United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 09-162**
	)	**Issued: August 11, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Lexington, KY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 22, 2008 appellant filed a timely appeal of schedule award decisions dated December 19, 2007 and May 15, 2008, by the Office of Workers' Compensation Programs and an August 25, 2008 nonmerit 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 this case.

ISSUES

The issues are: (1) whether appellant sustained permanent impairment of his upper extremities resulting from his accepted employment injuries; and (2) whether the Office properly denied appellant's request for a merit review of his claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On June 5, 2006 appellant, then a 43-year-old mail handler, filed an occupational disease claim alleging that on May 15, 2006 he first became aware of his back pain and that it was caused by his federal employment while lifting tubs out of an all-purpose container, his left arm became numb. Treatment notes dated May 17 to June 14, 2006 of Dr. Benjamin P. Lyon, a

Board-certified internist, diagnosed cervical radiculopathy. By letter dated July 10, 2006, the Office accepted appellant's claim for displacement of cervical intervertebral discs at C3-4, C5-6 and C6-7 and cervical radiculopathy. On July 19, 2007 appellant filed a claim for a schedule award.

By letter dated July 30, 2007, the Office requested that appellant submit a medical report from an attending physician, addressing whether he sustained any permanent impairment to his upper extremities due to his accepted employment injuries based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001).

By letter dated September 4, 2007, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions to be addressed, to Dr. Richard T. Sheridan, a Board-certified orthopedic surgeon, for a second opinion medical examination.[1]

In a September 24, 2007 report, Dr. Sheridan noted appellant's complaints of pain in his neck, both axilla, right greater than left and throughout his left upper extremity. Appellant also complained about popping and grinding in his neck. Dr. Sheridan reviewed a history of his medical and educational background. On physical examination of the cervical spine, he reported preservation of cervical lordosis and no evidence of facial asymmetry, torticollis or webbing of the neck. There were no points of tenderness over the skull, cervical spinous processes, interspinous ligaments or in the paracervical soft tissues. Appellant had full range of motion with 55 degrees of flexion, 50 degrees of extension, 60 degrees of lateral rotation to either side and 30 degrees of lateral flexion to either side. His Spurling, lateral root traction and foraminal encroachment tests were negative for both sides. Appellant had a sebaceous cyst the size of a quarter in the left sternocleidomastoid. There was no evidence of axillary lymphadenopathy or hidradenitis suppurativa in either axilla. On physical examination of the upper extremities, Dr. Sheridan reported full range of motion in the shoulders, elbows, wrists, finger and thumb joints. Appellant's arms measured 11 inches in circumference and his forearms measured 10 inches in circumference. He had a well-healed two-inch scar over the proximal phalanx of the left thumb dorsally. There was a 15-degree varus deformity of the interphalangeal joints of the thumbs. Reflexes were 2+ at the biceps, triceps and brachioradialis. Sensation was normal for light touch and pinwheel pinprick testing. Grip strength with the Jamar dynamometer was 46, 48 and 40 on the right and 25, 28 and 26 on the left. Manipulation, pinch and fine coordination were symmetric.

Dr. Sheridan opined that appellant reached maximum medical improvement on September 24, 2007. He determined that appellant did not sustain any permanent impairment to either upper extremity due to loss of range of motion or from sensory deficit, pain, discomfort or decreased strength (A.M.A., *Guides* 376, 424, Tables 15-15, 15-16 and 15-18).

On September 28, 2007 an Office medical adviser reviewed appellant's medical records including, Dr. Sheridan's September 24, 2007 findings, noting that he reached maximum medical

[1] A September 12, 2007 report of Edwin B. Robbins, a physician's assistant, stated that appellant sustained degenerative disc disease of the lumbar spine, cervical and lumbar radiculitis and myofascial pain syndrome.

improvement as of Dr. Sheridan's examination. The medical adviser opined that appellant had no impairment of the right and left upper extremities based on the A.M.A., *Guides.*

By decision dated October 4, 2007, the Office denied appellant's claim for a schedule award. It found that the medical evidence established that he did not sustain any permanent impairment to his upper extremities.

