U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BEVERLY DILLON-JONES and DEPARTMENT OF VETERANS AFFAIRS, LAKESIDE MEDICAL CENTER, Chicago, IL

Docket No. 99-1426; Submitted on the Record;
Issued November 14, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
VALERIE D. EVANS-HARRELL

The issue on appeal is whether appellant established greater than a 19 percent permanent impairment of the right upper extremity and a 15 percent permanent impairment of the left upper extremity for which she received a schedule award.

On June 15, 1995 appellant, then a 38-year-old dental hygienist, filed a notice of occupational disease and claim for compensation alleging that she sustained a bilateral hand and wrist condition as the result of having to type on a computer keyboard in the performance of duty. The Office of Workers' Compensation Programs accepted the claim for bilateral carpal tunnel syndrome and bilateral deQuervain's tenosynovitis. Appellant underwent a right carpal tunnel and deQuervain's release on May 21, 1996. Although the Office authorized bilateral releases, she refused to undergo surgery on her left wrist. Appellant received compensation for intermittent periods of wage loss. She last suffered a recurrence of disability on December 30, 1996. She was off work from December 31, 1996 until January 6, 1997 when she returned to limited duty under medical restrictions.

On March 1, 1997 appellant filed a (Form CA-7) claim for a schedule award.

In a letter dated March 12, 1997, the Office requested an impairment rating by appellant's treating physician, Dr. Richard Beaty, an orthopedic surgeon.

In a March 25, 1997 report, Dr. Beaty noted appellant's history of treatment and that she was on permanent medical restrictions of no repetitive use of her hands. He indicated that appellant had full range of motion and a mildly positive Phalen's and Tinel's sign on the left wrist, and left hand and a mildly positive Finkelstein's test over the left thumb. Dr. Beaty stated that he was unable to rate appellant's impairment because he did not have a copy of the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In a report dated October 14, 1997, Dr. John M. Stogin, Jr., an Office referral physician and Board-certified orthopedic hand surgeon, discussed appellant's history of bilateral tunnel syndrome with tenosynovitis and her decision to have only surgery on the right wrist. He noted that appellant's "wrists show extension and flexion of 45/70 degrees on the right and 40/80 degrees on the left with radial and ulnar deviation of 0/25 degrees on the right and 0/25 degrees on the left." He indicated that pronation and supination were normal bilaterally and that digital range of motion was also normal. Dr. Stogin further stated:

> "[Appellant] shows diffuse tenderness in both of her wrists, mostly on the radial aspects of her wrists extending from her first extensor compartment distally into her first web spaces, almost to the index finger metacarpal head. This distribution of discomfort is difficult to reconcile with her reported pathology. There is no palpable neuroma on either side and no particular area of hypersensitivity on either side to suggest neuroma formation. She does report some hypesthesia over the dorsal aspect of her first web space on the right. Two point discrimination on the right from thumb through small fingers in 7/5, 7/5, 5/7, 7/7 and 7/7 mm. These measurements were somewhat variable. Two point discrimination on the left is approximately 7/7 mm throughout percussion testing of the ulnar nerves at the elbows is negative. Percussion testing of the median nerves at the wrist is positive bilaterally with paresthesias radiating to the middle finger on the right and to thumb and index finger on the left. Phalen's test causes paresthesias in the index and ring fingers bilaterally."

According to Dr. Stogin, appellant's x-rays showed no signs of degenerative changes. He concluded that appellant reached maximum medical improvement on May 1, 1997 with a permanent impairment rating of 10 percent of each upper extremity based upon the reported objective findings of mild bilateral carpal tunnel syndrome.

In a report dated July 20, 1998, an Office medical adviser reviewed the medical record and stated that appellant's diffuse tenderness awards 2 percent upper extremity permanent impairment for Grade 3 pain in the distribution of the dorsal sensory branch of the radial nerve according to Table 15, page 3/54 and Table 11, page 3/48 of A.M.A., *Guides*. He noted that appellant's radial deviation of 0 degrees equaled a 4 percent permanent impairment and ulnar deviation of 25 degrees equaled a 1 percent permanent impairment according to figure 29, page 3/38 of the A.M.A., *Guides*. He further noted that appellant's lack of flexion at 45 degrees equaled a 3 percent permanent impairment and her lack of extension at 70 degrees equaled 0 percent permanent impairment according to figure 26, page 3/36. The Office medical adviser next indicated that under Table 16, page 3/57 of the A.M.A., *Guides* an additional 10 percent right upper extremity permanent impairment was allowed due to appellant's mild residuals of median nerve entrapment at the wrist. He applied the combined values at page 322 and concluded that appellant had a right upper extremity impairment of 19 percent. The date of maximum medical improvement was identified as six months following the surgical procedure, November 21, 1996.

