporate such findings as his own. *See* section 2.2, page 18 of the A.M.A., *Guides.* *See* 5 U.S.C. § 8101(2) (defines the term "physician"); *see also Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (medical opinion, in general, can only be given by a qualified physician).

[10] *Henninger*, *supra* note 4.

measurements three times and averaging the results.[11] Dr. Markenson did not explain why grip strength loss was the only appropriate measurement of impairment, nor did he indicate that the tests were performed in accordance with the A.M.A., *Guides.* Furthermore, impairment for loss of strength may be rated separately only if such a deficit has not been considered adequately by other rating methods. 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.[12] Dr. Markenson did not address why appellant's loss of range of motion and loss of grip strength were of separate etiologies. Therefore, his report is of diminished probative value.

In a November 24, 2003 report, Dr. Gragnani, the second opinion physician, noted appellant's history of injury and treatment and utilized the fifth edition of the A.M.A., *Guides.* He conducted a physical examination and discussed range of motion, pain and sensory change and chronic weakness and opined that appellant had a zero percent impairment under the A.M.A., *Guides.* Utilizing Figures 16-28 and 16-31, pages 467 and 469 of the A.M.A., *Guides*, Dr. Gragnani found that an extension of 66 degrees equaled a zero percent impairment; a flexion of 68 degrees equaled zero percent impairment; a radial deviation of 18 degrees equaled zero percent impairment and an ulnar deviation of 34 degrees equaled zero percent impairment. He found no grip strength or sensory changes of any type. Dr. Gragnani noted that, while appellant had complaints of tenderness and numbness over the scar line, there was no specific nerve level involvement and sensory examination of the fingers which showed normal two-point discrimination. Thus, he opined that Tables 16-10 and 16-11, pages 482 and 484 of the A.M.A., *Guides* were not applicable. Dr. Gragnani further opined that a rating from section 16.7, impairment of the upper extremity due to other disorders, was also not applicable.

The Board notes that appellant also submitted a November 10, 2006 report by Dr. Schlafly, who opined that appellant had seven percent permanent impairment of the right arm based on pain and weakness. Dr. Schlafly's finding that appellant had seven percent permanent impairment of the right arm also relied, in part, on grip strength deficits. He determined that appellant's right grip strength constituted four percent impairment of the right arm.[13] However, as previously noted, the A.M.A., *Guides* provides that decreased strength cannot be rated in the presence of painful conditions and that impairment ratings based on objective anatomic findings

[11] 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 4.

[12] *Cerita J. Slusher*, 56 ECAB ___ (Docket No. 04-1584, issued May 10, 2005).

[13] A.M.A., *Guides* 509, Table 16-34.

take precedence.[14] Dr. Schlafly's application of Table 16-18 on page 499 of the A.M.A., *Guides* in arriving at an impairment for weakness was also inappropriate. Section 16.7 of the A.M.A., *Guides*[15] provides that the severity of conditions contributing to impairments of the upper extremity, such as joint disorders and loss of strength, is rated separately according to Tables 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18. Section 16.7 of the A.M.A., *Guides* should be used only when the other criteria have not adequately encompassed the extent of the impairment. Dr. Schlafly provided no medical documentation to allow for the consideration of such rating process under any of the applicable Tables 16-19 through 16-30. Further, his impairment due to pain under Chapter 18 of the A.M.A., *Guides* was inappropriate as Chapter 18 should not be used 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., *Guide*s.[16] Dr. Schlafly did not explain why this could not be rated under Chapter 16 which pertains to the upper extremities. Thus, his report is insufficient to establish appellant's entitlement to a schedule award.

The Office medical adviser reviewed the case record and found that there was no ratable impairment for appellant's accepted condition under the A.M.A., *Guides*. He properly explained that Dr. Schlafly's report was insufficient to establish appellant's entitlement to a schedule award. Board precedent is well settled that, when an attending physician's report gives an estimate of impairment, but does not indicate that the estimate is based upon the application of the A.M.A., *Guides* or improperly applies the A.M.A., *Guides*, the Office may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.[17] Thus, the Board finds that appellant does not have a ratable permanent impairment pursuant to the A.M.A., *Guides*.

There is insufficient no probative medical evidence to establish that appellant sustained permanent impairment to her right arm. The Office properly found that she was not entitled to a schedule award due to her accepted right arm condition.

CONCLUSION

The Board finds that appellant is not entitled to a schedule award for her accepted right arm condition.

[14] *See id*. at 508, section 16.8a. *See Phillip H. Conte*, 56 ECAB ___ (Docket No. 04-1524, issued December 22, 2004) (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 and, only in rare cases should grip strength be used, and only when it represents an impairing factor that has not been otherwise considered adequately).

[15] A.M.A., *Guides* 498.

[16] *See Frantz Ghassan*, 57 ECAB ___ (Docket No. 05-1947, issued February 2, 2006).

[17] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982).

ORDER

IT IS HEREBY ORDERED THAT the January 10, 2007 and April 21, 2006 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: November 16, 2007
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