United States Department of Labor
Employees' Compensation Appeals Board

DANIEL J. RASKE, Appellant	)	
and	)	**Docket No. 04-1543**
	)	**Issued: February 11, 2005**
U.S. POSTAL SERVICE, POST OFFICE, North Reading, MA, Employer	)	

Appearances:
Ronald Watson, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On May 25, 2004 appellant filed a timely appeal from the April 15, 2004 merit decision of the Office of Workers' Compensation Programs granting a schedule award for a two percent permanent impairment for loss of use of the left thumb. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision in this case.

ISSUE

The issue is whether appellant has more than a two percent thumb impairment, for which he received a schedule award. Appellant's representative argues that the condition of bilateral medial epicondylitis, which the Office accepted under a different claim number, was not taken into account in determining appellant's schedule award.

FACTUAL HISTORY

On October 13, 1999 appellant, then a 52-year-old letter carrier, filed an occupational claim for carpal tunnel syndrome due to factors of his federal employment. The claim number is

010368598. The Office accepted that appellant sustained a bilateral carpal tunnel condition.[1] Appellant underwent surgery on February 10, 2000 for his left hand. His physician, Dr. Steven W. Margles, a Board-certified hand surgeon, released him to light-duty work on March 24, 2000 and to full-duty work on April 8, 2000.

Appellant filed a claim for a schedule award for permanent impairment to his left wrist on June 22, 2000. He underwent a second opinion evaluation with Dr. Donald Pettit, a Board-certified orthopedic surgeon, on December 26, 2000. The examination revealed that objectively appellant appeared to have fully recovered from the February 10, 2000 left carpel tunnel release as there was no objective evidence of any type of dysfunction. Thus, Dr. Pettit advised that, no impairment rating could be provided.

By decision dated January 24, 2001, the Office denied appellant's request for a schedule award.

On April 8, 2002 appellant filed an occupational claim for stiffness and pain in his fingers and palms, which he attributed to factors of his federal employment. On October 17, 2002 the Office accepted the condition of bilateral medial epicondylitis under claim number 012011766.

On October 21, 2002 appellant requested reconsideration on his schedule award claim. He submitted a July 26, 2002 report from his new physician, Dr. Albert Fullerton, a Board-certified neurologist. Dr. Fullerton noted the results of appellant's examination and opined that he had a mild residual right median neuropathy at the wrist affecting sensory components and a moderate left median neuropathy at the wrist affecting both sensory and motor components. Dr. Fullerton advised that these would reflect a 10 percent right upper extremity impairment and a 20 percent left upper extremity impairment. He further stated that those conditions have a moderate impact on appellant's daily activities as a letter carrier and at home.

In a June 19, 2003 letter, Dr. Fullerton advised that his opinion of July 26, 2002 was based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) and that appellant had reached maximum medical improvement on that date.

On July 28, 2003 the Office referred appellant's case record to its Office medical adviser, Dr. Barry W. Levine. In an August 1, 2003 report, the Office medical adviser noted that appellant had an accepted left carpal tunnel syndrome, which was released on February 10, 2000. The Office medical adviser also noted that Dr. Fullerton's July 26, 2002 examination revealed left upper extremity findings of atrophy of the left opponens muscle with some weakness and a slightly diminished two point discrimination. The Office medical adviser stated that the fifth edition of the A.M.A., *Guides* did not allow for atrophy alone or two point discrimination deficiencies which were not measured. Accordingly, he advised that grip and/or pinch strength

[1] The Office accepted the condition of right wrist strain and bilateral carpel tunnel condition for appellant's original claim, file number 01-0311082, filed on May 17, 1993. Appellant underwent surgery on February 21, 1994 for his right hand and was awarded a 10 percent permanent impairment for his right upper extremity on July 17, 1995.

and two point discrimination had to be measured before an impairment rating could be rendered for the left upper extremity.

On December 9, 2003 Dr. Fullerton advised that appellant reached maximum medical improvement on July 26, 2002. Based on the fifth edition of the A.M.A., *Guides*, he opined that appellant had a 2 percent impairment of the upper extremity due to loss of function from decreased strength and an 18 percent impairment due to loss of function resulting from sensory deficit, pain or discomfort.

In a March 1, 2004 report, the Office medical adviser stated that Dr. Fullerton, in his December 9, 2003 report, failed to furnish the physical examination requirements set forth in the fifth edition of the A.M.A., *Guides,* which included the use of a dynamometer to measure grip strength and the direct measurement of two point discrimination or quantification of any pain which related to sensory deficit and interfered with activity. The Office medical adviser recommended a second opinion evaluation as Dr. Fullerton was not using the A.M.A., *Guides.*

In a March 22, 2004 report, Dr. George W. Ousler, a Board-certified orthopedic surgeon and an Office referral physician, reviewed an October 12, 1999 statement of accepted facts, which noted that the Office had accepted the condition of bilateral carpel tunnel and that appellant had undergone surgery on February 21, 1994 for his right hand and February 10, 2000 for his left hand and set forth his examination findings. He stated that appellant's surgical scar was considered mild. As appellant had a normal sensory examination and normal opposition strength of the left thumb, Dr. Ousler opined that there was no objective basis for an impairment rating for carpel tunnel syndrome under those conditions. As his examination revealed that the left thumb lacked 2.5 centimeters of adduction, he opined that under the fifth edition of the A.M.A., *Guides* appellant had a 2 percent impairment of function of left thumb motion, which equated to a 1 percent impairment to the left hand.

