United States Department of Labor
Employees' Compensation Appeals Board

M.O., Appellant	)	
and	)	**Docket No. 08-2001**
	)	**Issued: March 12, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Newark, NJ, Employer	)	

Appearances:
James D. Muirhead, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 14, 2008 appellant filed an appeal of a nonmerit June 2, 2008 decision of the Office of Workers' Compensation Programs denying her request for reconsideration and December 10, 2007 and May 14, 2008 merit decisions concerning a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits and the nonmerit issue in this case.

ISSUES

The issues are: (1) whether appellant has more than a five percent impairment of the left upper extremity and more than a five percent impairment of the right upper extremity, for which she received schedule awards; and (2) whether the Office properly refused to reopen appellant's claim for merit review pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On March 4, 1999 appellant, then a 39-year-old letter carrier, filed a claim for carpal tunnel syndrome, which she alleged was due to her federal employment. The Office accepted

the claim for bilateral carpal tunnel syndrome. It paid appropriate benefits, including left carpal tunnel release, which appellant underwent March 2001. In May 2004, appellant was placed in a nonfederal position. By decision dated August 25, 2005, the Office determined that appellant's employment with the Hackensack University Medical Center as a medical assistant represented her wage-earning capacity.

On August 22, 2006 appellant filed a claim for a schedule award. In a November 9, 2005 medical report, Dr. David Weiss, an osteopath, noted that appellant had positive Tinel's sign, positive Phalen's sign and positive compression test for both the left and right wrists as well as diminished light touch sensibility over the median nerve distribution in the right and left hands. Grip strength testing via Jamar hand dynamometer at Level 3 revealed 18 kilograms (kg) on both the right and left sides. Pinch key unit measured 4 kg on the right versus 5 kg on the left. Semmes-Weinstein monofilament testing revealed a diminished light touch sensibility at 2.83 milligrams over the median nerve distribution in both the right and left hand. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Weiss opined that appellant sustained 31 percent right arm impairment and 13 percent left arm impairment. The 31 percent right arm impairment was comprised of 10 percent impairment for a Grade 4 in the right median nerve,[1] 20 percent right lateral pinch deficit[2] and 3 percent for pain.[3] The 13 percent left upper extremity impairment was comprised of 10 percent impairment for a Grade 4 in the left median nerve[4] and 3 percent pain.[5] Dr. Weiss concluded that appellant reached maximum medical improvement on November 9, 2005.

On September 27, 2006 an Office medical adviser reviewed appellant's case record. He opined that Dr. Weiss utilized a nonstandard Semmes-Weinstein method for determining sensory loss under the A.M.A., *Guides* and recommended reexamination to obtain an accurate reading.

By letter dated April 27, 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. Harold H. Alexander, a Board-certified orthopedic surgeon, for a second opinion examination. In a May 14, 2007 medical report, Dr. Alexander stated that his examination findings indicated no atrophy with intact pinprick sensation and full range of motion with normal grip strength. He opined that appellant sustained 11 percent impairment for each hand under Tables 15-15 and 15-16 of the A.M.A., *Guides*. For the left side, Dr. Alexander opined that appellant had a Grade 4 sensory deficit under Table 15-15, which would amount to a 10 percent sensory impairment. He found that appellant had a Grade 4 or 20 percent bilateral motor deficit under Table 15-16 on page 424, which, when multiplied by the maximum percent loss of function for the appropriate nerve root at Table 15-17 resulted in a 7 percent motor deficit on the right

[1] A.M.A., *Guides* 482, Table 16-10 and 492, Table 16-15.

[2] *Id*. at 509, Tables 16-33 and 16-34.

[3] *Id*. at 574, Figure 18-1.

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

[5] *Id*. at 574, Figure 18-1.

and 7 percent motor deficit on the left. Dr. Alexander also advised that under page 424 and the same charts, appellant had one percent sensory deficit bilaterally. He indicated that this would give her a combined motor sensory deficit of 11 percent for each hand.