On November 2, 2007 appellant requested reconsideration. In a medical report, Dr. Phillip A. Tibbs, a Board-certified neurosurgeon, stated that appellant was evaluated on August 22, October 25 and November 22, 2006. He advised that appellant reached maximum medical improvement on May 15, 2006. Dr. Tibbs determined that appellant sustained a 5 percent impairment due to sensory deficit and a 10 percent impairment due to decreased strength of the left upper extremity.

Reports dated October 16 and November 20, 2007, noted that appellant received cervical epidural steroid injections for his cervical radiculitis.

By decision dated December 19, 2007, the Office denied modification of the October 4, 2007 decision. It found that Dr. Sheridan's opinion constituted the weight of the medical evidence in finding that appellant did not sustain any upper extremity impairment.

A January 7, 2008 report stated that appellant received a cervical epidural steroid injection.

By letter dated March 14, 2008, appellant requested reconsideration of the Office's December 19, 2007 decision. In a March 12, 2008 report, Dr. Tibbs stated that a magnetic resonance imaging (MRI) scan showed no specific progression of degenerative disc disease or acute herniation in the cervical spine, although there was some foraminal stenosis at several levels. On physical examination, he reported symmetrical reflexes and good strength. Dr. Tibbs continued a conservative course of therapy.

On April 29, 2008 a second Office medical adviser reviewed appellant's medical record, noting that he had not yet reached maximum medical improvement. The medical adviser stated that appellant experienced neck pain radiating to his left arm with numbness. MRI scans showed disc osteophyte complex lateralizing to the left at C3-4. The medical adviser further stated that Dr. Tibbs' March 12, 2008 report recommended continued conservative treatment including, epidural steroid injections, which had so far provided temporary relief to appellant. The medical adviser stated that additional evidence was required to properly rate appellant's impairment based on the A.M.A., *Guides*.

In a May 15, 2008 decision, the Office denied modification of the December 19, 2007 decision. It found that the Office medical adviser's April 29, 2008 opinion established that appellant did not sustain any permanent impairment of either upper extremity based on the A.M.A., *Guides*.

Appellant submitted duplicate copies of reports regarding his cervical epidural steroid injections and from Dr. Witt and Mr. Robbins and Dr. Lyon.

In a June 11, 2008 report, Dr. Tibbs noted appellant's continuing employment-related cervical conditions and pain and numbness in his arms. On physical examination, he reported essentially normal findings with the exception of decreased range of motion in the lower back. Dr. Tibbs discussed performing a myelogram and surgery if the myelogram confirmed foraminal stenosis or root entrapment. He opined that appellant had not reached maximum medical improvement. In a June 12, 2008 physician outpatient order, Dr. Tibbs scheduled a cervical examination on July 9, 2008. In a July 9, 2008 report, he provided findings on physical examination. Dr. Tibbs reported minimal weakness in the left upper extremity and both biceps, triceps and anterior intrinsics which seemed to be overlaid by pain. Reflexes were symmetrical at 1/4. Sensation was decreased in the left C7 distribution and there was abnormal formation of both thumbs on the left more than the right. Dr. Tibbs stated that a cervical myelogram and computerized tomography (CT) scan showed some foraminal stenosis to the left at C5-6.

On August 11, 2008 appellant requested reconsideration of the Office's May 15, 2008 decision.

By decision dated August 25, 2008, the Office denied appellant's request for reconsideration on the grounds that the evidence submitted was cumulative and immaterial in nature and, thus, insufficient to warrant a merit review of its prior decisions.[2]

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] 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 of loss of use.[5] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[6]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for displacement of cervical intervertebral discs at C3-4, C5-6 and C6-7 and cervical radiculopathy. Appellant contends that he is entitled to a schedule award for permanent impairment to his upper extremities. The Board, however, finds

[2] On appeal, appellant has submitted additional evidence. The Board may not consider evidence for the first time on appeal which was not before the Office at the time it issued the final decision in the case. 20 C.F.R. § 10.501.2(c). Appellant can submit this evidence to the Office and request reconsideration. 5 U.S.C. § 8128; 20 C.F.R. § 10.606.

