United States Department of Labor
Employees' Compensation Appeals Board

H.F., Appellant	)	
and	)	**Docket No. 11-24**
	)	**Issued: October 26, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On October 4, 2010 appellant filed a timely appeal from a July 23, 2010 Office of Workers' Compensation Programs' (OWCP) decision that denied his request for reconsideration and a May 3, 2010 OWCP schedule award decision. Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit and nonmerit decisions.

ISSUES

The issues on appeal are: (1) whether appellant met her burden of proof to establish that she sustained more than a 33 percent permanent impairment of her left upper extremity and a 14 percent permanent impairment of her right upper extremity, for which she received schedule awards; and (2) whether OWCP properly refused to reopen appellant's case for further review of the merits pursuant to 5 U.S.C. § 8128(a).

[1] 5 U.S.C. § 8101 *et seq.*

On appeal appellant alleges that she believes a greater schedule award is warranted for all of her injuries.

FACTUAL HISTORY

On September 1, 2000 appellant, then a 47-year-old flat sorter operator, filed an occupational disease claim alleging that she sustained carpal tunnel syndrome in the performance of duty. On October 17, 2000 OWCP accepted her claim for bilateral carpal tunnel syndrome and authorized a bilateral carpal tunnel release. Appellant underwent right carpal tunnel release on December 7, 2000 and left carpal tunnel surgery on February 22, 2001. OWCP also accepted left shoulder sprain, a left rotator cuff strain with authorized repair,[2] bilateral shoulder bursitis and bilateral trigger finger with right thumb release.[3] Appellant received appropriate compensation benefits.

On February 24, 2004 appellant requested a schedule award. By decision dated May 17, 2005, OWCP granted her a schedule award for a total of 37.44 weeks of compensation for a 12 percent permanent impairment of the left arm due to her distal clavicle resection and residual shoulder pain. In a November 17, 2005 decision, it granted an additional award of 11 percent permanent impairment of the left arm, attributable to appellant's shoulder, for a total impairment of 23 percent to the left arm. On April 14, 2008 OWCP denied her claim for a schedule award to the right arm. On January 18, 2009 appellant requested reconsideration. In a March 17, 2009 decision, OWCP denied modification of its prior decision.

In a June 17, 2008 electromyogram (EMG) and nerve conduction velocity (NCV) study, Dr. Milena Appleby, a Board-certified psychiatrist and neurologist, diagnosed moderately severe bilateral median nerve neuropathy due to carpal tunnel syndrome.

On December 15, 2009 OWCP authorized Dr. Samuel Chmell, a Board-certified orthopedic surgeon and treating physician, to rate appellant's impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (6th ed. 2008) (A.M.A., *Guides*).

In a January 15, 2010 report, Dr. Chmell noted that he provided an evaluation of permanent impairment utilizing the A.M.A., *Guides*. He advised that he reviewed appellant's EMG and NCV studies performed in June 2008. Dr. Chmell opined that she had 73 percent impairment to her left arm and 57 percent impairment to her right arm. He referred to Table 15-34 for shoulder range of motion.[4] For the right shoulder, Dr. Chmell found flexion of 120 degrees, which corresponded to a 3 percent impairment; extension of 40 degrees, which corresponded to 1 percent impairment; abduction of 120 degrees, which corresponded to 3 percent impairment; adduction of 40 degrees, which corresponded to no impairment, internal rotation of 70 degrees, which corresponded to 2 percent impairment and external rotation of 60 degrees, which corresponded no impairment, for total impairment of 9 percent of the right arm

[2] The record reflects that she underwent an acromioplasty and clavicle resection.

[3] OWCP also accepted appellant's claims for a recurrence on March 16 and April 24, 2004.

