

FACTUAL HISTORY

On April 3, 1997 appellant, then a 49-year-old rigger, sustained an injury in the performance of duty when he tripped on a pipe and fell on his right upper extremity. The Office accepted his claim for right elbow fracture (radial neck fracture).²

On February 6, 1998 appellant sustained another injury in the performance of duty while picking up slings and putting them on a crane hook. The Office accepted his claim for right shoulder cuff sprain and authorized surgery. Appellant underwent an arthroscopic partial bursectomy and anterior acromioplasty of the right shoulder. He later underwent an arthroscopic debridement, arthroscopic biceps tenotomy, and open biceps tenodesis of the right shoulder.³

On March 12, 2002 Dr. David E. Lannik, appellant's orthopedic surgeon, reported that appellant had a 6 percent impairment due to occult shoulder instability, a 10 percent impairment due to loss of strength associated with biceps rupture and tenodesis procedure, and a 20 percent impairment due to strength deficit in elbow flexion and extension. The Office medical adviser reviewed these findings. On September 24, 2002 the Office issued a schedule award for a 36 percent impairment of the right upper extremity.

On May 19, 2006 Dr. Lannik rated the permanent impairment of appellant's right upper extremity at 38 percent. He based this rating on an April 26, 2006 functional capacity evaluation. Dr. Lannik found a 29 percent impairment due to decreased motion, a 5 percent impairment due to a Grade 2 decrease in tactile sensibility and a 4 percent impairment due to decreased grip strength.

An Office medical adviser reviewed the range of motion measurements in the functional capacity evaluation and determined that appellant had a 3 percent impairment of the right upper extremity due to loss of motion at the elbow and a 14 percent impairment due to loss of motion at the shoulder, for a total impairment of 17 percent. He disallowed decreased grip strength because the injury was to the shoulder and the elbow, which "in no way whatsoever" affected or related to an individual's grip strength. The medical adviser also disallowed any rating for weakness because there were no findings on manual muscle testing.

In a decision dated September 26, 2006, the Office denied an additional schedule award. The Office found that the medical evidence did not establish that appellant had more than a 36 percent impairment of his right upper extremity, for which he previously received an award.

On November 3, 2006 Dr. Lannik explained that grip strength should be included:

"Grip strength is affected by the fact that he has ulnar neuropathy causing weakness of grasp secondary to cubital tunnel syndrome which is secondary to his elbow injury. Therefore in my opinion, the impairment relative to the weakness of grip strength is in fact directly correlated to this elbow injury in that there is

² OWCP File No. 250504477.

³ OWCP File No. 250520103.

ulnar nerve impairment clinically and by nerve testing previously. This certainly explains his weakness of grasp and its relationship to his elbow injury. Therefore my [orthopedic] opinion is unchanged from that noted on May 19, 2006.”

The Office medical adviser reported that, if the 4 percent rating for decreased grip strength were combined with the previously calculated impairment of 17 percent for decreased motion, the total impairment of the right upper extremity would still not exceed the 36 percent impairment previously awarded.

On February 12, 2007 the Office reviewed the merits of appellant’s case and denied modification of its prior decision.

On March 2, 2007 appellant requested reconsideration. He submitted a copy of Dr. Lannik’s March 12, 2002 evaluation.

In a decision dated March 19, 2007, the Office denied a merit review of appellant’s case. The Office found that his request neither raised substantive legal questions nor included new and relevant evidence.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees’ Compensation Act⁴ authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.⁵

ANALYSIS -- ISSUE 1

To support his claim for an additional schedule award, appellant submitted a May 19, 2006 report from Dr. Lannik, his orthopedic surgeon, who rated three impairments: a 29 percent impairment due to decreased motion, a 5 percent impairment due to decreased tactile sensibility and a four percent impairment due to decreased grip strength. But appellant may not receive a schedule award for all three.

To avoid duplication, the A.M.A., *Guides* disallows the combination of certain impairments.⁶ Decreased strength, for one, cannot be rated in the presence of decreased motion.⁷ Dr. Lannik’s finding that appellant has a 29 percent impairment due to decreased motion necessarily precludes any additional rating for decreased grip strength.

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404. Effective February 1, 2001 the Office began using the A.M.A., *Guides* (5th ed. 2001).

⁶ A.M.A., *Guides* 499.

⁷ *Id.* at 508 (emphasis deleted).

There is another reason appellant may not receive an additional rating for decreased grip strength. Dr. Lannik explained in his November 3, 2006 report that appellant had an ulnar neuropathy or cubital tunnel syndrome secondary to his elbow injury. The A.M.A., *Guides* addresses the situation directly: “In compression neuropathies, additional impairment values are not given for decreased grip strength.”⁸

The Office, therefore, may not consider impairment due to decreased grip strength. This leaves appellant with two impairment ratings from Dr. Lannik’s May 19, 2006 report: a 29 percent rating for decreased motion and a 5 percent rating for decreased tactile sensibility. Dr. Lannik did not explain how he arrived at that latter. The A.M.A., *Guides* sets forth a procedure and grading scheme for determining impairment of the upper extremity due to sensory deficits or pain resulting from peripheral nerve disorders.⁹ Dr. Lannik noted an ulnar neuropathy in his November 3, 2006 report, but he did not report what value he used from Table 16-15, page 492 of the A.M.A., *Guides*, and he did not state what percentage deficit he selected from Table 16-10, page 482. Further, he did not justify a Grade 2 classification of appellant’s sensory deficit. Appellant’s sensory function, as reflected in the April 26, 2006 functional capacity evaluation, appears more consistent with a Grade 4 classification, which is less severe.¹⁰

Dr. Lannik’s May 19, 2006 report is not sufficient to establish a five percent impairment due to decreased tactile sensibility. All that remains, then, is the 29 percent impairment for decreased motion. The Office medical adviser reviewed the range of motion measurements in the functional capacity evaluation and determined that appellant had no more than a 17 percent impairment under the A.M.A., *Guides*. The Board need not perform that exercise because even a rating of 29 percent for decrease motion will not entitle appellant to additional compensation.