On August 2, 2007 an Office medical adviser reviewed appellant's case record and concluded that clarification was needed to find out how Dr. Alexander determined the impairment rating. He noted that Dr. Alexander used the tables for nerve root impairment although the medical examination revealed no atrophy, intact pin prick sensation, full range of motion and normal grip strength. The Office medical adviser indicated that the impairment assessment should have been calculated using the instructions for carpal tunnel syndrome conditions on page 495 of the A.M.A., *Guides.* He noted that appellant's impairment applied to scenario number 2 on page 495 of the A.M.A., *Guides,* which would entitle her to a five percent impairment for carpal tunnel syndrome for each upper extremity.

On August 24, 2007 Dr. Alexander reviewed the Office medical adviser's comments and agreed that a rating of 5 percent impairment for each upper extremity was warranted. On August 28, 2007 another Office medical adviser concurred with the impairment assessment of five percent impairment for each upper extremity.

A copy of appellant's February 17, 1999 electrodiagnostic studies of the upper extremities were submitted. Such testing revealed moderate to severe sensorimotor median neuropathies at the wrists, left greater than right (carpal tunnel syndrome).

By decision dated December 10, 2007, the Office granted appellant a schedule award for five percent impairment of the right arm and five percent impairment of the left arm. The period of the award ran from September 9, 2005 to April 15, 2006.

Appellant requested a review of the written record by an Office hearing representative. In a January 17, 2008 letter, appellant's attorney noted that the Office put appellant out on disability because there was no work for her. He referenced Dr. Weiss' experience and familiarity with the A.M.A., *Guides* and referred to Dr. Alexander's and Dr. Weiss' disability assessments.

By decision dated May 14, 2008, an Office hearing representative affirmed the Office's December 10, 2007 schedule award.

In a May 22, 2008 letter, appellant's attorney requested reconsideration. He noted Dr. Alexander's and Dr. Weiss' disability assessments and reiterated appellant was removed from federal employment due to her severe carpal tunnel syndrome.

By decision dated June 2, 2008, the Office denied appellant's request for reconsideration finding that she did not submit new and relevant evidence or legal argument in support of her claim.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulations[7] 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.[8] 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.[9]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides:

> "If, after 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 [carpal tunnel syndrome] 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 [electromyogram] testing of the thenar muscles: a residual [carpal tunnel syndrome] is still present and an impairment rating not to exceed five 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."[10]

The Board has found that, in accordance with the fifth edition of the A.M.A., *Guides*, impairment arising from carpal tunnel syndrome should be rated on motor and sensory deficits only.[11] The A.M.A., *Guides* provides that, in compression neuropathies, additional impairment

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[6] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[7] 20 C.F.R. § 10.404.

[8] 5 U.S.C. § 8107(c)(19).

[9] *See supra* note 7.

[10] A.M.A., *Guides* 495; *Silvester DeLuca*, 53 ECAB 500 (2002).

[11] *Id.* at 494; *Robert V. Disalvatore*, 54 ECAB 351 (2003).

values are not given for decreased motion in the absence of a complex regional pain syndrome.[12] Carpal tunnel syndrome is an entrapment/compression neuropathy of the median nerve.[13]

ANALYSIS -- ISSUE 1

The Office granted appellant a schedule award for five percent impairment of the right upper extremity and five percent impairment of the left upper extremity due to her employment-related bilateral carpal tunnel syndrome. On appeal, appellant contends that she is entitled to greater than the schedule award received.

Dr. Weiss provided an impairment rating on November 9, 2005. In considering an impairment rating for the right and left upper extremities, he included separate ratings for sensory deficit in the median nerve, lateral pinch deficit and pain. The A.M.A., *Guides* indicates that only sensory and motor deficits are to be considered when rating impairment due to carpal tunnel syndrome.[14] As noted, appellant underwent surgery to correct the carpal tunnel syndrome on the left side and the right side was treated nonsurgically. For the left side, Dr. Weiss provided a rating for sensory deficit in the median nerve, but did not explain how or why Table 16-10 applied as opposed to the scenarios present after surgical decompression as listed on page 495 of the A.M.A., *Guides*. He also provided a pain-related impairment under Chapter 18 of the A.M.A., *Guides* for the left side.[15] The Board notes, however, that the Office has advised its staff that Chapter 18 is generally not to be used.[16] The A.M.A., *Guides* warns that examiners should not use Chapter 18 to rate pain-related impairment for any condition that can be adequately rated on the basis of the body and organ impairment rating systems given in the other chapters.[17] Dr. Weiss did not adequately explain how any sensory impairment to appellant's left arm was not adequately addressed under the other Chapters of the A.M.A., *Guides* or how her condition came within one of the several situations identified under Chapter 18.3a.[18]