[3] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.404.

[5] 5 U.S.C. § 8107(c)(19).

[6] *See supra* note 4.

that he has not established that he has sustained any permanent impairment to his upper extremities due to his accepted cervical conditions.

Dr. Tibbs opined that appellant sustained a 5 percent impairment of the left upper extremity due to sensory deficit, as well as a 10 percent impairment due to decreased strength. However, he did not address how his injury was based on the A.M.A., *Guides*. As Dr. Tibbs did not provide an impairment rating based on the A.M.A., *Guides*, his impairment estimate is of diminished probative value and insufficient to establish that appellant sustained any permanent impairment of the upper extremities.

Dr. Sheridan, an Office referral physician, found no objective basis for an impairment rating for the right or left upper extremity under the A.M.A., *Guides*. On physical examination of the cervical spine, he reported essentially normal findings which included preservation of cervical lordosis and no evidence of facial asymmetry, torticollis or webbing of the neck. Dr. Sheridan found no points of tenderness over the skull, cervical spinous processes, interspinous ligaments or in the paracervical soft tissues. He reported full range of motion with 55 degrees of flexion, 50 degrees of extension, 60 degrees of lateral rotation to either side and 30 degrees of lateral flexion to either side. Dr. Sheridan further reported negative Spurling, lateral root traction and foraminal encroachment tests for both sides. He found a sebaceous cyst the size of a quarter in the left sternocleidomastoid. Dr. Sheridan did not find any evidence of axillary lymphadenopathy or hidradenitis suppurativa in either axilla. He reported essentially normal findings on physical examination of the upper extremities which included full range of motion in the shoulders, elbows, wrists, finger and thumb joints. Dr. Sheridan stated that appellant's arms measured 11 inches in circumference and his forearms measured 10 inches in circumference. He reported a well-healed two-inch scar over the proximal phalanx of the left thumb dorsally and a 15-degree varus deformity of the interphalangeal joints of the thumbs. Dr. Sheridan stated that reflexes were 2+ at the biceps, triceps and brachioradialis. He also stated that sensation for light touch and pinwheel pinprick testing was normal. Dr. Sheridan reported that grip strength was 46, 48 and 40 on the right and 25, 28 and 26 on the left. Lastly, he reported symmetric manipulation, pinch and fine coordination.

Dr. Sheridan opined that appellant reached maximum medical improvement on September 24, 2007. He concluded that appellant did not sustain any permanent impairment to either upper extremity due to loss of function from sensory deficit, pain, discomfort or decreased strength (A.M.A., *Guides* 376, 424, Tables 15-15, 15-16 and 15-18). Dr. Sheridan properly applied the A.M.A., *Guides* and provided rationale for finding that appellant did not sustain any impairment of the upper extremities. His opinion is supported by an Office medical adviser's September 28, 2007 report. An Office medical adviser reviewed Dr. Sheridan's findings and opined that there was no objective basis for an impairment rating for appellant's upper extremities under the A.M.A., *Guides*. The medical adviser determined that he sustained a zero percent impairment each of the right and left upper extremities.

In an April 29, 2008 report, a second Office medical adviser reviewed appellant's case record. He stated that he had not yet attained maximum medical improvement based on his continuing neck pain radiating to his left arm with numbness, MRI scans which showed disc osteophyte complex lateralizing to the left at C3-4 and Dr. Tibbs' continued conservative treatment plan. The second Office medical adviser recommended obtaining additional medical

evidence. However, he did not provide any explanation of the findings by Dr. Sheridan who opined that maximum medical improvement had been reached.

Dr. Sheridan and the first Office medical adviser provided sufficient medical rationale in determining that appellant does not have any impairment of his upper extremities. The Board finds that the opinions of Dr. Sheridan and the first Office medical adviser represent the weight of the medical evidence of record. Appellant is not entitled to a schedule award for his upper extremities.

