

**United States Department of Labor
Employees' Compensation Appeals Board**

K.C., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Burlington, NJ, Employer**

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**Docket No. 08-523
Issued: November 18, 2008**

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 11, 2007 appellant filed a timely appeal from June 5, 2007 schedule award decisions of the Office of Workers' Compensation Programs and August 29, 2007 decisions that denied her requests for reconsideration. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over this case.

ISSUES

The issues are: (1) whether appellant has more than a 37 percent impairment of the left upper extremity and no impairment of the right upper extremity; (2) whether the Office used a proper pay rate in determining appellant's schedule award compensation; and, (3) whether the Office properly refused to reopen her claims for further review of the merits under 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On February 22, 1989 appellant, then a 22-year-old letter carrier, sustained an employment-related right index finger injury. The claim was adjudicated by the Office under

file number xxxxxx936. The Office accepted right carpal tunnel syndrome and, on April 9, 1991, she underwent right median nerve decompression and right index finger surgery. Appellant stopped work that day and returned to limited duty on July 15, 1991. Her pay rate was \$14.67 per hour or \$517.92 per week.

On March 2, 1996 appellant filed a Form CA-1, traumatic injury claim, alleging that she fell while delivering mail and hurt her left hand, wrist, arm and shoulder. She returned to work on March 4, 1996. This claim was adjudicated under file number xxxxxx876 and accepted for lumbosacral strain, left wrist sprain and neck sprain.

On December 23, 1997 under file number xxxxxx809, the Office accepted that appellant sustained an employment-related left shoulder brachial plexopathy. Appellant's pay rate at that time was \$701.14 a week. She missed intermittent periods thereafter, and on October 17, 1998 sustained a recurrence of disability. Appellant was placed on the periodic rolls effective March 20, 1999 at a pay rate of \$727.20. She underwent left shoulder surgery on April 27, 1999, and left wrist surgery on September 4, 2001. Appellant returned to modified duty in 2003.

On January 25, 2005 appellant filed a schedule award claim. In an October 28, 2004 report, Dr. Nicholas Diamond, an osteopath, noted the histories of injury and that appellant was working permanent light duty. Dr. Diamond reported appellant's complaints of weakness of the right wrist and constant left shoulder pain and that she had difficulties with activities of daily living. He provided findings on physical examination including normal range of motion of the right hand and wrist and bilateral decreased sensation to pinprick and light touch, which was at the C8 level on the left. Dr. Diamond diagnosed carpal tunnel syndrome; right index finger stenosing tenosynovitis; status post carpal tunnel release; status post release of A1 metacarpal pulley of the right index finger; left thoracic outlet syndrome; status post left total anterior scalenectomy; post-traumatic left wrist ligament partial tear, ulnar ligament partial tear, synovitis chondromalacia; status post left wrist arthroscopy. He advised that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),¹ appellant had a 55 percent impairment of the left upper extremity and a 31 percent impairment of the right arm.

In a March 15, 2005 report, an Office medical adviser reviewed Dr. Diamond's report and found that maximum medical improvement (MMI) was reached on October 28, 2004. He concluded that, under the A.M.A., *Guides*, appellant had a 23 percent left upper extremity impairment and no right upper extremity impairment. Office file numbers xxxxxx936, 020710876 and 020733809 were combined, with the former becoming the master file.

The Office determined that a conflict in medical evidence arose between the opinions of Dr. Diamond and the Office medical adviser. On December 1, 2005 it referred appellant to Dr. David A. Bundens, a Board-certified orthopedic surgeon, for an impartial evaluation. By report dated December 29, 2005, Dr. Bundens noted the history of appellant's injuries and his review of the medical record. He provided findings on physical examination and advised that, in accordance with the fifth edition of the A.M.A., *Guides*, appellant had a 69.8 percent left upper extremity impairment.

¹ A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

In a February 8, 2006 report, a second Office medical adviser reviewed the medical record including Dr. Bundens' report. He agreed that the date of MMI was October 28, 2004, and that appellant had no right upper extremity impairment. The Office medical adviser found Dr. Bundens' report insufficient and agreed with the first Office medical adviser that appellant had a 23 percent right (sic) upper extremity impairment.