For the right arm, he provided an impairment rating for sensory deficit in the median nerve, lateral pinch deficit and pain. However, Dr. Weiss did not sufficiently explain how he calculated 10 percent sensory deficit in the median nerve on the right side or provide any explanation of how or why an additional impairment for pain was necessary. The Board notes

[12] *Id.* at 494; *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); *Kimberly M. Held*, 56 ECAB 670 (2005).

[13] *Id*. at 492.

[14] *See supra* note 11.

[15] *See* A.M.A., *Guides* 573.

[16] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 Exhibit 4 (November 2002).

[17] A.M.A., *Guides* 571.

[18] Section 18.3a of the A.M.A., *Guides* provides that a pain-related impairment can be rated when there is excess pain in the context of a verifiable medical condition that causes pain, when there are well-established pain syndromes without significant identifiable organ dysfunction to explain the pain and when there are other associated pain syndromes. *Id*. at 570.

that Office procedures provide that grip or pinch strength should not be used to calculate upper extremity impairment caused by a compression neuropathy such as carpal tunnel syndrome.[19] Additionally, the Office medical adviser who reviewed Dr. Weiss' report found that the physician did not use the standard Semmes-Weinstein method for determining sensory loss under the A.M.A., *Guides.* Therefore, the Board finds that Dr. Weiss' total impairment ratings are insufficient to form the basis for a schedule award for either upper extremity.

In his May 14, 2007 report, Dr. Alexander provided an impairment rating for the right and left upper extremities based on sensory and motor deficits arising from unilateral spinal nerve root, which affects the upper extremity under Tables 15-15, 15-16 and 15-17 of the A.M.A., *Guides.* However, he failed to identify the impaired nerve root or provide a clear description of how his calculations resulted in 11 percent impairment for both the right and left sides. Additionally, Dr. Alexander failed to explain why Tables 16-10 and 16-11, which relate to impairment relating from peripheral nerve disorders or Table 16-15, which notes the maximum impairment allowed for the median nerve, were not used. The Office medical adviser who reviewed Dr. Alexander's report correctly noted that the physician's impairment rating did not comport to the medical examination findings, which revealed no atrophy, intact pin prick sensation, full range of motion and normal grip strength. As Dr. Alexander did not adequately explain his impairment rating, the Office properly provided him an opportunity to explain his impairment findings under the A.M.A., *Guides*.[20]

In his August 24, 2007 report, Dr. Alexander rated impairment of both the right and left upper extremities as five percent for appellant's accepted bilateral carpal tunnel syndrome pursuant to 16.5d entrapment/compression neuropathy, carpal tunnel syndrome, page 495, of the A.M.A. *Guides*. As noted, however, the scenarios presented at page 495 pertain to individuals who have undergone surgical decompression. Appellant underwent surgery to correct her carpal tunnel syndrome on the left side, not on the right side. Thus, the method for determining residual impairment due to carpal tunnel syndrome postsurgery is only applicable for the left upper extremity in this case. In this case, there is no other evidence to indicate a greater impairment than the five percent left upper extremity impairment awarded appellant.

As appellant did not undergo surgery to correct her right carpal tunnel symptoms, the schedule award for carpal tunnel syndrome for the right upper extremity in this case should be based on motor and sensory impairments.[21] Dr. Alexander, in his May 14, 2007 report, did not use provisions in Chapter 16 of the A.M.A., *Guides* for rating motor and sensory impairments and his August 24, 2007 supplemental report provided no rationale for his five percent impairment rating or why he evaluated appellant's right upper extremity under the scenarios presented at page 495 of the A.M.A., *Guides* that pertain to surgical decompression. Therefore, he did not properly address whether appellant's right carpal tunnel syndrome resulted in motor or sensory impairment. Because Dr. Alexander's rating of permanent impairment for the right arm

[19] *See supra* note 16.

