U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ETHEL M. PIERCE and DEPARTMENT OF THE ARMY, ABERDEEN PROVING GROUND, Aberdeen, MD

Docket No. 99-379; Submitted on the Record;
Issued June 20, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM, BRADLEY T. KNOTT

The issue are: (1) whether appellant met her burden of proof to establish that she had more than a five percent permanent impairment of her right upper extremity for which she received a schedule award; and (2) whether the refusal of the Office of Workers' Compensation Programs to reopen appellant's case for further consideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a) constituted an abuse of discretion.

In the present case, on August 19, 1991 the Office accepted that appellant, then a 40-year-old secretary, developed de Quervain's tenosynovitis of the right wrist as a result of her federal employment duties. The Office subsequently authorized surgical correction of the condition, which was performed on October 18, 1991 and April 29, 1993. On August 20, 1996 appellant filed a claim for a schedule award. By decision dated July 11, 1997, the Office granted appellant a schedule award for a five percent permanent impairment of her right upper extremity. On July 17, 1997 appellant requested a review of the written record and submitted additional evidence in support of her claim. In a decision dated January 7, 1998, an Office hearing representative affirmed the Office's prior decision. By letters dated February 13 and July 31, 1998, appellant requested reconsideration of the prior Office decision and submitted additional evidence in support of her request. In a decision dated September 11, 1998, the Office found the additional evidence and arguments raised by appellant insufficient to warrant a merit review of the claim.

On May 14, 1997 appellant filed a separate occupational disease claim for a right thumb condition. On November 10, 1997 the Office accepted appellant's claim for employment-related carpometacarpal arthritis of the right thumb. On February 25, 1998 the Office doubled this claim with appellant's prior wrist claim, as both claims involved the same part of the body.

In support of her August 20, 1996 claim for a schedule award for her right de Quervain's tenosynovitis with surgical correction, appellant submitted a medical report dated November 1, 1996 from Dr. J. Russell Moore, a treating Board-certified orthopedic surgeon, who in his report,

explained that appellant had developed work-related tendinitis of her right wrist, for which she underwent dorsal compartment release surgery in 1991. Following this surgery, appellant developed scarring in and around the radial nerve and also had pain and deformity secondary to subcutaneous atrophy. To correct this condition, appellant underwent surgical neurolysis and dermatofascia fat graft in order to cover the nerve. Dr. Moore stated that, as a result of this second surgery, appellant did improve with respect to local sensitivity, but continues to have problems with her right wrist. Specifically, Dr. Moore stated:

> "[Appellant] claims to have some pain in the area of the wrist especially when using her wrist for heavy activities. She also has weakness of grasp and has numbness up the dorsal aspect of her thumb. Grip strengths were measured today and she has approximately 50 pounds grip strength of the left on position 2 of the Jamar dynamometer and 25 pounds on the right, approximately 50 percent. [Appellant's] range of motion is near full. She does have scarring over the area of the radial aspect of the wrist, which is well healed. [Appellant] does have a slight prominence of the fat graft, which leads to a small mass effect. She does wear a brace at work and is able to carry out her normal activities.
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> I feel that based on her deformity as well as weakness and pain that she has sustained a 20 percent impairment to the right upper extremity. This is based on the American Medical Association (A.M.A.), *Guides to the Evaluation of Permanent Impairment* and takes into account pain, loss of range of motion, atrophy, endurance and weakness. I do not think that she would benefit from reconstructive surgery or physical therapy at this point."

While Dr. Moore stated that he utilized the A.M.A., *Guides* in making his determination, he did not reference any specific sections of the A.M.A., *Guides* or specifically explain the calculations supporting his estimate of impairment. In addition, despite two requests from the Office, Dr. Moore did not complete and submit the forms provided by the Office for the calculation of permanent impairment.

