United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant	)	
	)	**Docket No. 07-254**
and	)	**Issued: August 23, 2007**
	)	
DEPARTMENT OF THE AIR FORCE, HILL AIR FORCE BASE, UT, Employer	)	

Appearances:
Appellant, pro se
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 November 6, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decisions dated May 3 and June 13, 2006 which denied an additional schedule award. Appellant also appealed a September 22, 2006 decision denying his request for reconsideration. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether appellant has more than 17 percent permanent impairment of the right arm and 13 percent impairment of the left arm for which he received schedule awards; and (2) whether the Office properly denied his request for reconsideration without a merit review.

FACTUAL HISTORY

This is the third appeal in the present case. In an April 7, 2004 decision, the Board vacated the Office's February 28, 2003 decision.[1] It determined that there was a conflict in medical opinion between the treating physicians, Dr. David A. Cook, a Board-certified orthopedic surgeon, and Dr. Corey D. Anderson, a Board-certified physiatrist, and an Office medical adviser with respect to the degree of permanent impairment to appellant's upper extremities.[2] In an August 17, 2005 decision, the Board affirmed the Office decisions dated September 1 and December 22, 2004, which determined that appellant was not entitled to an additional schedule award for the arms.[3] The facts and circumstances of the case up to that point are set forth in the Board's prior decision and incorporated herein by reference.[4]

Appellant submitted reports from Dr. Cook dated July 15 and August 10, 2005, for treatment of recurrent ulnar nerve symptoms. Dr. Cook diagnosed recurrent cubital syndrome five years following initially successful bilateral releases. He recommended an ulnar nerve transposition and referred appellant to another physician for surgery. An electromyogram (EMG) dated July 27, 2005, revealed prolongation of the distal delay of the ulnar nerve across the elbow suggestive of ulnar nerve entrapment with evidence of axonal degeneration. In an October 24, 2005 report, Dr. James W. Adams, a Board-certified orthopedic surgeon, noted a history of appellant's condition and subsequent bilateral ulnar nerve releases in 2000 and medial epicondylectomy. He diagnosed recurrent cubital tunnel syndrome bilaterally, worse on the left. Dr. Adams noted that appellant was reluctant to proceed to surgery and wanted an impairment rating performed. Appellant also submitted sensory testing performed by an occupational therapist. On March 30, 2006 he filed a claim for an additional schedule award.

The Office referred appellant to Dr. Brian H. Morgan, a Board-certified physiatrist, for an evaluation of the extent of permanent impairment arising from his accepted employment injury and any preexisting medical conditions in accordance with the A.M.A, *Guides*.[5] In a March 21, 2006 report, Dr. Morgan related appellant's history and diagnosed status post bilateral ulnar

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[1] Docket No. 04-279 (issued April 7, 2004).

[2] The Office accepted appellant's claim for left lateral epicondylitis and expanded the claim to include bilateral epicondylitis and right Achilles heel tendinitis. The Office authorized left and right ulnar nerve releases and epicondylectomies which were performed on July 13 and August 12, 2000. In a February 28, 2003 decision, appellant was granted a schedule award for 7 percent right arm impairment and 3 percent left arm impairment, which the Office characterized as 10 percent impairment for the "bilateral" upper extremities, for the period February 15 to September 21, 2002.

[3] Docket No. 05-849 (issued August 17, 2005).

[4] On October 11, 1995 appellant filed a claim for bilateral carpal tunnel syndrome, File No. 12-0158575, which was accepted for bilateral carpal tunnel syndrome. The Office authorized a right carpal tunnel release which was performed by Dr. Cook on March 29, 1996 and a left carpal tunnel release which was performed on April 26, 1996. On December 16, 1996 the Office granted appellant a schedule award for 10 percent permanent impairment of the right arm and 10 percent impairment of the left arm. Appellant also filed a claim which was accepted for binaural hearing loss and he was granted a schedule award for four percent monaural hearing loss for the period September 19 to October 3, 2005.

