United States Department of Labor
Employees' Compensation Appeals Board

H.B., Appellant	)	
and	)	**Docket No. 08-2137**
	)	**Issued: February 20, 2009**
DEPARTMENT OF THE NAVY, AVIATION SUPPLY OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 30, 2008 appellant, through his representative, filed a timely appeal from the May 8, 2008 merit decision of the Office of Workers' Compensation Programs' hearing representative, which affirmed a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than a 45 percent impairment of his right index finger.

FACTUAL HISTORY

On February 14, 1991 appellant, then a 37-year-old forklift operator, broke his right index finger in the performance of duty: "While disposing of furniture into scrap truck, table hit right hand." He was diagnosed with a nail avulsion, laceration and distal tuft fracture. The Office accepted appellant's claim for fracture of the right index finger.

On April 16, 2002 appellant filed a claim for a schedule award. Through his representative, he submitted a November 1, 2002 impairment evaluation by Dr. Nicholas P. Diamond, an osteopath, who reported distal interphalangeal (DIP) extension-flexion from 0 to 15 degrees, proximal interphalangeal (PIP) extension-flexion from 0 to 100 degrees and metacarpal phalangeal (MP) extension-flexion from -20 to 90 degrees. Dr. Diamond also reported grip strength testing. He noted decreased sensory examination involving the right index finger and gross motor strength of 4+/5 involving the right pronators. Dr. Diamond calculated a 40 percent impairment of the right upper extremity due to loss of motion in the right index finger, radial and ulnar sensory deficits in the right index finger and motor strength deficit in the right pronators, right grip strength deficit and a pain-related impairment.

On December 5, 2002 an Office medical adviser reviewed Dr. Diamond's findings. He noted that the injury did not involve other digits or extend into the hand or upper extremity. The Office medical adviser agreed with Dr. Diamond's rating for loss of finger motion. But grip strength, he explained, could not be rated in the presence of decreased motion and because only the index finger was injured, the medical adviser determined impairment for transverse and longitudinal sensory loss in the index finger based on the percentage of digit length involved. Combining loss of motion with sensory loss of the ulnar nerve with sensory loss of the radial nerve, the medical adviser calculated that appellant had a 45 percent total impairment of the right index finger.

On January 22, 2003 the Office issued a schedule award for a 45 percent impairment of the right index finger.

Appellant, through his representative, requested an oral hearing before an Office hearing representative. A hearing was held on September 24, 2003. On December 15, 2003 an Office hearing representative affirmed the schedule award. The Office reissued this decision on November 1, 2004. Appellant again requested an oral hearing, which was held on March 26, 2008.

In a decision dated May 8, 2008, an Office hearing representative affirmed the November 1, 2004 decision. He found that the Office medical adviser properly calculated appellant's impairment from Dr. Diamond's findings on examination.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[1] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*.[2]

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

Where the residuals of an injury to a member of the body specified in the schedule extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member.[3]

ANALYSIS

There is no dispute over the impairment due to loss of motion in the right index finger. The Office medical adviser agreed with the rating given by Dr. Diamond, the osteopath. Extension-flexion from 0 to 15 degrees in the DIP joint represents digital impairment between 26 and 31 percent.[4] Dr. Diamond reported 28 percent. Extension-flexion from 0 to 100 degrees in the PIP joint represents no impairment.[5] Extension-flexion from -20 to 90 degrees in the MP joint also represents no impairment.[6]

Dr. Diamond determined sensory loss by referring to Table 16-15, page 492. This table is for compressions or lesions of the major peripheral nerves from the hand to the thoracocervical region. Appellant's injury-related sensory loss is confined to the right index finger. Therefore, as the Office medical adviser reported, Table 16-7, page 448, is appropriate. Dr. Diamond reported that sensory examination involving the right index finger was "decreased." This brief description does not allow a proper application of the A.M.A., *Guides*. Nonetheless, giving appellant the benefit of doubt, the Office medical adviser took Dr. Diamond's description to mean a partial loss of both the ulnar and radial nerves along the entire length of the right index finger. This would represent digital impairment of 10 and 15 percent respectively. If both digital nerves are involved in the same digit, the sensory impairments relating to the ulnar and radial palmar nerves are added.[7] Appellant's sensory loss would therefore be 25 percent.

