

employment. By letter dated June 29, 1995, the Office advised appellant that it had accepted that she sustained right de Quervain's tenosynovitis in the performance of her duties, and it authorized the de Quervain's surgical release that had been performed on January 5, 1995. On August 27, 1998 appellant underwent a left carpal tunnel release. The Office later accepted that her carpal tunnel syndrome was related to her employment.

On September 21, 2000 appellant filed a claim for a schedule award. On October 26, 2000 appellant underwent right carpal tunnel release surgery, which the Office approved as employment related. Appellant returned to full-time limited duty on January 16, 2001.

In response to an Office request for an evaluation of her permanent impairment due to her bilateral carpal tunnel syndrome, appellant's attending physician, Dr. Linda H. Morse, who is Board-certified in occupational and preventive medicine, submitted a February 18, 2001 report describing the ranges of motion of the joints of her arms and her decreased grip strength. Dr. Morse stated that appellant had reached maximum medical improvement on January 29, 2001. An Office medical adviser reviewed Dr. Morse's report, and concluded that the losses of motion reported therein showed an eight percent permanent impairment of the right arm and a five percent permanent impairment of the left arm.

On June 15, 2001 the Office issued appellant a schedule award for an eight percent permanent impairment of the right arm and a five percent permanent impairment of the left arm. The period of the award was from January 29 to November 8, 2001.

On January 17, 2002 appellant filed another claim for a schedule award. On February 19, 2002 the Office referred appellant, prior medical reports and a statement of accepted facts to Dr. Stanley Baer, a Board-certified orthopedic surgeon, for an evaluation of the permanent impairments of her arms. In a March 14, 2002 report, Dr. Baer noted that appellant complained of constant hand pain and occasional numbness, and described the losses of motion of appellant's wrists and fingers. Dr. Baer stated that the date of maximum medical improvement would have been one year after any previous surgery or onset of symptoms. An Office medical adviser reviewed Dr. Baer's report and assigned percentages of impairment to the losses of motion and of sensation and strength reported therein, concluding that appellant had a 27 percent permanent impairment of the right arm and 12 percent permanent impairment of the left arm.

On May 7, 2002 the Office issued a schedule award for an additional 19 percent permanent impairment of the right arm (for a total of 27 percent) and an additional 7 percent permanent impairment of the left arm (for a total of 12 percent). The period of these awards was from November 9, 2001 to April 20, 2002.

On June 22, 2003 appellant filed another claim for a schedule award. On November 4, 2003 the Office referred appellant, prior medical reports and a statement of accepted facts to Dr. Alan Knifeman, a Board-certified physiatrist, for an evaluation of the permanent impairments of her arms. In a November 20, 2003 report, Dr. Knifeman reported that on examination appellant had, for each wrist, 60 degrees of dorsiflexion, 70 degrees of palmar flexion, 30 degrees of ulnar deviation and 20 degrees of radial deviation. Dr. Knifeman also reported that appellant's grip of the right hand averaged 21 pounds per square inch and her left hand averaged 56, that she had reduced sensitivity to touch in the median nerve distribution in

the right arm, and no evidence of carpal tunnel syndrome, nerve entrapment, or neuropathy in either arm on neurodiagnostic evaluation, which included an electromyogram and nerve conduction studies. Dr. Knifeman also reported ranges of motion of appellant's fingers and thumbs: for each finger, 70 degrees for the distal interphalangeal joints, 100 degrees for the proximal interphalangeal joints and 50 degrees for the metacarpophalangeal joints; for the thumbs, 80 degrees of interphalangeal joint motion on the left and 30 degrees on the right, 60 degrees of metacarpophalangeal joint motion on the left and 40 degrees on the right, 50 degrees of radial abduction on the left and 40 degrees on the right, 8 centimeters (cm) of adduction on the left and 7 cm on the right, and 0 cm of opposition on the left and 3 cm on the right. Dr. Knifeman indicated the date of maximum medical improvement was November 20, 2003.

On January 9, 2004 an Office medical adviser reviewed Dr. Knifeman's report and stated that appellant's permanent impairment could be determined, using the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, as follows:

“Impairment due to loss of range of motion: none.

“Impairment due to loss of strength: Grip strength loss index of 50 percent gives a 20 percent right upper extremity impairment, as per Table 16-34, page 509.

“Impairment due to sensory deficit or pain: Level of impairment is grade 3, 33 percent (Table 16-10, page 482). Maximum impairment based on the median nerve is 39 percent (Table 16-15, page 492). 33 percent x 39 percent = 13 percent.

“Using the Combined Values Chart, page 604, the total impairment for the right upper extremity equals 30 percent and for the left upper extremity equals 13 percent. There is an additional 3 percent impairment of the right upper extremity and an additional 1 percent impairment for the left upper extremity since the previous determination.

“The date of maximal improvement is November 20, 2003.”

On January 16, 2004 the Office issued appellant a schedule award for an additional 3 percent permanent impairment of the right arm (for a total of 30 percent) and an additional 1 percent permanent impairment (for a total of 13 percent) of the left arm.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act¹ and its implementing regulation² sets 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

¹ 5 U.S.C. § 8107.

² 20 C.F.R. § 10.404 (1999).

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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

ANALYSIS

The only decision before the Board on this appeal is the Office's most recent schedule award issued on January 16, 2004. Since more than one year elapsed between the Office's previous schedule awards, issued on May 7, 2002 and June 15, 2001, and the filing of his appeal on March 31, 2004, the Board lacks jurisdiction to review the earlier schedule awards.³

The Office used its medical adviser's review of Dr. Knifeman's November 20, 2003 report as the basis of its January 16, 2004 schedule award for a total of 30 percent permanent impairment of the right arm and 13 percent permanent impairment of the left arm. The Office medical adviser, however, did not assign any percentage to the losses of motion of appellant's right thumb reported by Dr. Knifeman. In addition, while the Office medical adviser referred to the correct tables of the A.M.A., *Guides* to rate appellant's loss of strength and sensation, the Office medical adviser did not explain how she arrived at the grip strength loss index of 50 percent, at the Grade 3 impairment due to sensory deficit or pain, or at 33 percent for this Grade 3 impairment, which Table 16-10 indicates is a 26 to 60 percent sensory deficit.⁴

On appeal appellant questions why the date of maximum medical improvement was November 20, 2003 for the January 16, 2004 schedule award, given that the date of maximum medical improvement for the prior two schedule awards was January 29, 2001. The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. Maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. The determination of the date of maximum improvement is factual in nature and depends primarily on the medical evidence.⁵

Both Dr. Knifeman and the Office medical adviser who reviewed his report listed the date of maximum medical improvement as November 20, 2003, the date of Dr. Knifeman's examination of appellant, but neither physician explained why this date was chosen. Dr. Baer, who examined appellant on March 14, 2002, stated that the date of maximum medical improvement was one year after the date of surgery.

³ 20 C.F.R. § 501.3(d) requires that an appeal be filed with the Board no later than one year from the date of issuance of the Office's decision.

⁴ An Office medical adviser, as a nonexamining physician, cannot select a percentage from an allowable range without any explanation or reference to the examining physician's findings. *John Keller*, 39 ECAB 543 (1988).

⁵ *Alsine Johnson*, 42 ECAB 619 (1991).

CONCLUSION

The case is not in posture for a decision on the percentage of permanent impairment of appellant's arms or on the date of maximum medical improvement, and will be remanded to the Office for further medical development on these issues.

ORDER

IT IS HEREBY ORDERED THAT the January 16, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for action consistent with this decision of the Board.

Issued: September 20, 2004
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member