United States Department of Labor
Employees' Compensation Appeals Board

BARBARA J. PATRICK, Appellant	)	
and	)	**Docket No. 04-1164**
	)	**Issued: November 24, 2004**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Fayetteville, AR , Employer	)	

Appearances:
Barbara J. Patrick, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On March 29, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated January 29, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained more than a two percent permanent impairment of her left upper extremity, for which she received a schedule award.

FACTUAL HISTORY

On March 7, 2000 appellant, then a 59-year-old laundry worker, filed a traumatic injury claim alleging that she sustained a crush injury to her left hand while in the performance of duty. Appellant stopped and returned to work on the same day. The Office accepted appellant's claim

for a contusion to the left hand and fingers, bilateral carpal tunnel syndrome and right and left carpal tunnel release. Appellant received appropriate compensation benefits.

Appellant subsequently filed a claim for a schedule award.

By letter dated June 17, 2002, the Office requested that appellant's physician provide an impairment rating pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001).

In a July 13, 2002 report, Dr. James F. Moore, a Board-certified orthopedic surgeon advised that appellant had a 15 percent impairment of the left little finger according to the A.M.A., *Guides* (4th ed. 1995). He also advised that no further medical treatment was needed.

By letter dated August 26, 2003, the Office referred appellant, together with a statement of accepted facts and copies of medical records, to Dr. William S. Piechal, Board-certified in physical medicine and rehabilitation, for a second opinion examination.

In a report dated October 10, 2003, Dr. Piechal indicated that, according to Table 16-6 at page 448 of the fifth edition of the A.M.A., *Guides,* appellant had a 15 percent impairment to the fifth finger, which translated to a 2 percent impairment to the left hand.[1] He also noted that appellant had a 10 percent loss of left hand grip strength compared to the right, resulting in a 10 percent impairment of the left nondominant hand pursuant to Table 16-34 at page 509.[2] The physician concluded that appellant had a 12 percent total impairment to the left hand. Dr. Piechal advised that appellant did not have an impairment of her right hand.

In a memorandum dated October 30, 2003, the Office medical adviser noted that Dr. Piechal's report could not be used because he did not provide the date of maximum medical improvement and did not provide sufficient physical findings.

By letter dated November 4, 2003, the Office referred appellant, together with a statement of accepted facts and copies of medical records, to Dr. Ted Honghiran, a Board-certified orthopedic surgeon, for a second opinion examination.

In a December 10, 2003 report, Dr. Honghiran advised that appellant had recovered from her injury and that she had a full range of motion in the fingers of her right and left hand, with full grip and full range of motion of the right and left wrist. He indicated that the incision scars were well healed, hardly noticeable and nontender. The physician also advised that appellant had weakness of the grip of her left hand as compared to the right, but added that they were only subjective findings. Dr. Honghiran also noted definite evidence of sensory loss of the left little finger as half of the finger was numb up to the ulnar border of the left hand. He advised that, pursuant to Table 16-6 at page 448 of the A.M.A., *Guides,* appellant had a 15 percent impairment to the left little finger due to numbness.[3] The physician advised that, as appellant

[1] A.M.A., *Guides* (5th ed. 2001).

[2] A.M.A., *Guides* 509, Table 16-34.

[3] Dr. Honghiran referred to Table 15-6; however, this appears to be a typographical error.

had residual weakness of her left hand as a result of the carpal tunnel syndrome, he would rate her impairment as five percent of her left hand. Dr. Honghiran advised that appellant had no permanent impairment on the right.

In a January 21, 2004 report, the Office medical adviser applied the findings of Dr. Honghiran to the fifth edition of the A.M.A., *Guides* and determined that appellant was entitled to a two percent impairment of her left upper extremity. In his report, the Office medical adviser referred to Table 16-6, page 448 of the A.M.A., *Guides* and indicated that, regarding the left upper extremity, appellant had a 15 percent impairment to the left little finger. He referred to Table 16-1, page 438 of the A.M.A., *Guides* and noted that 15 percent of the little finger would be 2 percent of the hand and advised that this would convert to 2 percent of the left upper extremity pursuant to Table 16-2 at page 439 of the A.M.A., *Guides.* Regarding appellant's carpal tunnel syndrome, he concluded that appellant was not entitled to any rating as there was no provision in the A.M.A., *Guides* for a rating based on subjective weakness. Furthermore, he noted that October 2, 2003 was the date of maximum medical improvement.

Accordingly, on January 29, 2004 the Office granted appellant a schedule award for a two percent impairment of the left upper extremity. The award covered a period of 6.24 weeks from October 2 to November 14, 2003.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[4] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[5] The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[6] The Act's implementing regulation has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.[7]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[8] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

[4] 5 U.S.C. §§ 8101-8193.