On April 10, 2006 appellant was granted a schedule award for a 23 percent right upper extremity impairment, for a total of 71.76 weeks, to run from October 28, 2004 to March 14, 2006, at the augmented compensation rate of \$387.99, based on her April 9, 1991 pay rate of \$517.32.

By letter dated April 9, 2006, appellant's attorney requested a schedule award for the left upper extremity and on April 18, 2006 requested a hearing. By decision dated July 17, 2006, an Office hearing representative found that it was unclear if Dr. Bundens followed the A.M.A., *Guides* and that the schedule award should have been issued for appellant's left upper extremity, not the right. He remanded the case to the Office to prepare a new statement of accepted facts that identified all accepted injuries to be referred to an Office medical adviser who should be asked to comment on Dr. Bundens' method of calculating appellant's left upper extremity impairment. Regarding appellant's right upper extremity, he found Dr. Diamond's report insufficient and found that on remand appellant should be referred for a second opinion evaluation regarding the degree of her right upper extremity impairment.

On February 8, 2007 an Office medical adviser noted his review of medical records regarding appellant's upper extremity impairments and advised that she had a 37 percent left upper extremity impairment.

The Office referred appellant to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for a second opinion evaluation to provide an impairment rating for appellant's right upper extremity. By report dated March 8, 2007,² Dr. Stark noted findings on physical examination of the right upper extremity. He concluded that appellant had reached maximum medical improvement and had no right upper extremity impairment, noting that she had no residual findings except for a scar from right index finger surgery and right carpal tunnel syndrome repair.

In an April 3, 2007 report,³ the Office medical adviser again concluded that appellant had a 37 percent left upper extremity impairment.

On June 5, 2007 appellant was granted a schedule award for an additional 14 percent left upper extremity impairment, for 46.80 weeks of compensation, to run from March 15, 2006 to January 14, 2007, at an augmented compensation rate of \$387.99, based on the April 9, 1991 pay

² Dr. Stark initially stated that he rated appellant's impairment in accordance with the first edition of the A.M.A., *Guides*. On April 30, 2007 he corrected page 3 of his report to indicate that he rated appellant's impairment in accordance with the fifth edition of the A.M.A., *Guides*.

³ Although the signatures are illegible, it appears that this Office medical adviser is the physician who provided the February 8, 2006 and February 8, 2007 reviews.

rate. In a separate June 5, 2007 decision, the Office determined that appellant was not entitled to a schedule award for her right upper extremity.

On August 10, 2007 appellant, through her attorney, requested reconsideration of the June 5, 2007 decisions. The attorney stated that he had not been sent copies of the June 7, 2007 decisions and had thus been precluded from timely requesting a hearing, and argued that a conflict existed between the reports of Dr. Diamond and Dr. Stark regarding appellant's right upper extremity and that a conflict remained regarding appellant's left upper extremity. He further argued that a recurrent pay rate should have been used in calculating appellant's schedule award.

In two decisions dated August 29, 2007, the Office addressed each June 5, 2007 decision separately and denied appellant's reconsideration requests.

LEGAL PRECEDENT -- ISSUE 1

Under section 8107 of the Federal Employees' Compensation Act⁴ and section 10.404 of the implementing federal regulation,⁵ schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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 Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.⁶

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*. 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.⁷ Chapter 16 provides the framework for assessing upper extremity impairments.⁸ Section 16.5b of the A.M.A., *Guides* describes the methods for evaluating upper extremity impairments due to peripheral nerve disorders and provides that the severity of the sensory or pain deficit and motor deficit should be classified according to Tables 16-10a and 16-11a respectively. The impairment is evaluated by multiplying the grade of severity of the sensory or motor deficit by the respective maximum upper extremity value resulting from

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ See *Joseph Lawrence, Jr.*, *supra* note 2; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

⁷ *Robert V. Disalvatore*, 54 ECAB 351 (2003).

⁸ A.M.A., *Guides*, *supra* note 2 at 433-521.