LEGAL PRECEDENT -- ISSUE 2

To require the Office to reopen a case for merit review under section 8128 of the Act,[7] the Office's regulations provide that a claimant must: (1) show that the Office erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by the Office; or (3) constitute relevant and pertinent new evidence not previously considered by the Office.[8] To be entitled to a merit review of an Office decision denying or terminating a benefit, a claimant also must file his or her application for review within one year of the date of that decision.[9] When a claimant fails to meet one of the above standards, the Office will deny the application for reconsideration without reopening the case for review of the merits.

ANALYSIS -- ISSUE 2

On August 11, 2008 appellant disagreed with the Office's May 15, 2008 decision, finding that he was not entitled to a schedule award for his upper extremities. The relevant issue in the case is whether he has established any permanent impairment of the upper extremities, causally related to the accepted employment injuries.

Appellant submitted duplicate copies of the cervical and lumbar epidural steroid injection reports covering the period July 10, 2007 to January 7, 2008, Dr. Witt's July 10, 2007 report, Dr. Lyon's May 17 to June 14, 2006 treatment notes and Mr. Robbins' September 12, 2007 report. This evidence was previously of record and addressed by the Office in its prior decisions and, thus, does not constitute a basis for reopening appellant's claim for merit review.[10]

Dr. Tibbs' June 11, 2008 report noted appellant's continuing cervical symptoms and provided his essentially normal findings on physical examination. He opined that appellant had not reached maximum medical improvement and ordered a myelogram to confirm the diagnosis of foraminal stenosis or root entrapment. Dr. Tibbs' June 12, 2008 physician outpatient order stated that appellant was scheduled for a cervical examination on July 9, 2008. His July 9, 2008

[7] 5 U.S.C. §§ 8101-8193. Under section 8128 of the Act, the Secretary of Labor may review an award for or against payment of compensation at any time on her own motion or on application. 5 U.S.C. § 8128(a).

[8] 20 C.F.R. § 10.606(b)(1)-(2).

[9] *Id.* at § 10.607(a).

[10] *James W. Scott*, 55 ECAB 606, 608 n.4 (2004); *Freddie Mosley*, 54 ECAB 255 (2002).

report provided appellant's physical examination findings which included minimal weakness in the left upper extremity and both biceps, triceps and anterior intrinsics, which seemed to be overlaid by pain. Dr. Tibbs reported symmetrical reflexes at 1/4, decreased sensation in the left C7 distribution and abnormal formation of both thumbs on the left more than the right. He stated that a cervical myelogram and CT scan demonstrated some foraminal stenosis to the left at C5-6. The August 14, 2007 report stated that appellant received a lumbar epidural steroid injection. The Board has held that the submission of evidence which does not address the particular issue involved in the case does not constitute a basis for reopening the claim.[11] The evidence submitted did not address the relevant issue of whether appellant sustained permanent impairment of the upper extremities based on the A.M.A., *Guides*, causally related to the accepted employment conditions. The Board finds that this evidence does not constitute a basis for reopening appellant's claim for merit review; therefore, the Office properly denied appellant's reconsideration request.

The evidence submitted by appellant did not show that the Office erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by the Office or constitute relevant and pertinent new evidence not previously considered by the Office. As appellant did not meet any of the necessary regulatory requirements, the Board finds that he is not entitled to further merit review.[12]

CONCLUSION

The Board finds that appellant is not entitled to a schedule award for his upper extremities resulting from his accepted employment injuries. The Board also finds that the Office properly denied his request for a merit review of his claim pursuant to 5 U.S.C. § 8128(a).

[11] *D. Wayne Avila*, 57 ECAB 642 (2006).

[12] *See* 20 C.F.R. § 10.608(b); *Richard Yadron*, 57 ECAB 207 (2005).

ORDER

IT IS HEREBY ORDERED THAT the August 25 and May 15, 2008 and December 19, 2007 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 11, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board