United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	**Docket No. 09-1111**
	)	**Issued: December 15, 2009**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Baltimore, MD, Employer	)	

Appearances:
James D. Muirhead, 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 March 18, 2009 appellant, through her attorney, filed a timely appeal from a November 7, 2008 schedule award decision of the Office of Workers' Compensation Programs and a January 22, 2009 nonmerit decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has more than 10 percent impairment of her right upper extremity; and (2) whether the Office properly refused to reopen her claim for further reconsideration of the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On May 26, 2000 appellant, then a 54-year-old food service worker, filed an occupational disease claim for carpal tunnel syndrome (CTS) that she attributed to factors of her federal

employment. The Office accepted her claim for bilateral carpal tunnel on August 15, 2000.[1] Dr. Errol L. Bennett, an orthopedic surgeon, performed right carpal tunnel release surgery on September 5, 2000.

Appellant requested a schedule award on December 17, 2007. The Office requested medical evidence in support of her claim of permanent impairment. Appellant did not respond.

In a March 6, 2008 decision, the Office denied a schedule award on the grounds that she failed to submit any medical evidence in support of her claim.

Appellant, through her attorney, requested reconsideration on March 21, 2008. In an August 30, 2007 report, Dr. Steven M. Allon, an orthopedic surgeon, provided an impairment rating. He diagnosed cumulative and repetitive trauma disorder; bilateral CTS; bilateral trigger fingers of the index fingers and thumbs; right polyneuropathy and cubital tunnel syndrome. On physical examination Dr. Allon found positive Tinel's and Phalen's signs and carpal compression. He found right wrist dorsiflexion of 25 degrees; flexion of 60 degrees and radial deviation of 18 degrees and ulnar deviation of 25 degrees. Dr. Allon noted hypothenar atrophy bilaterally with nodules on the flexor surface at the trigger of the index fingers bilaterally. He performed grip strength testing, which was 16 kilograms (kg) of force on the right hand and pinch key testing was five kg. Dr. Allon correlated his findings with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He rated loss of range of motion of the right wrist as 7 percent impairment, pinch strength deficit of 20 percent, sensory deficit of 10 percent of the median nerve and 2 percent of the ulnar nerve, or a total 34 percent impairment to the right upper extremity. Dr. Allon advised that appellant reached maximum medical improvement on August 30, 2007.

In a report dated August 3, 1999, Dr. Ira D. Gelb, a Board-certified orthopedic surgeon, noted appellant's history of right upper extremity pain, triggering of her right ring finger and a small tender nodule in the flexor tendon. The electrodiagnostic testing suggested median and ulnar nerve polyneuropathy compatible with her diabetes. Dr. Gelb diagnosed CTS of the right wrist, mild trigger finger right ring finger, diabetic polyneuropathy right upper extremity and mild right lateral epicondylitis.

On March 8, 2000 Dr. Garth A.S. Samuels, a surgeon, diagnosed right thoracic outlet syndrome. He reviewed appellant's February 2, 2000 electrodiagnostic studies and found peripheral diabetic neuropathy, right CTS and right thoracic outlet syndrome.

The district medical adviser reviewed the medical evidence on April 19, 2008 and noted that the accepted conditions included right CTS and bilateral trigger fingers. He found that appellant had 10 percent impairment to the right upper extremity and that she reached maximum medical improvement on August 30, 2007. The district medical adviser found no impairment for loss of motion, pinch strength or of the right ulnar nerve. He recommended that the Office obtain a second opinion evaluation as the rating by Dr. Allon was not reliable.

[1] Appellant has a separate claim regarding her left upper extremity.

On April 23, 2008 the Office granted appellant a schedule award for 10 percent impairment of her right upper extremity.

Appellant requested an oral hearing which was held on August 21, 2008. Following the oral hearing, she submitted a September 12, 2008 report from Dr. Allon who stated that he used three measurements in assessing pinch strength loss. Dr. Allon advised that constricted tenosynovitis of the right index and middle fingers resulted in an additional eight percent impairment of the right upper extremity.

By decision dated November 7, 2008, the Office hearing representative affirmed the April 23, 2008 schedule award. The hearing representative found that the impairment rating of the Office medical adviser was the weight of the medical evidence as Dr. Allon failed to provide the findings on pinch strength measurement or other physical findings supporting finger triggering.

Appellant, through her attorney, requested reconsideration on December 15, 2008 and contended that an Office medical adviser should have reviewed Dr. Allon's most recent report.

In a January 22, 2009 decision, the Office requested further reconsideration of the merits on appellant's claim.

