United States Department of Labor
Employees' Compensation Appeals Board

WILLIAM E. RIGLING, Appellant	)	
and	)	**Docket No. 05-23**
	)	**Issued: March 7, 2005**
U.S. POSTAL SERVICE, HAMILTON POST OFFICE, Hamilton, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On September 27, 2004 appellant filed an appeal of a November 19, 2003 merit decision of the Office of Workers' Compensation Programs granting a schedule award for a 15 percent permanent impairment of each upper extremity and a July 20, 2004 nonmerit decision denying merit review. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over both decisions.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish that he has more than a 15 percent impairment of both upper extremities; and (2) whether the Office properly refused to reopen appellant's case for further review pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On April 21, 1998 appellant, then a 52-year-old clerk, filed a Form CA-2, occupational disease claim, alleging that he injured his hands and wrists in the performance of duty. On August 4, 1998 the Office accepted his claim for bilateral carpal tunnel syndrome and ulnar

neuropathy -- left elbow. On September 29, 1998 he underwent surgery for a left ulnar nerve subcutaneous transposition, left elbow, after which he returned to work on a limited-duty status. On January 21, 2000 the Office accepted the additional diagnosis of bilateral aggravation of basilar arthritis of the thumbs. On February 28, 2000 appellant underwent right thumb CMC fusion and left thumb CMC fusion with distal radius bone graft on May 4, 2000. On May 17, 2001 appellant filed a claim for recurrence of disability, which was accepted on November 22, 2002. Appellant returned to work without restrictions on October 7, 2001.

Appellant filed several requests for a schedule award, including a request dated November 3, 2001. The Office referred appellant, together with a statement of accepted facts and the entire medical record, to Dr. Richard T. Sheridan, a Board-certified orthopedic surgeon, for a complete examination and a rating of any permanent partial impairment (PPI). In a report dated April 15, 2002, Dr. Sheridan opined that appellant's date of maximum medical improvement was October 8, 2001. He allocated 40 percent left upper extremity impairment for ulnar nerve neuropathy; 5 percent upper extremity impairment times two for bilateral carpal tunnel syndrome and releases; and 24 percent upper extremity impairment times two for 6 centimeter (cm) of preserved opposition of the thumbs in ankylosis from the carpometacarpal fusions.

The Office forwarded the medical record to an Office medical adviser for review. On a schedule award worksheet dated January 15, 2003 the Office medical adviser disagreed with Dr. Sheridan's assessment, stating that he could not assign additional PPI based on the ulnar and median nerves information of record. He indicated that Dr. Sheridan's finding of a 40 percent impairment would mean that appellant's entire motor and sensory ulnar nerve function was lost, a finding that did not comport with the evidence of record. The medical adviser requested that Dr. Sheridan provide median and ulnar nerve information based on motor and sensory function pursuant to Table 16-15, 16-10 and 16-11.

On February 12, 2003 Dr. Sheridan submitted a revised report based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[1] opining that appellant was entitled to a 15 percent impairment of each upper extremity. Having found no evidence of ulnar neuropathy in the left upper extremity on either a sensory or motor basis, he did not apply a rating for ulnar neuropathy pursuant to Table 16-15 on page 492. Referring to Table 16-8a, he determined that appellant merited a 7 percent impairment for each thumb for the 40 degrees of fixed abduction and 24 percent thumb impairment for the 6 cm preserved opposition, for a total thumb impairment on each side of 31 percent. Dr. Sheridan applied Tables 16-1, 16-2 and 16-3 on pages 438 and 439 to determine that appellant had a 12 percent permanent impairment of each hand, resulting in an 11 percent right and left upper extremity impairment, in addition to 5 percent awarded in each extremity for carpal tunnel syndrome.[2] Under the Combined Values Chart on page 604, Dr. Sheridan concluded that appellant is 15 percent impaired in each upper extremity.

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

[2] An impairment rating not to exceed five percent of the upper extremity may be justified. *See* A.M.A., *Guides*, *supra* note 1 at 495.

On March 5, 2003 the medical adviser agreed with Dr. Sheridan's calculations. He noted that there were no ulnar nerve symptoms and that residuals of the carpal tunnel syndrome warranted an impairment rating of five percent in each upper extremity.