[4] A.M.A, *Guides* 475.

for lost shoulder motion. For the left shoulder, his findings included: flexion of 80 degrees, which corresponded to 9 percent impairment; extension of 35 degrees, which corresponded to 1 percent impairment; abduction of 80 degrees, which corresponded to 6 percent impairment; adduction of 25 degrees, which corresponded to 1 percent impairment, internal rotation of 60 degrees, which corresponded to 2 percent impairment and external rotation of 40 degrees, which corresponded to 2 percent impairment for total impairment of 21 percent on the left arm for lost shoulder motion. For the wrist, Dr. Chmell referred to Table 15-32.[5] For the right wrist, he provided findings which included: flexion of 50 degrees, which corresponded to 3 percent impairment; extension of 50 degrees, which corresponded to 3 percent impairment; radial deviation of 20 degrees which corresponded to 0 percent impairment and ulnar deviation of 15 degrees which corresponded to 2 percent impairment for total impairment of 8 percent for lost motion of the right wrist. For the left wrist, Dr. Chmell found that flexion of 45 degrees corresponded to 3 percent impairment; extension of 45 degrees corresponded to 3 percent impairment; radial deviation of 10 degrees corresponded to 2 percent impairment, and ulnar deviation of 10 degrees corresponded to 4 percent impairment for a total impairment of 12 percent for lost motion of the left wrist. Additionally, he referred to Table 15-23 for carpal tunnel syndrome. Dr. Chmell noted that appellant had decreased sensation of two-point discrimination of nine millimeters, and had for sensory and motor impairment and significant pain based on the EMG findings. He determined that appellant would be entitled to 40 percent impairment for the right and the left arms for carpal tunnel syndrome. Dr. Chmell added the values for the right and left upper extremities and determined that appellant had 57 percent right arm impairment and 73 percent left arm impairment.

In a March 10, 2010 report, OWCP's medical adviser noted appellant's history, including the recent report from Dr. Chmell and utilized the A.M.A., *Guides.* For shoulder range of motion, his findings concurred with Dr. Chmell's findings, which resulted in 9 percent on the right and 21 percent on the left. The medical adviser also noted that appellant's prior history of a distal clavicle excision corresponded to a 10 percent rating according pursuant to Table 15-5.[6] Regarding appellant's carpal tunnel syndrome, he referred to Table 15-23.[7] The medical adviser determined that appellant had an impairment of five percent on the left and five percent on the right with regard to her carpal tunnel syndrome. He combined the values and determined that appellant had an impairment of 14 percent on the right upper extremity and 33 percent on the left.[8]

By decision dated May 3, 2010, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the left arm and 14 percent impairment of the right arm.[9] The award ran for total of 74.88 weeks

[5] A.M.A, *Guides* 473.

[6] *Id*. at 401.

[7] *Id*. at 449.

[8] *Id*. at 604.

[9] This decision corrected an April 13, 2010 decision which incorrectly indicated that appellant had 33 percent total impairment of the right arm, instead of the left arm.

By letter dated July 7, 2010, appellant requested reconsideration. She advised OWCP that her physician indicated that she should request an award and OWCP would contact him for additional evidence. OWCP received July 1, 2010 treatment notes from Dr. Chmell.

By decision dated July 23, 2010, OWCP denied appellant's request for reconsideration without a review of the merits on the grounds that her request was repetitious and neither raised substantial legal questions nor included new and relevant evidence and, thus, it was insufficient to warrant review of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of FECA[10] 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.[11] FECA, 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.[12] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[13] Effective May 1, 2009, schedule awards are determined in accordance with the A.M.A., *Guides* (6th ed. 2008).

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision.

In support of her claim for a schedule award, appellant submitted a report from Dr. Chmell dated January 15, 2010. The Board notes that Dr. Chmell referred to Table 15-34[14] for shoulder range of motion and determined that appellant had an impairment of nine percent on the right and 21 percent on the left.[15] However, Dr. Chmell did not explain how range of motion grade modifiers were used in accordance with Table 15-35.[16] He then found

[10] 5 U.S.C. § 8107.

[11] *Id*.

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

[13] 20 C.F.R. § 10.404.

[14] A.M.A., *Guides* 475.

