United States Department of Labor
Employees' Compensation Appeals Board

T.T., Appellant	)	
	)	**Docket No. 08-30**
and	)	**Issued: April 8, 2008**
DEPARTMENT OF THE NAVY, NAVY PUBLIC WORKS, San Diego, CA, Employer	)	

Appearances:
Appellant, pro se
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 October 1, 2007 appellant filed a timely appeal from a June 27, 2007 Office of Workers' Compensation Programs' decision, adjudicating his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

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

FACTUAL HISTORY

This is the second appeal in this case.[1] By decision dated January 8, 2007, the Board remanded the case for further development of the medical evidence. The facts of this case, as set forth in the prior decision, are incorporated herein by reference.

[1] *See* Docket No. 06-1982 (issued January 8, 2007).

On February 13, 2003 appellant, then a 40-year-old roofer, sustained injury to his back and left arm when he fell from a roof while working. The Office accepted his claim for a left wrist fracture and a lumbar compression fracture. On April 10, 2004 appellant filed a claim for a schedule award. On May 20, 2004 the Office granted appellant a schedule award from January 16 to September 12, 2004 or 34.32 weeks, for an 11 percent impairment of his left upper extremity.[2] The schedule award was based on a May 6, 2004 report from Dr. Arthur S. Harris, a Board-certified orthopedic surgeon and an Office medical consultant. On August 19, 2005 the Office denied modification of the May 20, 2004 decision.

In his May 20, 2004 report, Dr. Harris reviewed the January 16, 2004 report of Dr. Richard Yu, who provided findings on physical examination but did not provide an impairment rating. Dr. Harris did not examine appellant. He found that appellant had a combined 11 percent impairment to his left upper extremity. This included 10 percent for a 33 percent grip strength loss, based on Table 16-34 at page 509 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*)[3] and 1 percent for Grade 4 decreased sensation or pain, based on Table 16-10 at page 482 and Table 16-15 at page 492 (25 percent for a Grade 4 impairment multiplied by 5 percent for the radial nerve equals 1.25 percent, rounded to 1 percent).[4] Dr. Harris stated that appellant's grip strength loss was based on actual muscle weakness as well as pain that interfered with function. He stated that appellant had no impairment for loss of range of motion of his left wrist which included 65 degrees of dorsiflexion, 60 degrees of palmar flexion, 40 degrees of ulnar deviation and 20 degrees of radial deviation.

Following remand of the case by the Board, on June 7, 2007 the Office asked Dr. Harris to provide a supplementary report to include additional explanation for his impairment rating. It noted that the A.M.A., *Guides* provided for a 20 percent upper extremity impairment for a 33 percent grip strength loss according to Table 16-34, not 10 percent as determined by Dr. Harris. The Office noted that Dr. Yu found a loss of range of motion in appellant's left wrist but Dr. Harris found no impairment due to loss of range of motion, nor did he reference the applicable tables in the A.M.A., *Guides* or explain his conclusion. The Office asked Dr. Harris to determine whether his opinion of appellant's impairment had changed and to explain his reasoning.

In a June 20, 2007 report, Dr. Harris stated that he had reviewed the case file. He stated:

> "When the case file was reviewed by myself on May 6, 2004, it was noted [appellant] did have some loss of motion of his left wrist as compared to the right wrist. However, his residual left wrist motion did not result in any sort of ratable impairment. (Figure 16-2[8]/[p]age 467; Figure 16-31/[p]age 46[9]) As such,

[2] The Federal Employees' Compensation Act provides for 312 weeks of compensation for 100 percent loss or loss of use of an upper extremity. 5 U.S.C. § 8107(c)(1). Multiplying 312 weeks by 11 percent equals 34.32 weeks of compensation.

[3] A.M.A., *Guides* (5th ed. 2001).

[4] Dr. Yu stated that appellant experienced pain in his left wrist, described as "marked to severe," when he performed activities involving heavy use of his hand and wrist such as heavy pushing and pulling.

[appellant] was not provided with any impairment for loss of motion based on [the] A.M.A., *Guides*.

"As noted in my review of May 6, 2004, [appellant] did have a 33 percent loss of grip strength, however, it was my opinion that this grip strength represented both true grip strength loss due to the altered kinematics in his wrist as a result of his carpal navicular fracture as well as some residual pain. [Appellant] did provide history of having some pain with heavy activities. As such, [he] was only provided with a 10 percent impairment for his loss of grip strength (Table 16-34/[p]age 509) and not the full 20 percent since I felt that the 33 percent loss of grip strength on testing represented complete grip strength loss and some of it was secondary to pain. In addition, there was documentation of [appellant] having some residual pain in his left wrist in spite of which he was able to continue with his usual activities and, therefore, he was provided with 1 percent impairment for this (Table 16-10/[p]age 482; Table 16-15/[p]age 492). The A.M.A., *Guides* allow a physician to modify the impairment rating based on the medical evidence ([p]age 19, Chapter 2.5C). The A.M.A., *Guides* also encourage physicians to use their clinical judgment based on experience, training, skills, thoroughness and clinical evaluation when making calculations of clinical impairment ([p]age 11/[s]ection 1.5). As such, it was felt [appellant] had a 10 percent impairment for grip strength loss as well as 1 percent for residual symptoms, resulting in 11 percent impairment of the upper extremity. As noted above, he did have loss of motion as compared to the uninjured right side, however, his residual left wrist motion was functional and, therefore, did not result in any sort of ratable impairment based on the A.M.A., *Guides*.