On appeal, counsel contends that the Office failed to properly consider Dr. Allon's September 12, 2008 report.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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 regulations as the appropriate standard for evaluating schedule losses.[4] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[5]

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *Id.*

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

Grip strength is used to evaluate power weaknesses related to the structures in the hand wrist or forearm.[6] The A.M.A., *Guides* do not encourage the use of grip strength as an impairment rating because strength measurements are functional tests influenced by subjective factors that are difficult to control and the A.M.A., *Guides* is primarily based on anatomic impairment. The A.M.A., *Guides* do not assign a large role to such measurements. Only in rare cases should grip strength be used and only when it represents an impairing factor that has not been otherwise considered adequately.[7] The A.M.A., *Guides* state, "*Otherwise, the impairment ratings based on objective anatomic findings take precedence.*"[8] (Emphasis in the original.) The A.M.A., *Guides* provide that it is improper to combine impairments for decreased strength when there is decreased range of motion.[9]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for right CTS and bilateral trigger fingers. In evaluating CTS, the A.M.A., *Guides* provide that, if after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias or difficulties in performing certain activities three possible scenarios can be present. The first situation is: "Positive clinical finding of median nerve dysfunction and electrical conduction delay(s): The impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier."[10] In this situation, the impairment due to residual CTS is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity impairment value resulting from sensory or motor deficits of each nerve structure involved. When both sensory and motor functions are involved the impairment values derived for each are combined.[11] In the second scenario: "Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyogram testing of the thenar muscles: a residual CTS is still present and an impairment rating not to exceed [five] percent of the upper extremity may be justified." In the final situation: "Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating."[12]

[6] A.M.A., *Guides* 508, 16.8b.

[7] *Id.* at 507, 16.8 Strength Evaluation; *Cerita J. Slusher*, 56 ECAB 532 (2005); *Mary L. Henninger*, 52 ECAB 408, 409 (2001).

[8] *Id.* at 508.

[9] *Id.* at 526, Table 17.2; *Slusher*, *supra* note 7; *Patricia J. Horney*, 56 ECAB 256 (2005).

[10] *Id.* at 495.

[11] *Id.* at 494, 481.

[12] *Id.* at 495.

To accurately evaluate sensory impairment clinically and reduce the subjective nature of these findings,[13] the A.M.A., *Guides* recommend either the two-point test for fine discrimination, the monofilament touch-pressure threshold test or the pinprick test.[14]

There is no evidence in the record that appellant has undergone additional diagnostic testing following her right carpal tunnel release. The case is not in posture for a decision regarding appellant's right upper extremity due to the accepted condition of right CTS. In his 2007 report, Dr. Allon did not adequately provide findings supporting her bilateral trigger fingers. Before the A.M.A., *Guides* can be properly utilized, an examining physician must provide a description of appellant's impairment in order that the Office and subsequent reviewers of the record can visualize the nature and extent of impairment.[15] In obtaining medical evidence required for a schedule award, the evaluation should include the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other applicable descriptions of the impairment upon which a rating is made. The present medical evidence does not provide sufficient description of the nature or extent of appellant's permanent impairment to her right arm. The district medical adviser stated that he agreed with an impairment rating for sensory loss for right median nerve dysfunction as postsurgical sensory residuals commonly remained. He rated impairment of the median nerve below the forearm, noting that the maximum sensory loss at Table 16-15 was 39 percent to the upper extremity. The district medical adviser allowed a Grade 4 sensory deficit under Table 16-10, which corresponds to a 25 percent deficit. Multiplying the grade by the maximum allowed totaled 9.75 percent which was rounded to 10 percent. To this extent, he incorporated the rating of Dr. Allon; however, he did not address whether the range of motion findings resulted in permanent impairment or explain why sensory deficit of the right ulnar nerve should be excluded. Dr. Allon stated that the loss of range of motion to the right wrist totaled seven percent based on loss of dorsiflexion and ulnar deviation. His report September 12, 2008 does not cure the deficiencies noted in his prior impairment rating.

On remand, the Office should refer appellant to a physician for testing to establish the extent of permanent impairment of her right upper extremity due to the accepted conditions. After such development as it deems necessary, it should issue an appropriate decision of her claim for a schedule award.

CONCLUSION

The Board finds that the case is not in posture for a decision.[16]

[13] *Id.* at 446.

[14] *Id.* at 445.

[15] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[16] Due to the resolution of the initial issue, it is not necessary for the Board to address the nonmerit issue in this appeal.

ORDER

IT IS HEREBY ORDERED THAT January 22, 2009 and November 7, 2008 and decisions of the Office of Workers' Compensation Programs are set aside and remanded for further development consistent with this decision of the Board.

Issued: December 15, 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