By decision dated March 19, 2003, the Office granted appellant a schedule award for a 15 percent loss of use of each upper extremity for a total of 93.6 weeks, to run from April 15, 2002 to March 22, 2003. On March 30, 2003 appellant requested an oral hearing, which occurred on October 22, 2003. At the hearing, counsel for appellant argued that the Office was bound by Dr. Sheridan's determination that there was a 24 percent impairment of both upper extremities. By decision dated November 19, 2003, the hearing representative affirmed the Office's finding that appellant has a 15 percent permanent impairment of each upper extremity.

By letter dated June 28, 2004, appellant's attorney contacted the Office stating, "We have filed for reconsideration. I wrote you in November. I haven't received any notice. Please advise as to status."

By decision dated July 20, 2004, the Office denied appellant's request for reconsideration, finding that he had neither raised substantive legal questions nor included new and relevant evidence not previously considered.[3]

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulation[5] sets forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.[6] For consistent results and to ensure equal justice under the law to 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 implementing regulation as the appropriate standard for evaluating schedule losses.[7]

[3] By letter dated June 28, 2004, appellant's attorney indicated that he wrote to the Office in November (presumably November 2003) and that he previously requested reconsideration. No such letter appears in the record. However, there is no evidence in the record that any additional evidence was submitted in support of the request.

[4] 5 U.S.C. §§ 8101-8193.

[5] 20 C.F.R. § 10.404.

[6] *Linda R. Sherman*, 56 ECAB ___ (Docket No. 04-1510, issued October 14, 2004); *Danniel C. Goings*, 37 ECAB 781, 783-84 (1986).

[7] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

Regarding carpal tunnel syndrome (CTS), the A.M.A., *Guides* provides:

"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 CTS is rated according to the sensory and/or motor deficits as described earlier.
>
> (2) Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present and an impairment rating not to exceed 5 percent of the upper extremity may be justified.
>
> (3) Normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies: there is no objective basis for an impairment rating."[8]

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained employment-related bilateral CTS, ulnar neuropathy, left elbow and bilateral aggravation of basilar arthritis of the thumbs. In order to determine appellant's degree of impairment, pursuant to the A.M.A., *Guides*, the Office referred the medical record to Dr. Sheridan, an orthopedic surgeon, who initially found that appellant had a 24 percent upper extremity impairment. The Office medical adviser questioned Dr. Sheridan's calculations, particularly as they related to his finding regarding motor and sensory ulnar nerve function, and asked him to provide median and ulnar nerve information based on motor and sensory function pursuant to Table 16-15, 16-10 and 16-11.

After examining the medical evidence in light of the appropriate tables in the A.M.A., *Guides*, Dr. Sheridan issued a revised report dated February 12, 2003 opining that appellant was entitled to a 15 percent impairment rating of each upper extremity. Correcting his April 15, 2002 report, Dr. Sheridan specifically stated that he found no evidence of ulnar neuropathy in the left upper extremity on either a sensory or motor basis and, therefore, did not apply a rating for ulnar neuropathy pursuant to Table 16-15.

In evaluating appellant's thumb impairment pursuant to Table 16-8a,[9] appellant has 40 degrees of fixed abduction due to ankylosis which rates a 7 percent impairment rating for each thumb. Pursuant to Table 16-9[10] 6 cm preserved opposition rates a 24 percent thumb

[8] A.M.A., *Guides*, *supra* note 1 at 495.

[9] Dr. Sheridan's report actually cites A.M.A., *Guides*, Table 16-18A. This appears to be a typographical error, since the A.M.A., *Guides* does not contain a Table 16-18A, and Table 16-8a, page 459, provides values for thumb impairment due to lack of radial abduction and ankylosis.

[10] A.M.A., *Guides* at page 460.

impairment, for a total thumb impairment on each side of 31 percent. Appropriately applying Table 16-1[11] (conversion of impairment of the digits to impairment of the hand), appellant has a 12 percent permanent impairment of each hand. Applying Table 16-2[12] (conversion of impairment of the hand to impairment of the upper extremity), appellant has an 11 percent right and left upper extremity impairment.