"After review of the above, I do not wish to change any previously expressed opinions, as noted in my review of May 6, 2004. A diagnosis of left carpal navicular fracture of the wrist has been established and [appellant] has an 11 percent impairment of the left upper extremity with a date of maximum medical improvement as January 16, 2004."

By decision dated June 27, 2007, the Office found that appellant had no more than an 11 percent impairment of his left upper extremity.

LEGAL PRECEDENT

The schedule award provision of the Act[5] and its implementing regulations[6] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[7]

ANALYSIS

In a June 20, 2007 report, Dr. Harris stated that appellant had a 1 percent impairment for sensory deficit of his left wrist based on Table 16-10 at page 482 (Grade 4, ranging from 1 to 25 percent) and Table 16-15 at page 492 of the A.M.A., *Guides* (5 percent for sensory deficit of the radial nerve). However, a Grade 4 classification is not consistent with the previous findings of Dr. Yu. A Grade 4 sensory deficit or pain is described in Table 16-10 as "Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity." Dr. Yu stated that appellant experienced pain in his left wrist, described as "marked to severe", when he performed activities involving heavy use of his hand and wrist such as heavy pushing and pulling. This description of appellant's pain is not consistent with a Grade 4, as described in the A.M.A., *Guides*. Dr. Yu's description is more consistent with a Grade 2 which describes "moderate pain that may prevent some activities." Therefore, Dr. Harris' finding of a one percent impairment of appellant's left wrist due to sensory deficit or pain is not appropriate. He indicated that section 1.5 at page 11 of the A.M.A., *Guides* encourages a physician to use his clinical judgment in making an impairment rating. The section referenced by Dr. Harris reads as follows:

> "The physician's judgment, based upon experience, training, skill, *thoroughness in clinical*[8] *evaluation* and ability to apply the [A.M.A.] *Guides* criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment. Clinical judgment, combining both the 'art' and 'science' of medicine, constitutes the essence of medical practice." (Emphasis added.)

In this case, Dr. Harris did not conduct a clinical (physical) evaluation of appellant. Only Dr. Yu performed a physical examination and evaluation. Therefore, this portion of the A.M.A., *Guides* is inapplicable to Dr. Harris' impairment rating.

Dr. Harris determined that appellant had a 10 percent impairment due to a 33 percent loss of grip strength, based on Table 16-34 at page 509 of the A.M.A., *Guides*. The Board, in its January 8, 2007 decision, found that he did not adequately explain why an impairment rating was warranted for grip strength. The Board also noted that Table 16-34 provided for a 20 percent impairment, not 10 percent. The A.M.A., *Guides* states in section 16.8 at page 508:

> "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…. 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*

[7] A.M.A., *Guides* (5th ed. 2001).

[8] "Clinical" is defined as "pertaining to or founded on actual observation and treatment of patients." *See* DORLAND'S, *Illustrated Medical Dictionary* (30th ed. 2003) 376.

> *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*…. (Emphasis in the original.)

Dr. Harris did not adequately explain why grip strength deficit was an appropriate rating method to apply in determining appellant's left upper extremity impairment. He did not explain why his loss of strength represented an impairing factor that had not been considered adequately by other methods in the A.M.A., *Guides.* Additionally, he explained his finding of a 10 percent impairment for a 33 percent loss of grip strength, rather than the 20 percent provided in Table 16-34, by referencing section 1.5 at page 11.[9] As noted, this section of the A.M.A., *Guides* is applicable in cases of clinical evaluation.

CONCLUSION

The Board finds that this case is not in posture for a decision. The case requires further development of the medical evidence. On remand, the Office should refer appellant to a different Office medical consultant or an Office medical adviser for an impairment rating of appellant's left wrist based on correct application of the A.M.A., *Guides.*

[9] Dr. Harris also mentioned section 2.5 at page 19 of the A.M.A., *Guides* which provides for modification of an impairment rating that is based on consistency tests (repeated tests designed to ensure reproducibility and greater accuracy such as those involved in grip strength tests, repeatedly squeezing a Dynamometer). Section 2.5 states that the physician "must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests are plausible and consistent with the impairment being evaluated." As noted, Dr. Harris did not conduct a clinical evaluation of appellant.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 27, 2007 is set aside and the case is remanded for further development consistent with this decision.

Issued: April 8, 2008
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