As noted earlier, decreased strength cannot be rated in the presence of decreased motion. Appellant’s decreased motion not only precludes an additional impairment for decreased grip strength, it precludes his previous ratings for loss of strength associated with biceps rupture and tenodesis procedure and for strength deficit in elbow flexion and extension. The A.M.A., *Guides*

⁸ *Id.* at 494.

⁹ *Id.* at 482 (Table 16-10).

¹⁰ Individuals in Grade 4 have diminished light touch, with fair (6 to 10 millimeters) to good two-point discrimination, localization of sensory stimuli, and good protective sensibility. Sensory deficit or pain does not interfere with or prevent activity (for example, appellant’s driving). Individuals in Grade 2, on the other hand, have decreased protective sensibility, which is defined as a conscious appreciation of pain, temperature or pressure before tissue damage results from the stimulus. They have diminished hand function. The mislocalization and overresponse (hyperesthesia or paresthesias, hyperpathia, or allodynia) to sensory stimuli result in decreased manipulative skills and gripping function and complaints of hand weakness. It is possible to have a gross appreciation of two-point discrimination (11 to 15 millimeters) at this level. *Id.* at 483. Abnormal sensations or moderate pain may prevent some activities. *Id.* at 482 (Table 16-10).

does allow decreased motion to be combined with the previous rating for shoulder instability,¹¹ but combining a 6 percent impairment for shoulder instability with even a 29 percent impairment for decreased motion yields a total impairment of only 33 percent.¹² So assuming, only for the sake of argument, that Dr. Lannik properly determined the impairment for decreased motion, the medical evidence does not support that appellant has more than a 36 percent impairment of his right upper extremity. The Board will affirm the Office's September 26, 2006 and February 12, 2007 decisions denying an additional schedule award.

LEGAL PRECEDENT -- ISSUE 2

The Federal Employees' Compensation Act provides that the Office may review an award for or against payment of compensation at any time on its own motion or upon application.¹³ The employee shall exercise this right through a request to the district Office. The request, along with the supporting statements and evidence, is called the "application for reconsideration."¹⁴

An employee (or representative) seeking reconsideration should send the application for reconsideration to the address as instructed by the Office in the final decision. The application for reconsideration, including all supporting documents, must be in writing and must set forth arguments and contain evidence that either: (1) shows that the Office erroneously applied or interpreted a specific point of law; (2) advances a relevant legal argument not previously considered by the Office; or (3) constitutes relevant and pertinent new evidence not previously considered by the Office.¹⁵

An application for reconsideration must be sent within one year of the date of the Office decision for which review is sought.¹⁶ A timely request for reconsideration may be granted if the Office determines that the employee has presented evidence or argument that meets at least one of these standards. If reconsideration is granted, the case is reopened and the case is reviewed on its merits. Where the request is timely but fails to meet at least one of these standards, the Office

¹¹ "Shoulder instability patterns are based on the parameters listed in Table 16-26 and can be classified as occult instability, instability with a subluxating humeral head, and instability with a dislocating humeral head. The shoulder representing 60 percent of the upper extremity (Table 16-18), the patterns of occult (10 percent), subluxating (20 percent), and dislocating (40 percent) instabilities represent upper extremity impairments of 6 percent, 12 percent, and 24 percent, respectively. *This value may be combined only with impairments due to decreased motion (Section 16.4). Pain and decreased muscle strength are not rated separately.*" *Id.* at 504 (emphasis in the original).

¹² *Id.* at 604 (Combined Values Chart).

¹³ 5 U.S.C. § 8128(a).

¹⁴ 20 C.F.R. § 10.605 (1999).

¹⁵ *Id.* § 10.606.

¹⁶ *Id.* § 10.607(a).

will deny the application for reconsideration without reopening the case for a review on the merits.¹⁷

ANALYSIS -- ISSUE 2

Appellant filed his March 2, 2007 request for reconsideration within one year of the Office's most recent merit decision on February 12, 2007. The request is therefore timely. But it does not show that the Office erroneously applied or interpreted a specific point of law. Neither does it advance a relevant legal argument not previously considered by the Office. To support his request, appellant submitted a copy of Dr. Lannik's March 12, 2002 evaluation. This is the same evaluation appellant submitted previously, the same evaluation the Office previously considered when it issued its September 24, 2002 schedule award. The evidence, therefore, does not constitute relevant and pertinent new evidence not previously considered by the Office.

Appellant's March 2, 2007 request for reconsideration does not meet at least one of the three standards for obtaining a merit review of his case. The Board will therefore affirm the Office's March 19, 2007 decision denying that request.

CONCLUSION

The Board finds that the medical evidence is insufficient to establish that appellant has more than a 36 percent impairment of his right upper extremity. The Board also finds that the Office properly denied appellant's March 2, 2007 request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the March 19 and February 12, 2007 and September 26, 2006 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 7, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

¹⁷ *Id.* § 10.608.