In an April 8, 2004 report, the Office medical adviser noted that Dr. Ousler examined appellant on March 22, 2004 and reported a normal range of motion of the left wrist, normal grip strength and that the thumb lacked 2.5 centimeters of adduction. The date of maximum medical improvement was noted as being March 22, 2004. The Office medical adviser stated that the thumb had a two percent impairment,[2] which equated to a one percent upper extremity impairment.[3]

By decision dated April 15, 2004, the Office awarded appellant a 2 percent permanent loss of use of the left thumb for a period of 1.5 weeks, to run from March 22 to April 1, 2004.

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[2] A.M.A., *Guides*, Table 16-8b, page 459.

[3] *Id.* at Table 16-2, page 439.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulation[5] 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 all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[6]

ANALYSIS

In the instant case, the Office medical adviser applied the A.M.A., *Guides* to the physical findings of Dr. Ousler, the second opinion physician, to determine that appellant was entitled to a two percent schedule award. In his April 8, 2004 report, the Office medical adviser reviewed Dr. Ousler's March 22, 2004 report and noted that appellant's left thumb lacked 2.5 centimeters of adduction, while finding a normal range of motion and normal grip strength of the left wrist. He then stated that a 2.5 centimeter lack of adduction for the thumb was a 2 percent thumb impairment due to abnormal motion.[7] The medical adviser then indicated that the impairment extended into the arm by converting the two percent thumb impairment into one percent arm impairment pursuant to the A.M.A., *Guides*. Although the Office awarded appellant a two percent thumb impairment on April 15, 2004 the Board notes that when an impairment extends into an adjoining area, the schedule award should be made for the larger member.[8] Thus, under the A.M.A., *Guides,* a two percent thumb impairment would equate to a one percent hand impairment, which, in turn, would equate to a one percent upper extremity impairment.[9] In this case, the Office awarded appellant a 2 percent thumb impairment or 1.5 weeks of compensation; however, based on the Office medical adviser's report, he would have been entitled to a 1 percent upper extremity impairment or 3.12 weeks of compensation.[10]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *See* 20 C.F.R. § 10.404; *Jacqueline S. Harris*, 54 ECAB ___ (Docket No. 02-303, issued October 4, 2002).

[7] A.M.A., *Guides, see supra* note 2. The Board notes that impairment values for measured distances falling between those shown in Table 16-8b may be adjusted or interpolated proportionally in the corresponding interval. As a 2 to 3 centimeter measured lack of adduction equates to a 1 to 3 percent thumb impairment due to abnormal motion, the Board finds that the 2.5 centimeter measured lack of adduction would properly correspond to a 2.5 percent thumb impairment due to abnormal motion. *Id.*

[8] *Janet L. Adamson*, 52 ECAB 431, 434 (2001).

[9] A.M.A., *Guides*, Table 16-1, 16-2, pp. 438, 439.

[10] *Compare* 5 U.S.C. § 8107(c)(1), (c)(6).

Moreover, the Board notes that the Office, in referring appellant to Dr. Ousler for a second opinion medical examination, did not include within the statement of accepted facts appellant's current bilateral medial epicondylitis condition which it accepted on October 17, 2002. Office procedures indicate that accepted conditions must be included in a statement of accepted facts and further provides that when an Office medical adviser, second opinion specialist or referee physician "renders a medical opinion based on a statement of accepted facts which is incomplete or inaccurate or does not use the statement of accepted facts as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether."[11] In this case, Dr. Ousler and the Office medical adviser should have based their medical opinions on a complete statement of accepted facts, which should have included the Office's acceptance on October 17, 2002 that appellant's bilateral medial epicondylitis condition was causally related to his employment duties. Since Dr. Ousler rendered his medical opinion based on incomplete factual information, the probative value of his report is limited. Accordingly, the Board finds that the case must be remanded for further medical development as Dr. Ousler's medical opinion and the subsequent opinion of the Office medical adviser are of diminished probative value as it was based on an incomplete statement of accepted facts.[12]

The case, therefore, will be remanded for further development. On remand the Office should combine the files from appellant's accepted bilateral carpal tunnel condition, claim number 010368598 and his accepted bilateral medial epicondylitis condition, claim number 012011766.[13] The Office should then submit the medical record and a statement of accepted facts including appellant's bilateral medial epicondylitis condition to an appropriate medical specialist or to Dr. Ousler for a supplemental report for a determination as to whether he is entitled to an increased schedule award based on his bilateral medial epicondylitis condition. After such development as the Office deems necessary, an appropriate merit decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision to determine whether appellant is entitled to more than a two percent impairment of the thumb, which the Office previously awarded. The opinions on which the Office relied in accessing the schedule award, Dr. Ousler's medical opinion and the subsequent opinion of the Office medical adviser, are of diminished probative value as it was based on an incomplete set of facts.

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[11] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

[12] Once the Office starts to procure medical opinion, it must do a complete job. The Office has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case. *Richard F. Williams,* 55 ECAB ___ (Docket No. 03-1176, issued February 23, 2004).

[13] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *File Maintenance and Management*, Chapter 2.400.8 (February 2000) regarding the Office procedures for doubling case files.

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision.

Issued: February 11, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member