[5] 5 U.S.C. § 8107.

[6] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[7] 20 C.F.R. § 10.404.

[8] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

ANALYSIS

In this case, the Board notes that Dr. Moore used the fourth edition of the A.M.A., *Guides* in making his assessment. The fifth edition of the A.M.A., *Guides* was required for schedule award evaluations effective February 1, 2001.[9] The Board has held that a medical opinion not based on the appropriate edition of the A.M.A., *Guides* has diminished probative value in determining the extent of a claimant's permanent impairment.[10] Consequently, his report is of limited probative value.

The Office referred appellant for a second opinion evaluation with Dr. Piechal, Board-certified in physical medicine and rehabilitation; however, the Office medical adviser indicated that his report could not be used because he did not provide sufficient physical findings, or a date of maximum medical improvement. Although Dr. Piechal's finding that appellant had a 15 percent impairment of the fifth finger according to page 448 and Table 16-6 of the A.M.A., *Guides* is consistent with Dr. Honghiran's subsequent finding, Dr. Piechal's determination that appellant had 10 percent impairment for the left hand due to loss of grip strength pursuant to Table 16-34 at page 509 of the A.M.A., *Guides* is not explained. For example, the doctor did not note how the grip strength testing was performed and how his results were calculated.[11] Thus, the Office properly referred appellant for another second opinion examination from Dr. Honghiran, a Board-certified orthopedic surgeon.

Dr. Honghiran indicated that appellant had full range of motion, and grip on the right and left hands, although there were subjective signs of weakness in the left hand. He referred to page 448 of the A.M.A., *Guides* and concluded that appellant had a 15 percent impairment of the left little finger due to numbness. In addition, he advised that appellant would be entitled to an additional impairment of five percent for her carpal tunnel syndrome. However, regarding the carpal tunnel syndrome, he did not provide any objective findings to support such a rating. For example, the fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides that, if after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present: (1) positive clinical findings of median nerve dysfunction and electrical conduction delay(s), the impairment due to residual carpal tunnel syndrome is rated according to the sensory and/or motor deficits; (2) normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal electromyogram testing of the thenar muscles, a residual carpal tunnel syndrome is still present and an impairment rating not to exceed five percent of the upper extremity may be justified; and (3) normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve

[9] FECA Bulletin No. 01-05 (issued January 29, 2001).

[10] *Carolyn E. Sellers*, 50 ECAB 393, 394 (1999).

[11] Furthermore, the A.M.A., *Guides* state that the loss of strength should be rated separately only if it is based on an unrelated cause or mechanism. Otherwise, the impairment ratings based on objective anatomic findings take precedence. A.M.A., *Guides*, p. 508 (5th ed. 2001).

conduction studies, in which case there is no objective basis for an impairment rating.[12] In this case, he did not sufficiently explain the objective findings that would entitle appellant to the five percent for her carpal tunnel syndrome. He indicated that he based his carpal tunnel rating on subjective residual weakness. He did not discuss any other findings that supported his opinion regarding this. Regarding the right upper extremity, no impairment rating was given as he indicated that appellant had no impairment.

The Office medical adviser subsequently reviewed this report and agreed that appellant's sensory loss in the left little finger, under Table 16-6, equated to a partial sensory loss of the ulnar digit which was equivalent to a 15 percent impairment of the ulnar digit. The Office medical adviser referred to Table 16-1 at page 438 of the A.M.A., *Guides*, for the corresponding hand impairment values and noted that this would translate to two percent impairment of the left hand. The Office medical adviser subsequently referred to Table 16-2 at page 439 of the A.M.A., *Guides* and concluded that two percent of the hand would translate to a two percent impairment of the upper extremity. As noted above, regarding her carpal tunnel syndrome, appellant was not entitled to an impairment rating as there were insufficient objective findings.[13] The Board finds that the Office medical adviser properly concluded that appellant was entitled to a two percent impairment of the left upper extremity. Regarding the right upper extremity, as noted previously, he noted that appellant full range of motion and grip and did not have any impairment. The Board finds that there is no medical evidence in the record following the date of maximum medical improvement suggesting that appellant had more than a two percent impairment of the left upper extremity for which she received a schedule award.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained more than a two percent permanent impairment of her left upper extremity, for which she received a schedule award.

[12] *Silvester DeLuca*, 53 ECAB ___ (Docket No. 01-1904, issued April 12, 2002); A.M.A., *Guides*, p. 495 (5th ed. 2001).

[13] *Id.*; *see also* A.M.A., *Guides* at 493 (for entrapment/compression neuropathies, only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating; the diagnosis is made not only on believable symptoms but, more important, on the presence of positive clinical findings and loss of function).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 29, 2004 is affirmed.

Issued: November 24, 2004
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member