United States Department of Labor
Employees' Compensation Appeals Board

DANIEL E. HILL, Appellant	)	
and	)	**Docket No. 05-731**
	)	**Issued: May 17, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Daytona Beach, FL, Employer	)	

Appearances:
Ronald Webster, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On February 7, 2005 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated January 24, 2005, which denied further merit review and the Office's schedule award decisions dated May 6, September 24 and December 16, 2004. Pursuant to its regulations, the Board has jurisdiction over the merit and nonmerit decisions.

ISSUES

The issues on appeal are: (1) whether appellant met his burden of proof to establish that he sustained more than a 30 percent permanent impairment of his left upper extremity and a 48 percent permanent impairment of his left lower extremity, for which he received schedule awards; and (2) whether the Office properly refused to reopen appellant's case for further review of the merits pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On April 24, 1996 appellant, then a 53-year-old supervisor, filed an occupational disease claim alleging that his condition arose from several prior claims accepted by the Office.[1] The Office accepted appellant's claims for reflex sympathetic dystrophy (RSD) and adjustment disorder with depressed mood.[2] Appellant received appropriate compensation benefits.[3]

By letter dated August 18, 2003, appellant, through his representative, requested a schedule award. By letter dated November 7, 2003, the Office requested an impairment rating from Dr. Alyn Benezette, a Board-certified neurologist and appellant's treating physician. The Office advised Dr. Benezette to use the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (5th ed. 2001).

In a November 13, 2003 report, Dr. Benezette diagnosed complex regional pain syndrome (CRPS) involving the left upper extremity, which caused significant aching and burning pain and associated swelling of the distal left upper extremity, along with temperature changes and hypersensitivity to touch in the left upper extremity. Dr. Benezette advised that this was known as allodynia, which resulted in significant guarding of the left upper extremity and impaired motor function, particularly fine dexterity, reaching and grasping, lifting or carrying. He explained that any use of the left upper extremity aggravated appellant's sympathetically mediated pain. He "noted decreased strength in the proximal left upper extremity at 5-/5 with 4/5 strength in the distal left upper extremity." Appellant had restriction of motion of his left glenohumeral joint as a result of the CRPS. Appellant's range of motion of the left glenohumeral joint was abduction to 75 degrees, adduction to 50 degrees, internal and external rotation of the left shoulder was 45 degrees and flexion of the left shoulder was restricted to 140 degrees and extension of the left shoulder was restricted to 20 degrees. Appellant had full range of motion of the left elbow and left wrist flexion and extension were restricted to 40 degrees. Dr. Benezette indicated that, for the left hand, the metacarpal joints showed restriction of flexion at 80 degrees, restriction of extension at 20 degrees and the proximal interphalangeal joint flexion was restricted to 90 degrees with extension, restricted to 10 degrees. He opined that appellant had an impairment of 33 percent of the left upper extremity based upon the A.M.A., *Guides.* He advised that appellant reached maximum medical improvement on March 4, 1996.

On April 20, 2004 the Office indicated that appellant's accepted conditions included left RSD and adjustment disorder with depressive mood. The Office requested that an Office medical adviser review the impairment rating.

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[1] The accepted claims included a November 1, 1990 injury No. 06-0649750 and a December 2, 1992 claim for aggravation of cervical radiculopathy. No. 06-0625739.

[2] Appellant retired on disability on September 20, 2004.

[3] The record includes a December 5, 2002 decision, in which the Board found that the Office properly refused to reopen appellant's case for review of the merits of his claim pursuant to 5 U.S.C. § 8128(a). Docket No. 01-129 (issued December 5, 2002).

On April 21, 2004 the Office medical adviser determined that appellant's medical examination showed decreased pinprick in the upper and lower extremities, which equated to Grade 4 sensory deficit under Table 16-10 page 482 of the A.M.A., *Guides.* He determined that this was 20 percent deficit of the maximum of the upper extremity peripheral nerve. Under Table 16-15 he noted that the maximum for sensory loss of the radial nerve was equal to 5 percent, the ulnar nerve was equal to 7 percent and the median nerve was equal to 39 percent. He added the maximum impairment values for sensory loss and determined that they equated to 51 percent. The Office medical adviser multiplied the maximum impairment values for sensory loss by the 20 percent value for sensory deficit and determined that appellant had a 10 percent left upper extremity impairment.