If other impairments of the same digit are present, such as decreased motion, their percentages are combined with the percentage due to sensory loss.[8] According to the Combined Values Chart,[9] a 28 percent loss of motion combines with a 25 percent sensory loss for a total digit impairment of 46 percent, which is one percent more than the Office awarded. The Board will modify the Office's hearing representative's May 8, 2008 decision to find 46 percent impairment to the right index finger.

Dr. Diamond combined loss of motion and sensory loss with loss of grip strength, but the A.M.A., *Guides* strongly cautions against this practice. The A.M.A., *Guides* notes that, because

[3] *Asline Johnson*, 42 ECAB 619 (1991); *Manuel Gonzales*, 34 ECAB 1022 (1983).

[4] A.M.A., *Guides* 461 (Figure 16-21).

[5] *Id*. at 463 (Figure 16-23).

[6] *Id*. at 464 (Figure 16-25).

[7] *Id*. at 449.

[8] *Id*.

[9] *Id*. at 604.

strength measurements are functional tests influenced by subjective factors that are difficult to control, and the A.M.A., *Guides* is for the most part based on anatomic impairment, the A.M.A., *Guides* does not assign a large role to such measurements.[10] The A.M.A., *Guides* states that 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. The A.M.A., *Guides* advises, however:

> "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."[11]

Impairment due to loss of strength may be rated separately if the examining physician believes loss of strength represents an impairing factor that has not been considered adequately by other methods, if the loss of strength is based on unrelated etiologic or pathomechanical causes and if decreased motion or painful conditions do not prevent effective application of maximal force in the region being evaluated. However, Dr. Diamond did not address any of these matters.[12]

Dr. Diamond added three percent for pain-related impairment, but he offered no rationale. Discussing the difficulties associated with integrating pain-related impairment into an impairment rating system, the A.M.A., *Guides* states:

> "Finally, at a practical level, a chapter of the A.M.A., *Guides* devoted to pain-related impairment should not be redundant of or inconsistent with principles impairment rating described in other chapters. The A.M.A., *Guides'* impairment ratings currently include allowances for the pain that individuals typically experience when they suffer from various injuries or diseases, as articulated in Chapter 1 of the A.M.A., *Guides*: 'Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the A.M.A., *Guides* already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly

[10] *Id*. at 507.

[11] *Id*. at 508 (original emphasis).

[12] Further, it does not appear that Dr. Diamond tested grip strength more than once. The A.M.A., *Guides* states that tests repeated at intervals during an examination are considered reliable if there is less than 20 percent variation in the readings. If there is more than 20 percent variation in the readings, one may assume the individual is not exerting full effort. The test is usually repeated three times with each hand at different times during the examination and the values are recorded and later compared. *Id.* Dr. Diamond simply reported that testing at Level III revealed 30 kilograms of force strength involving the right hand versus 13 kilograms involving the left. The reliability of this reading is not demonstrated.

> seen, has been accounted for in the cervical spine impairment rating' (p. 10). Thus, if an examining physician determines that an individual has pain-related impairment, he or she will have the additional task of deciding whether or not that impairment has already been adequately incorporated into the rating the person has received on the basis of other chapters of the A.M.A., *Guides*."[13]

Without a sound explanation for incorporating pain-related impairment,[14] Dr. Diamond did not justify a three percent increase in appellant's rating.

CONCLUSION

The Board finds that appellant has a 46 percent impairment of his right index finger due to loss of motion and sensory deficit.

ORDER

IT IS HEREBY ORDERED THAT the May 8, 2008 decision of the Office of Workers' Compensation Programs is affirmed as modified to find a 46 percent impairment of the right index finger.

Issued: February 20, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[13] *Id*. at 570.

[14] *See Id*. ("When This Chapter Should Be Used to Evaluate Pain-Related Impairment").