[20] *See Robert Kirby*, 51 ECAB 474 (2000); *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); *Richard W. Kinder*, 32 ECAB 863, 866 (1981) (where the Board found that the report of the Office referral physician did not resolve the issue in the case).

[21] A.M.A., *Guides* 494-95; *see E.L.*, 59 ECAB ___ (Docket No. 07-2421, issued March 10, 2008).

does not conform to the standards adopted by the Office, it is of diminished probative value. The Board will set aside the Office's December 10, 2007 decision in part and remand the case for proper development of the medical evidence pertaining to appellant's right arm. After such further development as may be required, the Office shall issue an appropriate final decision on appellant's entitlement to schedule award compensation for the right upper extremity.

LEGAL PRECEDENT -- ISSUE 2

Section 8128(a) of the Act vests the Office with discretionary authority to determine whether it will review an award for or against compensation, either under its own authority or on application by a claimant.[22] Section 10.606(b)(2) of Office regulations provide that a claimant may obtain review of the merits of the claim by either: (1) showing that the Office erroneously applied or interpreted a specific point of law; (2) advancing a relevant legal argument not previously considered by the Office; or (3) constituting relevant and pertinent new evidence not previously considered by the Office.[23] Section 10.608(b) provides that when an application for reconsideration does not meet at least one of the three requirements enumerated under section 10.606(b)(2), the Office will deny the application for reconsideration without reopening the case for a review on the merits.[24] The Board has held that the submission of evidence which does not address the particular issue involved does not comprise a basis for reopening a case.[25] Likewise, it is well established that evidence which repeats or duplicates that already of record does not constitute a basis for reopening a case for merit review.[26]

ANALYSIS -- ISSUE 2

As noted above, appellant has not established that she has greater than the five percent impairment to her left upper extremity. On reconsideration, she contended that the Office considered her disabled and unable to work in her date-of-injury position. Disability, however, is a separate determination from impairment, which is at issue in this case.[27] Thus, appellant's argument pertaining to disability is irrelevant to the issue in this case. Her contention does not represent an argument that the Office erroneously applied a point of law or a new relevant legal argument. Moreover, appellant did not submit any medical evidence relevant to the issue of the

[22] 5 U.S.C. § 8128(a).

[23] 20 C.F.R. § 10.606(b)(2).

[24] *Id.* at § 10.608(b).

[25] *Joseph A. Brown, Jr.*, 55 ECAB 542 (2004).

[26] *See Arlesa Gibbs*, 53 ECAB 204 (2001).

[27] The term disability is defined as an inability, due to an employment injury, to earn the wages the employee was receiving at the time of the injury, *i.e.*, an impairment resulting in loss of wage-earning capacity. *See S.F.*, 59 ECAB ___ (Docket No. 08-426, issued July 16, 2008); *Prince E. Wallace*, 52 ECAB 357 (2001). Disability is thus not synonymous with physical impairment, which may or may not result in an incapacity to earn wages. An employee who has a physical impairment causally related to a federal employment injury, but who nevertheless has the capacity to earn the wages he or she was receiving at the time of injury, has no disability as that term is used in the Act. *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

extent of permanent impairment of the left upper extremity. She did not meet any of the requirements for reopening her case for merit review under section 10.606(b)(2). The Office properly denied further consideration of appellant's case on the merits.[28]

CONCLUSION

The Board finds this case is not in posture for decision regarding appellant's entitlement to a schedule award for her right upper extremity. With respect to the left upper extremity, the Board finds that appellant has no more than five percent impairment and that the Office properly denied her request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs decision dated June 2, 2008 is affirmed and the May 14, 2008 and December 10, 2007 decisions are affirmed in part and set aside in part and the case remanded for further action consistent with this decision.

Issued: March 12, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[28] As noted in the analysis of issue one, appellant will receive a merit review regarding her entitlement to a schedule award for her right upper extremity.