On April 26, 2004 the Office medical adviser noted that he had previously determined that appellant had a 10 percent left upper extremity impairment. He combined the previous rating with the percentages for loss of motion in the shoulder (15 percent) and wrist (7 percent). The Office medical adviser explained that the 10 percent impairment to the left upper extremity for sensory loss, when combined with the 22 percent impairments for loss of motion in the shoulder and wrist were equal to a 30 percent impairment to the left upper extremity pursuant to the Combined Values Chart.[4] In a separate report, also dated April 26, 2004, the Office medical adviser provided calculations and referred to Tables 16-28, Figures 16-40, 16-43 and 16-46 of the A.M.A., *Guides,* to determine the percentages of impairment for the wrist and the shoulder.[5] On April 28, 2004 the Office medical adviser opined that appellant reached maximum medical improvement on November 13, 2003. He also recalculated that appellant had 30 percent permanent impairment of the left arm pursuant to the A.M.A, *Guides*.

By decision dated May 6, 2004, the Office granted appellant a schedule award for a total of 93.60 weeks of compensation for a 30 percent permanent impairment of the left upper extremity.

By letter dated June 17, 2004, appellant requested reconsideration and submitted additional evidence.[6] In a June 11, 2004 report, Dr. Benezette determined that appellant had 33 percent whole body impairment attributable to his left arm and 19 percent whole body impairment attributable to his left leg related to his CRPS. He opined that appellant had a combined whole body impairment rating of 46 percent.

In a July 2, 2004 report, the Office medical adviser determined that Dr. Benezette's report of July 11, 2004, which provided appellant with a rating of a 19 percent whole body impairment to the left lower extremity due to gait alteration from CRPS per the A.M.A.,

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

[5] *Id*. at 506.

[6] By letter dated May 12, 2004, appellant's representative requested an explanation regarding why appellant only received an award for the left upper extremity, when he also requested an award for the left foot and ankle. By letter dated May 26, 2004, the Office advised appellant's representative that they had not accepted that the lower extremity was an accepted condition related to a job injury.

Guides,[7] was equal to a 48 percent impairment of the left lower extremity due to the CRPS. He referred to Table 17-3, page 527 of the A.M.A., *Guides* and advised that there was no change in the upper extremity calculations.

By decision dated September 17, 2004, the Office vacated the May 6, 2004 decision in part. The Office determined that appellant was also entitled to a schedule award for an impairment of 48 percent to the left lower extremity. By decision dated September 24, 2004, the Office granted appellant a schedule award for a total of 138.24 weeks of compensation for a 48 percent permanent impairment of the left lower extremity.

By letter dated October 15, 2004, appellant requested reconsideration and submitted additional evidence. Appellant asserted that Dr. Benezette's June 29, 2004 report indicated appellant's impairment of 55 percent of the left arm. In reports dated June 28 and November 3, 2004, Dr. Benezette diagnosed CRPS and post left fibular fracture.

In a December 14, 2004 report, the Office medical adviser opined that the June 28, 2004 report of Dr. Benezette "did not support an increase in the rating for the [left upper extremity]."

By decision dated December 16, 2004, the Office denied modification of the Office's May 6, 2004 decision.

In a December 2, 2004 report, Dr. Benezette repeated his previous findings and recommended follow up with appellant's psychiatrist.

By letter dated January 4, 2005, appellant requested reconsideration and enclosed the June 29, 2004 report of Dr. Benezette. In this report, Dr. Benezette indicated that he wished to "clarify" his opinion and opined that appellant had a 55 percent permanent impairment of the upper extremity based on the A.M.A., *Guides.* He further opined that appellant also had an impairment of 48 percent of the left lower extremity, which was causally related to appellant's employment injury. The Office also received a psychiatric treatment note dated January 5, 2005 from a provider whose signature is illegible, prescribing additional follow up and treatment.

