U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ISABEL GIAMPIETRO-KNOLL and DEPARTMENT OF HOUSING & URBAN DEVELOPMENT, OFFICE OF PUBLIC HOUSING, New York, N.Y.

Docket No. 97-1731; Submitted on the Record;
Issued March 23, 1999

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether appellant has established that she has greater than a 12 percent impairment for loss of use of her right arm and a 10 percent impairment of her left arm for which she has received a schedule award.

On March 26, 1993 appellant, a 72-year-old clerk/typist, filed a Form CA-2 claim based on occupational disease, alleging that she sustained pain and swelling in both hands which was caused by repetitive and continuous office duties such as typing, filing, stapling and stuffing and sealing envelopes. The Office of Workers' Compensation Programs accepted appellant's claim for left carpal tunnel syndrome by letter dated April 29, 1994.[1] Appellant accepted a buyout from the employing establishment, effective March 17, 1995, and has not worked since that date.

By letter dated September 11, 1995, appellant's attorney requested an award under the schedule award based on partial loss of use of her upper extremities. Accompanying the request was an August 8, 1995 report from Dr. David Weiss, an osteopath. In his report, Dr. Weiss reviewed appellant's medical history and stated his findings on examination. With regard to appellant's right hand, Dr. Weiss stated:

> "Examination of the right hand reveals tenderness over the metacarpophalangeal joint and interphalangeal joint of the thumb. There is a well-healed surgical scar at the base of the metacarpophalangeal joint of the thumb with marked muscle wasting of the intrinsic muscle. There is tenderness over the first dorsal compartment. There is swan neck deformity involving the right thumb. Range of motion of the thumb reveals extension-flexion of 45/55 degrees involving the metacarpophalangeal joint with pain at the extreme; and extension-flexion of -5 to

[1] By letter dated January 17, 1995, appellant's attorney requested that the Office expand appellant's accepted conditions to include bilateral carpal tunnel syndrome and the aggravation of preexisting arthritic conditions in her back and neck. The Office denied this claim.

-50/-5 to 65 involving the interphalangeal joint with pain at the extreme. There is hypothenar/thenar atrophy involving the right hand. There is no trigger/locking involving the metacarpophalangeal joint of the thumb."

Dr. Weiss further found that sensory examination revealed mild hypoesthesia involving the C5-6 dermatome of the left hand, with no sensory deficit involving the right hand. He stated that grip strength testing revealed a six kilogram force strength in right dominant hand as opposed to an eight kilogram force strength in the left hand.

Dr. Weiss concluded that, pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fourth edition), appellant had a 1.5 percent impairment based on the right metacarpophalangeal range of motion deficit in flexion pursuant to page 27, figure 27 of the A.M.A., *Guides*; and a 2.0 percent impairment based on the right interphalangeal range of motion deficit in flexion pursuant to page 26, figure 10 of the A.M.A., *Guides*, which amounted to a total 3.5 percent impairment. This figure, according to conversion Tables 1 and 2 on pages 18 and 19 translated into a right upper extremity impairment of 1.5. Dr. Weiss further found that appellant had a 20 percent impairment due to strength of grip deficit pursuant to page 65, Table 34 of the A.M.A., *Guides*, which amounted to a total right upper extremity impairment of 21.5 percent. Lastly, he calculated a 20 percent impairment based on median nerve entrapment of the left wrist pursuant to page 57, figure 16 of the A.M.A., *Guides*, which equated to a 20 percent left upper extremity impairment.

On October 30, 1995 an Office medical adviser reviewed appellant's medical records and Dr. Weiss' report and determined that appellant had a 22 percent permanent impairment for loss of use of her upper extremities. The Office medical adviser calculated that, with regard to the right thumb, a range of motion in the metacarpophalangeal joint of 0 to 45 degrees accounted for a 1.5 percent impairment of the thumb pursuant to page 27, figure 13 of the A.M.A., *Guides*; a range of motion in the interphalangeal joint of 5 degrees, extension, accounted for a 1 percent impairment of the thumb pursuant to page 26, figure 10 of the A.M.A., *Guides*; a range of motion in the interphalangeal joint of 50 degrees, flexion, accounted for a 2 percent impairment of the thumb pursuant to page 26, figure 10 of the A.M.A., *Guides*. Taken together, these figures amounted to a 4.5 percent total right thumb impairment. Under conversion Table 1 at page 18 of the A.M.A., *Guides*, a 4.5 percent total right thumb impairment translated into a 2 percent total impairment of the right hand, which in turn translated into a 2 percent impairment to the right upper extremity pursuant to conversion Table 2 at page 19 of the A.M.A., *Guides*.