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.⁹

Chapter 16 of the fifth edition of the A.M.A., *Guides* provides the framework for assessing upper extremity impairments.¹⁰ Section 16.4 provides that in evaluating abnormal motion both active and passive motion measurements are necessary to evaluate the joint motion under the appropriate charts, and these should be added to obtain the total motion impairment.¹¹ Section 16.8a of the A.M.A., *Guides* provides that, in a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods, the loss of strength may be rated separately. An example of such situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.¹²

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.¹³

ANALYSIS -- ISSUE 1

The Board initially finds that the August 29, 2007 decision addressing appellant's right upper extremity is a decision on the merits of appellant's schedule award claim as the Office both addressed appellant's arguments and weighed the medical evidence. The Office therefore conducted merit review.

The Board finds that appellant has no right upper extremity impairment that would entitle her to a schedule award. In an October 28, 2004 report, Dr. Diamond advised that, in accordance with the A.M.A., *Guides*, under Table 16-10, appellant had a sensory deficit of the median nerve of 31 percent on the right. An Office medical adviser reviewed Dr. Diamond's report and found that appellant had no right upper extremity impairment. While Dr. Diamond advised that appellant had diminished sensation to pinprick and light touch, he did not follow the procedures outlined in Table 16-10 of the A.M.A., *Guides*.¹⁴ In his March 8, 2007 report, Dr. Stark advised that examination of the right shoulder, elbow and wrist revealed no tenderness or atrophy, that range of motion was normal, and impingement, apprehension, Phalen's and Tinel's tests were negative. A well-healed scar was present on the volar aspect of the right wrist. Dr. Stark concluded that appellant had reached maximum medical improvement and had no right upper

⁹ *Id.* at 481; *Kimberly M. Held*, 56 ECAB 670 (2005).

¹⁰ *Id.* at 433-521.

¹¹ *Id.* at 451-52.

¹² *Id.* at 508.

¹³ 5 U.S.C. § 8123(a).

¹⁴ A.M.A., *Guides*, *supra* note 2 at 482.

extremity impairment, noting that she had no residual findings except for scars from surgery for the right index finger injury and right carpal tunnel syndrome repair. Because Dr. Diamond's report does not comport with the A.M.A., *Guides*,¹⁵ the Board finds that the weight of the medical evidence regarding appellant's right upper extremity rests with the opinion of Dr. Stark who provided a well-reasoned report in which he concluded that appellant had no permanent impairment of her right upper extremity.¹⁶

The Board finds this case is not in posture for decision regarding appellant's left upper extremity impairment. The Office found that a conflict in medical evidence had been created between the opinions of Dr. Diamond and the Office medical adviser and referred appellant to Dr. Bundens for an impairment evaluation. The Board finds that a conflict remains.

In a December 29, 2005 report, Dr. Bundens advised that appellant had permanent symptoms of thoracic outlet syndrome, left wrist instability, traumatic arthritis, and persistent dysesthesias in the left arm which she was unable to use normally due to weakness and loss of motion. He advised that grip strength testing performed three times with the Jamar dynamometer demonstrated a 55.7 percent loss of strength on the left, and that, under Figures 16-28 and 16-31, she had left wrist flexion of 40 degrees for a 3 percent loss, and extension of 38 degrees for a 4 percent loss with normal radial deviation of 20 degrees and ulnar deviation of 35 degrees, for a 7 percent wrist impairment.¹⁷ Regarding the left shoulder, Dr. Bundens advised that, under Figure 16-40, flexion of 150 degrees equaled a 2 percent impairment, and extension of 25 degrees equaled a 1.5 percent impairment, that, under Figure 16-43, abduction of 85 degrees equaled a 4.5 percent impairment and adduction of 15 degrees equaled a 1 percent impairment, that, under Figure 16-46, 38 degrees of external rotation equaled a 1 percent impairment, with normal internal of 85 degrees, for a total 10 percent left shoulder impairment.¹⁸ He also advised that appellant had a Grade 3 brachial plexus. Dr. Bundens stated that he had "no real firm guidelines" on how to calculate the impairment but gave half for pain and sensation and half for strength, or impairments of 25 percent and 27.8 percent respectively, for 52.8 percent shoulder impairment. He then added all impairments for a total 69.8 percent left upper extremity impairment.