[15] For the right shoulder, Dr. Chmell's findings included: flexion of 120 degrees equates to a 3 percent impairment; extension of 40 degrees, corresponded to a 1 percent impairment; abduction of 120 degrees, warrants a 3 percent impairment; adduction of 40 degrees, corresponds to 0 percent impairment, internal rotation of 70 degrees, corresponds to 2 percent impairment and external rotation of 60 degrees does not warrant an impairment. For the left shoulder: flexion of 80 degrees equates to a 9 percent impairment; extension of 35 degrees, corresponds to a 1 percent impairment; abduction of 80 degrees, warrants a 6 percent impairment; adduction of 25 degrees, corresponds to 1 percent impairment, internal rotation of 60 degrees, corresponds to 2 percent impairment and external rotation of 40 degrees warrants a 2 percent impairment for a total of 21 percent on the left.

[16] A.M.A., *Guides* 477.

additional impairment for appellant's carpal tunnel syndrome which he combined with the range of motion findings for the shoulders and wrists. However, a range of motion impairment stands alone and is not combined with diagnosis-based impairment.[17] The Board further notes that Dr. Chmell's explanation regarding the extent of her carpal tunnel syndrome is flawed. For example, Dr. Chmell referred to Table 15-23 and found 40 percent impairment of each arm for carpal tunnel syndrome without any clear explanation of how he determined this amount. The Board notes that the highest impairment rating a claimant may receive for the severest entrapment or compression neuropathy under Table 15-23, page 449, is 9 percent, which is much less than the 40 percent rating that Dr. Chmell prescribed for each arm. Additionally, Dr. Chmell improperly added the findings instead of combining the aforementioned ratings under the Combined Values Chart.[18] Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP is correct to follow the advice of its medical adviser or consultant where he or she has properly applied the A.M.A., *Guides.*

The Board notes that OWCP's medical provider, provided range of motion findings which concurred with Dr. Chmell's findings for shoulder range of motion. As noted above, it is not clear any applicable grade modifiers were considered regarding range of motion impairment. OWCP's medical adviser also provided findings for appellant's carpal tunnel syndrome. Dr. Chmell referred to Table 15-23 and determined that appellant had an impairment of five percent for each arm based on her carpal tunnel syndrome.[19] The finding of five percent corresponds to grade modifier 2 in Table 15-23 but the medical adviser did not explain how he considered grade modifiers in reaching his determination. OWCP's medical adviser also determined that a distal clavicle excision on the left yielded 10 percent impairment pursuant to Table 15-5.[20] The medical adviser also provided no rationale for combining the distal clavicle rating with a stand alone range of motion rating which, as explained, is not contemplated by the A.M.A., *Guides*. He referred to the Combined Values Chart and determined that appellant had an impairment of 14 percent on the right upper extremity and 33 percent on the left.[21] However, as the medical adviser did not fully explain how he calculated range of motion or carpal tunnel syndrome impairment, consistent with the A.M.A., *Guides*, and he inappropriately combined stand alone range of motion impairment with diagnosis-based impairment, the medical opinion of OWCP's medical adviser requires clarification.

It is well established that proceedings under FECA are not adversarial in nature and, while the claimant has the burden to establish entitlement to compensation, OWCP shares

[17] *Id*. at 461 (provides that the section for range of motion impairment is to be used as a stand-alone rating and only when other grids refer the user to the range of motion section). The Board also notes that the carpal tunnel grid referenced by Dr. Chmell, Table 15-23, page 449, does not indicate that range of motion may be used as a stand alone alternative. Shoulder range of motion may be used as a stand alone alternative rating to diagnosis-based shoulder ratings in Table 15-5 of the A.M.A., *Guides* (see page 405).

[18] A.M.A, *Guides* 604.

[19] *Id*. at 449.

[20] *Id*. at 401.

[21] *Id*. at 604.

responsibility in the development of the evidence.[22] Upon return of the case record, OWCP shall obtain clarification of appellant's impairment rating from an OWCP medical adviser. If OWCP's medical adviser is unable to render an appropriate opinion in conformance with the A.M.A., *Guides*, OWCP shall refer appellant to an appropriate Board-certified specialist for a reasoned medical opinion regarding the extent of appellant's permanent impairment pursuant to the A.M.A., *Guides*. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.[23]

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the May 3, 2010 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision.

Issued: October 26, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[22] *Richard E. Simpson*, 55 ECAB 490 (2004).

[23] In light of the Board's finding on the first issue, the second issue is moot.