Relying on the figures calculated by Dr. Weiss for right grip strength, the Office medical adviser, employing the formula outlined in Table 34, page 65 of the A.M.A., *Guides*, calculated that appellant had a 25 percent loss of strength loss index. The Office medical adviser found that, pursuant to Table 34, page 65 of the A.M.A., *Guides*, this 25 percent loss of strength converted into a 10 percent loss of strength in appellant's right upper extremity, which, when combined with the 2 percent impairment to the right upper extremity calculated above, amounted to a total schedule award of 12 percent for loss of use of the right upper extremity.

The Office medical adviser then found that appellant had a 10 percent impairment based on median nerve entrapment of the left wrist pursuant to page 57, figure 16 of the A.M.A., *Guides*, which was based on a mild nerve impairment in accordance with the applicable tables.

The Office medical adviser found that this translated into a 10 percent impairment of the left upper extremity, which, when combined with the 12 percent impairment on the right, amounted to an overall 22 percent impairment of the upper extremities. The office medical adviser further found that appellant reached maximum medical improvement on August 8, 1995, the date of Dr. Weiss's report.

On November 7, 1995 the Office granted appellant a schedule award for "22 percent permanent impairment of upper extremity" for the period from August 8, 1995 to November 30, 1996, for a total of 68.64 weeks of compensation.

By letter dated November 17, 1995, appellant's attorney requested an oral hearing. A hearing was held on June 17, 1996, at which appellant's attorney contended that the office medical adviser had essentially ignored the findings made by Dr. Weiss and had therefore erred in calculating an impairment rating less than that rendered by Dr. Weiss. Appellant's attorney contended that appellant was entitled to the 41.5 percent upper extremity impairment calculated by Dr. Weiss.

By decision dated August 22, 1996, the Office denied appellant's request for reconsideration. The Office hearing representative found that the office medical adviser, after relying on the figures derived from Dr. Weiss's impairment evaluation, properly utilized the specific procedures outlined in the A.M.A., *Guides* in determining the precise degree of appellant's impairment. The hearing representative therefore affirmed the Office's schedule award of a 10 percent impairment of the left upper extremity and 12 percent impairment to the right upper extremity.

By letter dated October 28, 1996, appellant's attorney requested reconsideration of the Office's prior decision. Accompanying the request was a September 3, 1996 report from Dr. Dale J. Lange, Board-certified in psychiatry and neurology, which contained electromyelogram (EMG) results indicating appellant had bilateral carpal tunnel syndrome and cervical radiculopathy.

By decision dated January 27, 1997, the Office denied appellant's application for review on the grounds that it neither raised substantial legal questions nor included new and relevant evidence such that it was sufficient to require the Office to review its prior decision.

The Board finds that appellant has no more than a 10 percent impairment of her left upper extremity and a 12 percent impairment of her right upper extremity for which she received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[4] However, neither the Act nor its regulations specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to insure equal justice under the law to all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants seeking schedule awards. The A.M.A., *Guides* have been adopted by the Office for evaluating schedule losses, and the Board has concurred in such adoption.[5]

On appeal, appellant's attorney contends that the difference in impairment ratings between that of Dr. Weiss and the office medical adviser constitutes a conflict in medical opinion which must be resolved by remanding for resolution by an independent medical examiner pursuant to section 8123(a).[6]

In the instant case, the Office medical adviser determined that appellant had a 22 percent impairment of her upper extremities by adopting the conclusions of Dr. Weiss regarding appellant's range of motion and degree of strength and then calculating the precise impairment rating based on the applicable figures and table of the A.M.A., *Guides.* With regard to calculating loss of strength in appellant's right hand, the Office medical adviser -- using Dr. Weiss' findings for right grip strength -- employed the formula outlined in Table 34, page 65 of the A.M.A., *Guides*, by subtracting 6 kilograms of force (the amount of strength in appellant's right hand gauged by Dr. Weiss) from 8 kilograms of force (the amount of strength in appellant's left hand) and divided the total into 8 kilograms of force, which amounted to a 25 percent loss of strength loss index. The Office medical adviser found that, pursuant to Table 34, page 65 of the A.M.A., *Guides,* this 25 percent loss of strength converted into a 10 percent loss of strength in appellant's right upper extremity, which, when combined with the 2 percent impairment to the right upper extremity based on the right hand, amounted to a total schedule award of 12 percent for loss of use of the right upper extremity.