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

nerve releases with medial epicondylectomies and bilateral ulnar nerve neuropathy in the mid forearm region. He opined that under the fifth edition of the[6] A.M.A., *Guides*, appellant had four percent permanent impairment of the right arm and a five percent permanent impairment of the left arm. Dr. Morgan stated that appellant had a Grade 4 sensory loss (25 percent) associated with the ulnar nerve distribution above the mid forearm for both the left and right arm which, when multiplied by the 7 percent maximum value for ulnar nerve loss, yielded a 1.75 (rounded to 2 percent) impairment for both arms.[7] With regard to motor deficit on both the right and left side, Dr. Morgan advised that appellant was not giving full effort such that his loss of strength could not be objectified or used in the impairment rating. He noted that range of motion deficit of the right elbow secondary to bilateral epicondylitis was calculated as follows: flexion of 130 degrees for 1 percent impairment[8] and extension deficit of 5 degrees for 1 percent impairment,[9] for a total 2 percent right arm impairment. Dr. Morgan noted that range of motion deficit for the left elbow was calculated as follows: flexion of 120 degrees for two percent impairment[10] and extension deficit of 5 degrees for one percent impairment,[11] for a total three percent left arm impairment for range of motion deficit. Dr. Morgan found that appellant sustained a four percent impairment of the right arm and a five percent of the left arm. In a report dated April 14, 2006, an Office medical adviser concurred with the impairment calculations of Dr. Morgan.

By decision dated May 3, 2006, the Office denied appellant's claim for an additional schedule award. It found that the medical evidence did not establish greater impairment of his upper extremities than previously awarded.

On May 25, 2006 appellant requested reconsideration and submitted additional evidence. In a May 10, 2006 report, Dr. Cook stated that under the A.M.A., *Guides*, he sustained a 33 percent permanent impairment of both the right and left arm. He noted a Grade 3 sensory loss[12] (50 percent) associated with the ulnar nerve distribution above the mid forearm for both the right and left arms which, when multiplied by the 7 percent maximum value for ulnar nerve loss, yielded a 3.5 percent (rounded to 4 percent) impairment for each arm.[13] Dr. Cook also calculated that impairment due to grip strength deficit on the right was tested at 34 kilograms for 26 percent strength loss index.[14] With regard to the left, his calculated impairment due to grip strength

[6] *Id*.

[7] *Id*. at 482, 492, Table 16-10, 16-15

[8] *Id*. at 472, Figure 16-34.

[9] *Id.*

[10] *See supra* note 8.

[11] *Id.*

[12] *Id*. at 447, Table 16-5. Dr. Cook noted that he estimated appellant's sensory deficit at 50 percent.

[13] *Id*. at 482, 492, Table 16-10, 16-15. Dr. Cook referenced Table 16-5, page 492; however, this appears to be a typographical error and should be Table 16-5, page 492.

[14] *Id*. at 492, Table 16-32.

deficit was tested at 25 kilograms for a 43 percent strength loss index.[15] Dr. Cook assessed pinch strength and noted that on the right, appellant had a 58 percent strength loss deficit[16] and on the left he assessed a 70 percent strength loss deficit.[17] Using the impairment calculation for pinch strength, he opined that appellant sustained 30 percent arm impairment on both the left and right arm due to loss of grip and pinch strength.[18] He opined that appellant had 30 percent impairment due to weakness combined with 4 percent impairment due to sensory deficit for 33 percent bilateral arm impairment.

In a June 9, 2006 report, the Office medical adviser noted that maximum medical improvement occurred on March 21, 2006. He found that Dr. Cook failed to provide objective medical rationale, supported by the A.M.A., *Guides*, to justify the impairment rating of May 10, 2006. He noted that the variation of impairment from the ratings of Drs. Morgan and Cook was based partly on a difference in interpretation of appellant's symptoms and an inappropriate application of the A.M.A., *Guides.* The medical adviser noted that Dr. Cook erred in using grip strength in determining impairment as this was inconsistent with the procedures set forth in the A.M.A., *Guides*.