In a memorandum dated July 2, 1997, an Office medical adviser, having reviewed Dr. Moore's reports at the Office's request, stated that the diagnosed radial nerve neuritis of the right forearm was a complication of the initial surgical release and, therefore, was causally related to the accepted condition. The Office medical adviser further stated that, while there was no basis for rating impairment based on the diagnosis of tenosynovitis alone, pursuant to the fourth edition of the A.M.A., *Guides*, radial nerve impairment for sensory loss only, below the elbow, equates to five percent permanent impairment.[1] The Office medical examiner further opined that appellant's diagnosed carpometacarpal arthritis of the right thumb was not related to the accepted de Quervain's tenosynovitis. He explained that arthritis involved the joint, while de Quervain's tenosynovitis is due to a narrowing of the tendon sheath and does not involve the joint.

The Board has duly reviewed the case record in the present case and finds that this case is not in posture for decision as further clarification of the medical opinion evidence is required.

[1] A.M.A., *Guides*, fourth edition, Table 15, page 54.

An employee seeking compensation under the Federal Employees' Compensation Act [2] has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence,[3] including that she sustained an injury in the performance of duty as alleged and that her disability, if any, was causally related to the employment injury.[4] Section 8107 of the Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[5] 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 Office has adopted the A.M.A., *Guides* as a standard for evaluating schedule losses and the Board has concurred in such adoption.[6]

The Office based its assessment of appellant's right upper extremity impairment on the evaluation of an Office medical adviser. The Board has held 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 if he or she has properly used the A.M.A., *Guides*.[7] The Board concludes that, in the present case, while the Office medical adviser properly applied the A.M.A., *Guides*, specifically Table 15, page 54, to the description of appellant's condition provided by Dr. Moore, to find a five percent permanent impairment based sensory loss, this final impairment rating does not appear to include any additional percentage of impairment based on Dr. Moore's assessment of appellant's weakness of grip strength as measured using the Jamar dynamometer. The A.M.A., *Guides* provides that, if the examiner believes that a patient's loss of strength represents an impairment factor that has not been considered adequately, the loss of strength may be rated separately and would be combined with any other upper extremity impairments.[8] Although appellant's treating physician, Dr. Moore, did not specifically state the sections of the A.M.A., *Guides* utilized in drawing his conclusion that appellant has a 20 percent permanent impairment of the left upper extremity, the Board notes that Dr. Moore's grip strength measurements as described in his November 1, 1996 report, when applied to Tables 31, 32 and 34 on pages 64 and 65 of the A.M.A., *Guides*, actually equate to a 20 percent upper extremity impairment for loss of strength. As the Office medical adviser did not discuss the grip strength measurements provided by Dr. Moore, or explain why he did not use these ratings to determine whether appellant has any additional impairment due to loss of strength, the Board will remand the case for further development of the medical evidence.[9] After such development as the Office deems necessary, it

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[2] 5 U.S.C. §§ 8101-8193.

[3] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

[4] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] 5 U.S.C. § 8107(a).

[6] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

[7] *Paul R. Evans, Jr.*, 44 ECAB 646 (1993).

[8] A.M.A., *Guides*, fourth edition, Table 15, page 54.

should issue an appropriate decision. Based on this determination, the issue of whether the Office abused its discretion in denying appellant's request for reconsideration is moot.

The Board notes, that in her July 31, 1998 letter requesting reconsideration of her right wrist claim, appellant also referenced the Office's February 25, 1998 letter advising her that her wrist claim had been doubled with her accepted right thumb claim. She requested that her right thumb condition be evaluated for possible entitlement to a schedule award.

The decisions of the Office of Workers' Compensation Programs dated September 11 and January 7, 1998 is set aside and the case remanded for further action consistent with this decision of the Board.

Dated, Washington, D.C.
June 20, 2000

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

[9] The medical evidence should include a detailed description of the impairment and a rationalized opinion as to the percentage of permanent impairment under the A.M.A., *Guides*. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 1995).