Finally, both Dr. Sheridan and the Office medical adviser concluded that appellant should be awarded an additional five percent for CTS in each extremity. Both physicians agreed that appellant's residual CTS findings should be rated under the second scenario of carpal tunnel assessment found on page 495 of the A.M.A., *Guides*, which allows up to a maximum award of five percent. Although Dr. Sheridan did not thoroughly explain how he rated appellant's CTS residuals, his April 15, 2002 report is replete with evidence of residuals of carpal tunnel syndrome and, therefore, under the A.M.A., *Guides*, an award of five percent was justified. Under the Combined Values Chart, Dr. Sheridan properly found that appellant was 15 percent impaired in both extremities. He examined appellant, analyzed his condition and determined his degree of impairment by properly applying the applicable tables in the A.M.A., *Guides*. Dr. Sheridan's February 12, 2003 report does not lack probative value because it corrected a finding made in his April 15, 2002 report, but rather the revised report reflects thoughtful consideration and proper application of the A.M.A., *Guides* and constitutes probative evidence.

After reviewing Dr. Sheridan's reports, the medical adviser concurred with his utilization of the A.M.A., *Guides*, the calculations involved and the determination of a 15 percent impairment of each upper extremity. He also agreed that there were no ulnar nerve symptoms and that residuals of CTS warranted an impairment rating of 15 percent in each upper extremity.

The Board finds that appellant's counsel's contention that the Office is bound by Dr. Sheridan's original conclusion that appellant was 24 percent permanently impaired is without merit. The Office's obligation is to ascertain, with the assistance of its medical adviser, appellant's correct rating of permanent partial impairment based on the A.M.A., *Guides*. To knowingly accept an incorrect assessment would be contrary to the intent of the Act and its implementing legislation.

The Board further finds that, in his February 12, 2003 report, Dr. Sheridan properly rated appellant's upper extremities in accordance with A.M.A., *Guides*. He articulated a thorough review of the medical evidence and referenced the proper section and tables which address impairment of the upper extremities due to peripheral nerve disorders. His report establishes that appellant has no more than a 15 percent impairment of each upper extremity.[13]

[11] *Id*. at page 438.

[12] *Id*. at page 439.

[13] Office procedures state that claims for increased schedule awards may be based on incorrect calculation of the original award or new exposure. To the extent that a claimant is asserting that the original award was erroneous based on his or her medical condition at that time, this would be a request for reconsideration. A claim for an increased schedule award may be based on new exposure or on medical evidence indicating the progression of an employment-related condition, without new exposure to employment factors, has resulted in a greater permanent impairment than previously calculated. *Linda T. Brown*, 51 ECAB 115 (1999).

LEGAL PRECEDENT -- ISSUE 2

Section 10.608(a) of the Act's implementing regulation provides that a timely request for reconsideration may be granted if the Office determines that the claimant has presented evidence and/or argument that meets at least one of the standards described in section 10.606(b)(2).[14] This section provides that the application for reconsideration must be submitted in writing and set forth arguments and contain evidence that either: (i) shows that the Office erroneously applied or interpreted a specific point of law; (ii) advances a relevant legal argument not previously considered by the Office; or (iii) constitutes relevant and pertinent new evidence not previously considered by the Office.[15] Section 10.608(b) provides that, when a request for reconsideration is timely, but fails to meet at least one of these three requirements, the Office will deny the application for reconsideration without reopening the case for a review on the merits.[16]

ANALYSIS -- ISSUE 2

The only evidence of record submitted in support of appellant's request for reconsideration is the June 28, 2004 letter from appellant's attorney. The letter does not present a new legal argument and does not constitute new, relevant evidence not previously considered or evidence that the Office erroneously applied or interpreted a point of law. Thus, appellant is not entitled to a review of the merits of his claim pursuant to any of the three requirements under section 10.606(b)(2), and the Board finds that the Office properly denied his request for reconsideration.

CONCLUSION

The Board finds that appellant has not established that he is entitled to greater than a 15 percent impairment of each upper extremity. The Board also finds that the Office properly denied appellant's request for merit review.

[14] 20 C.F.R. § 10.608(a).

[15] 20 C.F.R. § 10.608(b)(1) and (2).

[16] 20 C.F.R. § 10.608(b).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated November 19, 2003 and July 20, 2004 be affirmed.

Issued: March 7, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member