In a February 8, 2007 report, an Office medical adviser reviewed Dr. Bundens' report and advised that, under Figures 16-40, 16-43 and 16-46, appellant had shoulder impairments of 2 percent for flexion of 150 degrees, 2 percent for extension of 25 degrees, 5 percent for abduction of 85 degrees, 1 percent for adduction of 15 degrees, 1 percent for external rotation of 38 degrees and no impairment for internal rotation of 38 degrees for a total 11 percent left shoulder impairment due to loss of motion.¹⁹ Regarding the left wrist, he found that, under Figures 16-28 and 16-31, appellant had impairments of 3 percent for 40 degrees of flexion, 4 percent for

¹⁵ *Carl J. Cleary*, 57 ECAB 563 (2006).

¹⁶ *James R. Taylor*, 56 ECAB 537 (2005).

¹⁷ A.M.A., *Guides*, *supra* note 2 at 467, 469.

¹⁸ *Id* at 476-77, 479.

¹⁹ *Id.*

extension of 38 degrees, and no impairment for radial and ulnar deviation of 20 and 35 degrees respectively for a 7 percent left wrist impairment due to loss of motion.²⁰ The Office medical adviser also found that appellant's left brachial plexopathy affected her grip strength and award her a 20 percent deficit.

The Board notes that, while Dr. Bundens' findings of a 7 percent impairment for loss of wrist motion and a 10 percent impairment for loss of shoulder motion conform to the A.M.A., *Guides*,²¹ he also found a 52.8 percent shoulder impairment due to loss of shoulder impairment due to sensory and motor deficits. The fifth edition of the A.M.A., *Guides* provides, that loss of strength should be rated separately only if it is based on an unrelated cause or mechanism,²² and only if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods. Furthermore, decreased strength is not to be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.²³ Both Dr. Bundens and the Office medical adviser explained that appellant's left brachial plexopathy affected her grip strength, with Dr. Bundens finding 27.8 impairment and the Office medical adviser 20 percent impairment. Neither, however, explained why this should be given in addition to the objective anatomic findings described above.

Regarding Dr. Bundens' finding of 25 percent impairment for pain and loss of sensation, in an April 3, 2007 report, the Office medical adviser stated that Dr. Bundens' method of calculating appellant's sensory deficit was very vague and not in accordance with the A.M.A., *Guides*. The A.M.A., *Guides* provide that when an impairment results strictly from a peripheral nerve lesion, in the absence of complex regional pain syndrome, motion impairment values found in section 16.4 are not to be used to avoid duplication or an unwarranted increase in the impairment determination.²⁴

Dr. Bundens did not explain why appellant should be granted an additional impairment rating for her loss of grip strength or why her brachial plexus condition yielded a 25 percent sensory deficit.²⁵ The Board finds that the conflict in medical evidence remains regarding appellant's left upper extremity impairment. When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the

²⁰ *Id.* at 467, 469.

²¹ It is proper Office policy to round the calculated percentage of impairment to the nearest whole number. *J.Q.*, 59 ECAB ____ (Docket No. 06-2152, issued March 5, 2008). Fractions are rounded down from 0.49 and up from 0.50. *Carl J. Cleary*, *supra* note 16. As explained in Figure 16-53b of the A.M.A., *Guides*, regional impairments due to loss of motion are to be combined. A.M.A., *Guides*, *supra* note 2 at 517.

²² A.M.A., *Guides*, *supra* note 2 at 508; *James R. Taylor*, *supra* note 17.

²³ *Id.* at 508.

²⁴ *Id.* at 480.

²⁵ Section 16.5c of the A.M.A., *Guides* provides an explanation for an impairment determination for brachial plexus injuries. *Id.* at 489.

responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report.²⁶ The case will therefore be remanded to the Office for appropriate further development.

LEGAL PRECEDENT -- ISSUE 2

Section 8107 of the Act provides that compensation for a schedule award shall be based on the employee's monthly pay.²⁷ Section 8105(a) provides: "If the disability is total, the United States shall pay the employee during the disability monthly monetary compensation equal to 66 2/3 percent of his monthly pay, which is known as his basic compensation for total disability."²⁸ Section 8101(4) defines monthly pay for purposes of computing compensation benefits as follows: The monthly pay at the time of injury or the monthly pay at the time disability begins or the monthly pay at the time compensable disability recurs, if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater.²⁹ Office regulations provide that a recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition resulting from a previous injury or illness without a new or intervening injury.³⁰