On August 28, 1998 the Office issued a schedule award for 19 percent permanent impairment of the right upper extremity for the period of November 21, 1996 to January 9, 1998.

Appellant requested reconsideration on November 6, 1998.

In a report dated December 7, 1998, an Office medical adviser reviewed Dr. Stogin's physical findings for the purpose of calculating an impairment rating for appellant's left upper extremity. The Office medical adviser noted that appellant had a good range of wrist and elbow motion, with only slight restriction in wrist dorsiflexion, diffuse tenderness of the wrist with slightly increased 2-point discrimination (7 mm), and positive Phalen's and Tinel's tests. He stated that the permanent partial impairment (PPI) was best determined by diagnosis-based estimates. Citing Table 16, page 3/57 of the A.M.A., *Guides*, he stated that there was a 10 percent impairment due to mild symptoms of median nerve entrapment at the wrist, with an additional 5 percent warranted for pain in the radial nerve distribution at Table 15, page 3/54 and Table 11, page 3/48 due to deQuervain's tenosynovitis. The Office medical adviser concluded that under the Combined Values Chart on page 322, appellant had a 15 percent permanent impairment of the left upper extremity.

In a December 9, 1998 decision, the Office denied modification following a merit review.[1]

In a decision dated December 22, 1998, the Office issued a schedule award for a 15 percent permanent impairment of the left upper extremity. The period of the award was January 10 to December 3, 1998.

The Board finds that appellant has failed to establish that she is entitled to an increased schedule award for either her right or left upper extremity.

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.304 of the implementing federal regulations,[3] schedule awards are paid for the loss or permanent disability of certain specified body members, functions or organs. Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[4]

In order to meet her burden, appellant must submit sufficient medical evidence to show a permanent impairment causally related to her employment that is ratable under the A.M.A., *Guides*. The Office's procedures discuss the type of evidence required to support a schedule award. The evidence must show that the impairment has reached a permanent and fixed state

[1] Appellant submitted "return to work slips" dated March 25, 1997 and October 7, 1998, a copy of a March 25, 1997 medical report, by Dr. Beaty that was already of record and informational letters regarding his disability retirement.

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.304.

[4] *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

and indicate the date this occurred, describe the impairment in detail and contain an evaluation of the impairment under the A.M.A., *Guides*.

Before the A.M.A., *Guides* may be utilized, however, a description of appellant's impairment must be obtained from appellant's attending physician. In obtaining medical evidence required for a schedule award, the evaluation made by an attending physician must include a detailed description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of atrophy or deformity, degrees in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description 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 resulting restrictions and limitations.[5]

Appellant contends on appeal that she is entitled to a greater percentage of impairment than determined by the Office with respect to her upper extremities.

In the instant case, the Boards notes that the Office was unable to visualize the degree of appellant's impairment under the A.M.A., *Guides* based solely on the report provided by appellant's attending physician. Therefore, in accordance with Office procedures, the Office properly referred appellant for an examination with a Board-certified physician. In his October 14, 1997 report, Dr. Stogin, the Office referral physician who was a Board-certified orthopedic hand surgeon, provided a detailed description of physical findings and rated appellant's impairment as 10 percent each in the right and left upper extremities. He, however, did not cite references to the A.M.A., *Guides*. The Office next forwarded a copy of Dr. Stogin's report to an Office medical adviser for review. The Office medical adviser applied Dr. Stogin's physical findings to the A.M.A., *Guides* and determined on July 20, 1998 that appellant had a 19 percent permanent impairment of the right upper extremity. It was later determined by a different Office medical adviser in a report dated December 7, 1998 that appellant had a 15 percent permanent impairment of the left upper extremity.

It is well settled that when an attending physician's report gives an estimate of permanent impairment but does not indicate that the estimate is based on the application of 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*.[6] The Board finds that the Office medical advisers properly utilized the A.M.A., *Guides* in rendering their respective impairment ratings. Consequently, the Board finds that appellant has failed to establish that she is entitled to greater than a 19 percent impairment rating for her right upper extremity. Appellant has also failed to establish that she is entitled to greater than a 15 percent impairment for the left upper extremity.

[5] *John H. Smith*, 41 ECAB 444 (1990).

[6] *See, e.g., Roel Santos*, 41 ECAB 1001 (1990); *Luis Chapa, Jr.*, 41 ECAB 159 (1989).

The decisions of the Office of Workers' Compensation Programs dated December 22 and 9 and August 28, 1998 are hereby affirmed.

Dated, Washington, DC
November 14, 2000

Michael J. Walsh
Chairman

Willie T.C. Thomas
Member

Valerie D. Evans-Harrell
Alternate Member