By decision dated January 24, 2005, the Office denied appellant's request for reconsideration without a review of the merits on the grounds that his 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.

[7] *See* A.M.A., *Guides*, Table 13-15 at 336. This table allows for up to 19 percent whole person impairment for a Class 2 station or gait disorder. Chapter 17.2m of the A.M.A., *Guides* directs use of Chapter 13 to evaluate impairment when CRPS occurs in an extremity. *See* A.M.A., *Guides* 553.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulation[9] 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. However, the Act does not specify the manner in which the percentage of loss shall be determined. 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.[10]

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*.[11] 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.[12]

ANALYSIS -- ISSUE 1

Regarding appellant's left upper extremity, Dr. Benezette provided several reports and utilized the A.M.A., *Guides*. In his November 13, 2003 report, Dr. Benezette determined that appellant had an impairment of 33 percent of the left upper extremity. He provided certain range of motion measurements for the left arm. While he referenced the A.M.A., *Guides*, Dr. Benezette did not list any tables, figures or pages which he applied in order to make his findings. His subsequent report dated June 11, 2004 was also of limited probative value, as it merely contained a percentage without any explanation of how he arrived at his conclusion pursuant to the A.M.A., *Guides*.[13]

The Office properly referred the case to the Office medical adviser who, on April 21, 2004, utilized the findings provided by Dr. Benezette. Regarding sensory deficit loss due to peripheral nerve disorders, he noted the findings provided by Dr. Benezette included impairment

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[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

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

[11] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[12] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000); *see also Paul A. Toms*, 28 ECAB 403 (1987).

[13] *See Shalanya Ellison*, 56 ECAB ___ (Docket No. 04-824, issued November 10, 2004) (schedule awards are to be based on the A.M.A., *Guides*; an estimate of permanent impairment is irrelevant and not probative where it is not based on the A.M.A., *Guides*).

of motor functions such as fine dexterity, aching and burning pain and referred to Table 16-10.[14] He determined that decreased pinprick in the upper and lower extremities, warranted a Grade 4 classification for which he assigned a sensory deficit of 20 percent. He referred to Table 16-15 and noted that the maximum impairment values for sensory deficits for the involved nerves were: radial nerve 5 percent, ulnar nerve 7 percent and median nerve 39 percent.[15] The Office medical adviser added the maximum impairment values for sensory deficit, which equated to 51 percent and multiplied this percentage by the 20 percent sensory deficit he derived from a Grade 4 for pain in Table 16-10. The Office medical adviser determined that this would equate to a 10 percent left upper extremity impairment. The Board notes that the Office medical adviser should have rated each impairment value for sensory deficit individually by the grade of 4 for pain, instead of combining the impairment values for sensory deficit for pain and then multiplying them by the grade of 4 for pain. Then after each sensory loss was evaluated, they should have been combined.[16] For example, the radial nerve, which was assigned a 5 percent sensory deficit, when multiplied by the 20 percent sensory deficit given for a grade of 4 for pain would equate to 1 percent impairment. The ulnar nerve when assigned a value of 7 percent for sensory loss for pain, when multiplied by a grade of 4 for pain, which was given a 20 percent sensory deficit, would equate to an impairment of 1.4 percent. The median nerve, which was assigned a value of 39 percent for sensory loss for pain, when multiplied by a grade of 4 for pain, which was given a 20 percent sensory deficit, would equate to an impairment of 7.8 percent or 8 percent when rounded to the nearest whole number. These values for sensory loss when combined, equal an impairment of 10 percent to the left upper extremity. The Board notes that the Office medical adviser committed harmless error, by adding the sensory deficits as the grade for pain, was the same for each nerve and the impairment to the left upper extremity equates to 10 percent.