In applying section 8101(4), the statute requires the Office to determine monthly pay by determining the date of the greater pay rate, based on the date of injury, date of disability, or the date of recurrent disability. The Board has held that rate of pay for schedule award purposes is the highest rate which satisfies the terms of section 8101(4).³¹

It is well established that the period covered by a schedule award commences on the date that the employee reaches MMI from the residuals of the accepted employment injury. The Board has explained that MMI means that the physical condition of the injured member of the body has stabilized and will not improve further. The determination of whether MMI has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician, which is accepted as definitive by the Office.³²

The Board has held that the date of injury is the date of last exposure to the work factors causing injury. This necessarily occurs prior to the medical examination relied upon for determining the extent of permanent impairment. The Board has found that the date of injury is the date of the last exposure which adversely affects the impairment because every exposure

²⁶ *Nancy Keenan*, 56 ECAB 687 (2005).

²⁷ 5 U.S.C. § 8107.

²⁸ 5 U.S.C. § 8105(a).

²⁹ 5 U.S.C. § 8101(4).

³⁰ 20 C.F.R. § 10.5(x).

³¹ *Patricia K. Cummings*, 53 ECAB 623 (2002).

³² *D.R.*, 57 ECAB 720 (2006).

which has an adverse effect (an aggravation) constitutes an injury.³³ In the usual case, the claimant has either retired or is no longer being exposed to any injurious work factors prior to the date of the medical examination and, as a result, there is a clearly defined date of last exposure. Where exposure to work factors continues, the date of injury is the date of relevant medical evaluation, *i.e.*, the date of the medical examination upon which the extent of permanent impairment has been determined.³⁴

ANALYSIS -- ISSUE 2

On April 10, 2006 and June 5, 2007, appellant was granted schedule awards for a left upper extremity impairment totaling 37 percent. Her schedule award compensation was based on an April 19, 1991 weekly pay rate of \$517.32. The Board notes that the Office used an incorrect pay rate for schedule award compensation purposes.

Appellant's initial injury to her right index finger occurred in 1989 and she sustained a recurrence of disability on April 9, 1991 when she underwent corrective right upper extremity surgery. The schedule awards granted in this case are for appellant's left upper extremity. Left shoulder brachial plexopathy was not accepted until December 23, 1997, and appellant did not stop work for this condition until October 17, 1998. Her weekly pay rate at that time was \$727.20.

Monthly pay for compensation purposes is defined as the monthly pay at the time of injury, or the monthly pay at the time disability begins, or the monthly pay at the time compensable disability recurs, if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater.³⁵ In this case, the proper weekly pay rate to be used in calculating appellant's schedule award compensation is the pay rate in effect the date the disability for her left upper extremity injury began, or October 17, 1998. Appellant's weekly pay rate at that time was \$727.20. Assuming *arguendo* that she stopped work on October 17, 1998 due to her right upper extremity condition, a recurrent pay rate would then apply, which would also be \$727.20. The case must also be remanded to the Office for determination of appellant's correct pay rate for schedule award compensation.

CONCLUSION

The Board finds that appellant has not established that she has a permanent impairment of the right upper extremity. The Board further finds that the case is not in posture for decision regarding appellant's left upper extremity impairment, and that the Office used an incorrect pay

³³ R.S., 58 ECAB ___ (Docket No. 06-1346, issued February 16, 2007).

³⁴ *Id.*

³⁵ 5 U.S.C. § 8101(4).

rate for schedule award compensation purposes. In light of the Board's findings regarding issues 1 and 2, Issue 3 need not be addressed.³⁶

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 29 and June 5, 2007 regarding appellant's right upper extremity are affirmed. The decisions dated August 29 and June 5, 2007 regarding appellant's left upper extremity are vacated and the case is remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: November 18, 2008
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

³⁶ Appellant has asserted that her attorney did not receive the June 7, 2007 Office decisions. In the absence of evidence to the contrary, correspondence properly addressed and mailed in the due course of business is presumed to have arrived at the mailing address in due course. *W.P.*, 59 ECAB ___ (Docket No. 08-202, issued May 8, 2008). The record in this case indicates that the June 7, 2007 decisions were mailed to appellant's attorney.