On June 13, 2006 the Office consolidated appellant's File No. 12-0158575, accepted for bilateral carpal tunnel syndrome and for which appellant was granted a 10 percent permanent impairment of the right arm and a 10 percent permanent impairment of the left arm and File No. 12-0188726, accepted for left lateral epicondylitis, bilateral epicondylitis and right Achilles heel tendinitis and for which appellant was granted a schedule award for 10 percent "bilateral" arm impairment (7 percent right arm impairment and 3 percent left arm impairment).

In a decision dated June 13, 2006, the Office denied modification of its prior decision. It advised that appellant failed to show that he was entitled to an award greater than previously granted.

On June 19, 2006 appellant requested reconsideration and asserted that Dr. Cook had been his treating physician since 1999 and was the best qualified physician to evaluate his condition. Appellant submitted duplicate reports from Dr. Cook dated January 3, 2001 to May 10, 2006, a duplicate EMG dated July 27, 2005 and duplicate sensory testing performed by an occupational therapist on February 22, 2006.

In a September 22, 2006 decision, the Office denied appellant's reconsideration request on the grounds that his request was insufficient to warrant review of the prior decision.

[15] *Id.*

[16] *Id*. at 509, Table 16-34.

[17] *Id.*

[18] *Id*.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[19] and its implementing regulation[20] set 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.[21]

ANALYSIS -- ISSUE 1

Appellant contends that he is entitled to an additional schedule award for each of his arms. As noted, the Office consolidated File Nos. 12-0158575 and 12-0188726, which pertain to appellant's claims for bilateral carpal tunnel syndrome and bilateral epicondylitis. In File No. 12-0158575, the Office previously granted schedule awards for 10 percent permanent impairment of both the right and left arms. In File No. 12-0188726, the Office previously paid a schedule award for a 10 percent impairment of the "bilateral" upper extremities which was comprised of 7 percent for the right arm and 3 percent for the left arm.[22] Consequently, appellant has received schedule awards for 17 percent impairment of the right arm and 13 percent impairment of the left arm.

The Office referred appellant to Dr. Morgan for an evaluation of his permanent impairment. Dr. Morgan issued a report dated March 21, 2006. However, he found only 4 percent impairment of the right arm and 5 percent impairment of the left arm which does not exceed the 17 percent impairment of the right arm and 13 percent impairment of the left arm previously awarded. Thus, Dr. Morgan's report offers no basis on which an additional schedule award can be made. As to motor deficit, he noted that appellant did not give a full effort on examination which precluded an objective impairment rating.

Dr. Cook stated that appellant sustained a 33 percent permanent impairment of both the right and left arms. However, his report does not offer a proper basis for an increased schedule award. Dr. Cook calculated that appellant had a Grade 3 sensory loss,[23] (50 percent) associated with the ulnar nerve distribution above the mid forearm for both the right and left arms which,

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[19] 5 U.S.C. § 8107.

[20] 20 C.F.R. § 10.404 (1999).

[21] *See id.*; *Jacqueline S. Harris*, 54 ECAB 139 (Docket No. 02-203, issued October 4, 2002).

[22] To the extent that the Office purported to combine impairment for the right and left legs into an award for "bilateral" impairment, the Board notes that there is no provision for bilateral arm impairment under 5 U.S.C. § 8107. Each arm impairment is considered separately under the Act. *Cf. Carl J. Cleary*, 57 ECAB ___ (Docket No. 05-1558, issued May 10, 2006) (each leg impairment is considered separately under the Act; there is no provision for bilateral leg impairment).

[23] *See supra* note 7.

when multiplied by the 7 percent maximum value for ulnar nerve loss, yielded a 3.5 percent (rounded to 4 percent) impairment for each arm.[24] He also calculated that impairment due to loss of grip and pinch strength was 30 percent arm impairment on both the left and right arm.[25] However, the Board notes that the A.M.A., *Guides* do not encourage the use of grip strength as an impairment factor because strength measurements are functional tests influenced by subjective factors that are difficult to control. The A.M.A., *Guides* for the most part is based on anatomic impairment. Only in rare cases should grip strength be used and only when it represents an impairing factor that has not been otherwise considered adequately. The A.M.A., *Guides* state that, otherwise, the impairment ratings based on objective anatomic findings take precedence.[26] Dr. Cook provided no medical opinion explaining why grip strength deficit should be considered in the sensory impairment determination. Moreover he did not address appellant's cooperation on evaluation of this testing, a matter commented upon by Dr. Morgan. Dr. Cook's findings with regard to sensory deficit establish only a 4 percent impairment of both the left and right arm. This rating does not exceed the impairment ratings for each arm which appellant previously received. Therefore, he is not entitled to an additional schedule award based on this report.