With regard to the Office medical adviser's calculation of a 10 percent impairment based on median nerve entrapment of the left wrist, the he did not specifically indicate how he arrived at this figure. However, Dr. Weiss indicated in his impairment evaluation that "sensory

[2] 5 U.S.C. §§ 8101-8193*; see* 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.304.

[4] 5 U.S.C. § 8107(c)(19).

[5] *Thomas D. Gunthier,* 34 ECAB 1060 (1983).

[6] 5 U.S.C. § 8123(a),

examination reveals mild hypoesthesia involving the C5-6 dermatome[7] of the left hand, and cited page 57, Table 16 of the A.M.A., *Guides*, which indicates that a "mild" degree of impairment [*e.g.*; "mild" hypoesthesia"], due to median entrapment neuropathy[8] of the wrist translates into a 10 percent impairment. Dr. Weiss calculated a median nerve entrapment at the left wrist of 20 percent, which in Table 16, page 57 is based on a "moderate" degree of impairment; however, he did not indicate the source of this calculation. Thus the Office medical adviser relied on Dr. Weiss' finding of a mild nerve impairment in finding that appellant had a 10 percent impairment of the left upper extremity.

The Board concludes that the Office medical adviser correctly applied the A.M.A., *Guides* in determining that appellant has no more than a 10 percent impairment of her left arm and a 12 percent impairment of her right arm for which she has received a schedule award.

The Board finds that the Office did not abuse its discretion by refusing to reopen appellant's case for further review on the merits of his claim under 5 U.S.C. §8128(a).

Under 20 C.F.R. § 10.138(b)(1), a claimant may obtain review of the merits of his or her claim by showing that the Office erroneously applied or interpreted a point of law; by advancing a point of law or fact not previously considered by the Office; or by submitting relevant and pertinent evidence not previously considered by the Office.[9] Section 10.138(b)(2) provides that when an application for review of the merits of a claim does not meet at least one of these three requirements, the Office will deny the application for review without reviewing the merits of the claim.[10] Evidence that repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case.[11]

In the present case, appellant has not shown that the Office erroneously applied or interpreted a point of law and has not advanced a point of law or fact not previously considered by the Office. The only new medical evidence appellant submitted was Dr. Lange's September 3, 1996 report, in which he merely noted the results of an EMG and stated that appellant had bilateral carpal tunnel syndrome, with no evidence to support the presence of a superimposed cervical radiculopathy. Appellant's attorney contended in his October 28, 1996 letter that appellant was entitled to a schedule award greater than that awarded but failed to support this contention with new and relevant medical evidence. Therefore, the Office did not abuse its discretion in refusing to reopen appellant's claim for a review on the merits.

---

[7] According to *Dorland's Illustrated Medical Dictionary*, (25th ed.), [*Dorland's*], hypoesthesia is defined as "abnormally decreased sensitivity of the skin or of a special sense;" and dermatome is defined as " … 2. The area of skin supplied with afferent nerve fibers by a single posterior spinal root; called also *dermatomic area*."

[8] *Dorland's* defines entrapment neuropathy as "any of a group of neuropathies, including the carpal tunnel syndrome … in which a peripheral nerve is injured by compression in its course through a fibrous or osseofibrous tunnel or at a point where it abruptly changes its course through deep fascia over a fibrous or muscular band."

[9] 20 C.F.R. § 10.138(b)(1); *see generally* 5 U.S.C. § 8128(a).

[10] 20 C.F.R. § 10.138(b)(2).

[11] *Howard A. Williams*, 45 ECAB 853 (1994).

Accordingly, the decisions of the Office of Workers' Compensation Programs dated January 27, 1997 and August 22, 1996 are hereby affirmed.

Dated, Washington, D.C.
March 23, 1999

David S. Gerson
Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member