In his April 26 and 28, 2004 reports, the Office medical adviser determined that appellant was entitled to an additional impairment of 15 percent for loss of motion of the shoulder and 7 percent for the loss of motion of the wrist or 22 percent. Initially, the Board notes that the impairment for loss of motion of the shoulder and of the wrist should be combined instead of added.[17] Further, the medical adviser did not correctly calculate impairment due to loss of motion in the shoulder. Regarding the shoulder, the medical adviser referred to Figure 16-46[18] and found that 45 degrees of internal rotation was equal to 4 percent and that 45 degrees of external rotation was equal to 1 percent for lack of internal and external rotation of the shoulder. However, the Board notes that 45 degrees of internal rotation would actually equate to 3 percent impairment under the A.M.A., *Guides*.[19] Other range of motion impairment findings noted by

[14] A.M.A., *Guides*, 482.

[15] *Id*. at Table 16-15, at 492.

[16] *See id.* at 481, for a description of the impairment determination method.

[17] A.M.A., *Guides*, at 16.1c at 438.

[18] *Id*. at 479.

[19] *See id.*

the medical adviser conform with the A.M.A., *Guides*. He referred to Figure 16-40,[20] which provided 3 percent for 140 degrees of forward elevation and 2 percent for 20 degrees of backward elevation due to lack of flexion and extension of the shoulder. The Office medical adviser also referred to Figure 16-43[21] and found that appellant was entitled to 5 percent for 75 degrees abduction and 0 percent for 50 degrees of adduction due to lack of abduction and adduction of the shoulder. He added the values for loss of elevation, abduction, adduction and rotation and indicated that they equated to 15 percent for the shoulder. However, as noted above, since internal rotation of the shoulder is properly 3 percent, these values add to 14 percent. For the wrist, the medical adviser properly referred to Figure 16-28,[22] which provides three percent for dorsiflexion and four percent for palmar flexion or seven percent due to lack of flexion and extension for the wrist.

The medical adviser then added the percentage for lost motion of the wrist to the percentage for lost motion for the shoulder to total 22 percent impairment. However, as noted above, the A.M.A., *Guides* provide that multiple regional impairments, such as the wrist and the shoulder, should be combined.[23] Accordingly, pursuant to the Combined Values Chart, the correct impairment for lost shoulder range of motion, 14 percent as noted above, combined with 7 percent impairment due to lost motion of the wrist, yields 20 percent impairment for lost motion of the arm.[24] Combining 20 percent for loss of motion with the 10 percent for sensory deficit, noted above, yields 28 percent impairment of the left upper extremity.

Regarding the left lower extremity, Dr. Benezette provided a June 11, 2004 report, in which he provided physical findings and concluded that appellant had a 19 percent whole body impairment, for the left lower extremity. He opined that appellant had a combined impairment rating of 46 percent of the body. However, he did not refer to the A.M.A., *Guides.* Dr. Benezette did not discuss how he arrived at his conclusion and did not specifically refer to any tables or pages of the A.M.A., *Guides* in determining the amount of the impairment. The Board therefore finds that as Dr. Benezette did not include an impairment rating under the A.M.A., *Guides,* the Office properly relied upon the findings of the Office medical adviser.

The Office medical adviser, in a July 2, 2004 report, utilized Dr. Benezette's report of June 11, 2004, which provided appellant with a rating of a 19 percent whole body impairment to the left lower extremity due to CRPS. This is consistent with a Class 2 impairment under Table 13-15 of the A.M.A., *Guides*.[25] While the A.M.A., *Guides* provide for both impairment to the individual member and to the whole person, the Act does not provide for permanent impairment for the whole person.[26] The Board notes that whole person impairment ratings are not provided

[20] *Id*. at 476.

[21] *Id*. at 477.

[22] *Id*. at 467.

[23] *Supra* note 17.

[24] *Supra* note 4.

[25] *Id*. at 336.

[26] *Robert Romano,* 53 ECAB 649 (2002).

for under the Act as section 8107 provides a compensation schedule in terms of specific members of the body.[27] Therefore, the Office medical adviser correctly utilized the A.M.A., *Guides* and referred to Table 17-3, which translates whole person impairment values into lower extremity impairment values.[28] He correctly determined that this was equal to an impairment of 48 percent of the left lower extremity.