The medical adviser who reviewed the reports of Dr. Cook and Dr. Morgan found no basis on which to attribute any greater impairment to either arm.

The Board finds that the medical evidence does not establish that appellant has greater than 17 percent impairment of the right arm and 13 percent impairment of the left arm for which he received schedule awards.

LEGAL PRECEDENT -- ISSUE 2

Under section 8128(a) of the Act,[27] the Office has the discretion to reopen a case for review on the merits. The Office must exercise this discretion in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations,[28] which provides that a claimant may obtain review of the merits of his or her written application for reconsideration, including all supporting documents, sets forth arguments and contain evidence that:

> "(i) Shows that [the Office] erroneously applied or interpreted a specific point of law; or
>
> "(ii) Advances a relevant legal argument not previously considered by the [Office]; or

[24] *Id*.

[25] *Id*.

[26] *See* A.M.A., *Guides*, 16.8 Strength Evaluation, Principles, page 507-08; *Phillip H. Conte*, 56 ECAB ___ (Docket No. 04-1524, issued December 22, 2004).

[27] 5 U.S.C. § 8128(a).

[28] 20 C.F.R. § 10.606(b).

"(iii) Constitutes relevant and pertinent new evidence not previously considered by [the Office]."

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.[29]

ANALYSIS -- ISSUE 2

Appellant's June 19, 2006 request for reconsideration neither alleged nor demonstrated that the Office erroneously applied or interpreted a specific point of law. Additionally, he did not advance a relevant legal argument not previously considered by the Office.

Appellant contended that the Office improperly determined that Dr. Cook erred in calculating his impairment rating and that Dr. Cook was the best qualified physician to evaluate his condition. However, his letter did not show how the Office erroneously applied or interpreted a point of law nor did it advance a point of law or fact not previously considered by the Office. Consequently, appellant is not entitled to a review of the merits of his claim based on the first and second above-noted requirements under section 10.606(b)(2).

With respect to the third requirement, submitting relevant and pertinent new evidence not previously considered, appellant resubmitted reports from Dr. Cook dated January 3, 2001 to May 10, 2006, an EMG dated July 27, 2005 and sensory testing performed by an occupational therapist on February 22, 2006. However, this evidence is duplicative of that already contained in the record and previously considered by the Office. 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.[30] Therefore, these records are insufficient to require the Office to reopen the claim for a merit review.

Appellant neither showed that the Office erroneously applied or interpreted a point of law; advanced a point of law or fact not previously considered by the Office; nor did he submit relevant and pertinent evidence not previously considered by the Office."[31] Consequently, he was not entitled to a review of the merits of his claim pursuant to any of the three requirements under section 10.606(b)(2).

[29] 20 C.F.R. § 10.608(b).

[30] 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; *see Daniel Deparini,* 44 ECAB 657 (1993); *Eugene F. Butler,* 36 ECAB 393, 398 (1984); *Bruce E. Martin,* 35 ECAB 1090, 1093-94 (1984).

[31] 20 C.F.R. § 10.606(b).

CONCLUSION

The Board finds that appellant is not entitled to an additional impairment rating for his upper extremities. The Board further finds that the Office properly denied appellant's request for reconsideration.[32]

ORDER

IT IS HEREBY ORDERED THAT the September 22, June 13 and May 3, 2006 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 23, 2007
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

[32] With his appeal appellant submitted additional evidence. However, the Board may not consider new evidence on appeal; *see* 20 C.F.R. § 501.2(c).