The Board will modify the ratings provided by the Office medical adviser as noted to find that appellant has no more than 28 percent impairment of the left upper extremity and 48 percent of the left lower extremity. Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that appellant has a greater schedule award.[29]

LEGAL PRECEDENT -- ISSUE 2

Under section 8128(a) of the Act,[30] the Office may reopen a case for review on the merits in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations, which provides that a claimant may obtain review of the merits if the written application for reconsideration, including all supporting documents, sets forth arguments and contains evidence that:

> "(i) Shows that [the Office] erroneously applied or interpreted a specific point of law; or
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> "(ii) Advances a relevant legal argument not previously considered by the Office; or
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> "(iii) Constitutes relevant and pertinent new evidence not previously considered by the [the Office]."[31]

Section 10.608(b) provides that any application for review of the merits of the claim which does not meet at least one of the requirements listed in section 10.606(b) will be denied by the Office without review of the merits of the claim.[32]

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[27] *See Paul A. Zoltek*, 56 ECAB ___ (Docket No. 04-2185, issued February 9, 2005).

[28] A.M.A., *Guides*, 527.

[29] The Board notes that appellant retains the right to file a claim for an increased schedule award based on new exposure or on medical evidence indicating that 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).

[30] 5 U.S.C. § 8128(a).

[31] 20 C.F.R. § 10.606(b).

[32] 20 C.F.R. § 10.608(b).

ANALYSIS -- ISSUE 2

Appellant disagreed with the amount of his schedule award and requested reconsideration on January 4, 2005. The underlying issue on reconsideration was whether appellant was entitled to a greater impairment than the 30 percent that he received for the left arm and the 48 percent that he received for the left leg. However, appellant did not provide any relevant or pertinent new evidence to the issue of whether he was entitled to an increased schedule award.

In his January 4, 2005 request for reconsideration appellant alleged that he was entitled to a greater award and enclosed the June 29, 2004 report of Dr. Benezette. However, Dr. Benezette essentially reiterated his previous findings and opined that appellant was entitled to an award of 55 percent of the upper extremity and 48 percent of the left lower extremity based on the fifth edition of the A.M.A., *Guides.* He merely related a percentage without any description of the findings. While new, it was not pertinent as he did not provide any explanation as to how these figures were derived pursuant to the A.M.A., *Guides*. Furthermore, this report was similar to previously submitted reports. The submission of evidence which repeats or duplicates evidence that is already in the case record does not constitute a basis for reopening a case for merit review.[33] Appellant did not provide any relevant and pertinent new evidence to establish that she sustained an emotional condition in the performance of duty.

He also submitted a psychiatric report from an unknown provider. However, this was not relevant to the issue of an increased schedule award. The submission of evidence that does not address the particular issue involved does not constitute a basis for reopening a case.[34]

Consequently, the evidence submitted by appellant on reconsideration does not satisfy the third criterion, noted above, for reopening a claim for merit review. Furthermore, appellant also has not shown that the Office erroneously applied or interpreted a specific point of law or advanced a relevant new argument not previously submitted. Therefore, the Office properly denied her request for reconsideration.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has greater than the 30 percent impairment of the left upper extremity and 48 percent impairment of the left lower extremity, for which he received a schedule award. The Board also finds that the Office properly refused to reopen appellant's case for further review of the merits of his claim under 5 U.S.C. § 8128(a)

[33] *David J. McDonald*, 50 ECAB 185 (1998); *John Polito*, 50 ECAB 347 (1999); *Khambandith Vorapanya*, 50 ECAB 490 (1999).

[34] *Robert P. Mitchell*, 52 ECAB116 (2000); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000); *Alan G. Williams*, 52 ECAB 180 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated December 16 and September 24, 2004 are affirmed as modified. The decision of the Office dated January 24, 2005 is affirmed

Issued: May 17, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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