United States Department of Labor
Employees' Compensation Appeals Board

T.M., Appellant	)	
and	)	**Docket No. 08-964**
	)	**Issued: September 15, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 14, 2008 appellant, filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated July 10, 2007 and a nonmerit decision dated February 4, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit and nonmerit issues of this case.

ISSUES

The issues are: (1) whether appellant has more than 12 percent impairment of each of her upper extremities for which she has received schedule awards; and (2) whether the Office properly refused to reopen her case for further consideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

This case has previously been before the Board on appeal on three occasions. On October 28, 1992 appellant, then a 34-year-old mail processor, filed an occupational disease claim alleging that she developed right carpal tunnel syndrome due to factors of her federal

employment. Her occupational disease claim was expanded to include bilateral carpal tunnel syndrome and she underwent a right carpal tunnel release on April 13, 1993 and left carpal tunnel release on January 31, 1995.

On October 21, 1997 the Office granted appellant a schedule award for 10 percent impairment each of her upper extremities due to this condition. The Branch of Hearings and Review affirmed this decision on July 27, 1998 and by decision dated November 21, 2001,[1] the Board found that appellant had established no more than 10 percent impairment of her upper extremities due to her accepted conditions.

On February 13, 2002 appellant filed an occupational disease claim alleging that she had developed bilateral brachial plexopathy, bilateral radial neuropathy and bilateral ulnar nerve neuropathy due to her employment duties. The Office denied this claim by decision dated May 2, 2002 finding that it was not timely filed. Appellant requested an oral hearing and by decision dated March 11, 2003, the hearing representative affirmed the Office's May 2, 2002 decision. She appealed this decision to the Board and by decision dated March 15, 2004;[2] the Board found that her claim was not timely filed.

On January 11, 2002 and November 26, 2003 appellant requested reconsideration of the Board's November 21, 2001 decision. By decision dated February 24, 2004, the Office declined to reopen her claim for consideration of the merits on the grounds that her request for reconsideration was not timely filed and did not establish clear evidence of error on the part of the Office. By decision dated May 9, 2005,[3] the Board found that appellant's January 11, 2002 request for reconsideration was timely filed and remanded the claim for additional development. The facts and the circumstances of the case as set out in the Board's prior decisions are adopted herein by reference.

In a report dated June 26, 2003, Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, provided his findings and opined that appellant had 10 percent impairment of the upper extremities due to bilateral carpal tunnel syndrome. He also found that appellant had two percent impairment bilaterally due to ulnar neuropathy and an additional one percent impairment due to loss of motion in the shoulder. Dr. Mandel also found that appellant had loss of motion of the cervical spine. He concluded that appellant had reached maximum medical improvement.

Dr. David Weiss, an osteopath and a Board-certified orthopedic surgeon, provided an additional report on July 21, 2003 diagnosing bilateral brachial plexopathy based on repeat electromyogram (EMG) scan and nerve conduction velocity (NCV) testing, bilateral ulnar nerve neuropathy and bilateral radial neuropathy. He noted appellant's range of motion as left shoulder forward elevation of 160 degrees, abduction of 140 degrees, adduction of 65 degrees, external rotation of 80 degrees. Dr. Weiss found that appellant had a positive Tinel's sign over the cubital and radial tunnels. In regard to appellant's right upper extremity, he found 160

[1] Docket No. 99-1462 (issued November 21, 2001).

[2] Docket No. 04-210 (issued March 15, 2004).

[3] Docket No. 04-990 (issued May 9, 2005).

degrees of shoulder forward elevation, abduction of 160 degrees and adduction of 45 degrees and external rotation of 80 degrees. Dr. Weiss found thenar atrophy and flattening in the left hand and bilaterally positive Tinel's and Phalen's signs at the wrists. He reported sensory deficit over T2-1 and C5 dermatomes on the right and C5-6 sensory deficits on the left. Dr. Weiss concluded that appellant had 53 percent impairment on the left and 37 percent impairment on the right.

By decision dated February 3, 2006, the Office accepted appellant's claim for the additional conditions of bilateral brachial plexus lesions, lesion of the ulnar nerve on the left and lesion of the radial nerve on the right and left. It referred appellant's claim to the Office medical adviser for calculation of a schedule award based on the accepted conditions. In a report dated February 13, 2006, Dr. Morley Slutsky, the Office medical adviser, stated that appellant's final right upper extremity impairment was 12 percent and her final left upper extremity impairment was 12 percent. He stated that his conclusions were based on three percent impairment rating examinations on December 30, 1996, June 26 and July 21, 2003 from Drs. Weiss and Mandel. Dr. Slutsky relied on Dr. Mandel's report for the impairment of the upper extremity due to sensory and motor deficits of the median nerve caused by carpal tunnel syndrome to reach 10 percent impairment. He also agreed with Dr. Mandel that appellant had two percent impairment of the upper extremities due to ulnar neuropathy. Dr. Slutsky combined the impairment ratings for the ulnar neuropathy and carpal tunnel syndrome to reach 12 percent impairment of each upper extremity. He noted that Dr. Mandel found mildly reduced flexion and abduction of the shoulder but concluded that this was not part of the accepted conditions.

The Office granted appellant a schedule award for an additional two percent impairment of each of her upper extremities on July 19, 2006. Appellant requested an oral hearing on July 21, 2006. She testified at the oral hearing on December 12, 2006 and requested that her schedule award be evaluated under the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Appellant also alleged that she had preexisting cervical condition which should be considered in the schedule award evaluation of her upper extremities. By decision dated March 1, 2007, the hearing representative set aside the Office's July 19, 2006 decision noting that appellant's preexisting congenital spinal conditions should not be considered, but Dr. Slutsky failed to consider the brachial plexopathy condition and any resulting impairment.

In a report dated March 15, 2007, Dr. Slutsky opined that appellant had no additional permanent impairment due to her brachial plexopathy. He found that the record did not contain consistent physical evidence of clinically significant brachial plexopathy and that appellant was not entitled to an impairment rating for this condition. Dr. Slutsky stated that there would have to be consistent physical evidence of deficits to multiple cervical nerve roots as this would reflect clinical support of the presence of significant brachial plexopathy.

By decision dated March 22, 2007, the Office denied appellant's claim for an additional schedule award. Appellant requested reconsideration on March 26, 2007 and argued that all conditions affecting her arms should have been considered in calculating her increased schedule awards. She submitted a report dated April 25, 2007 from Dr. Mandel noting her accepted condition as thoracic outlet syndrome, bilateral radial and left ulnar neuropathy and brachial plexopathy. Dr. Mandel diagnosed bilateral carpal tunnel syndrome, bilateral ulnar and radial neuropathies as well as bilateral brachial plexopathy and cervical disease. He stated that

appellant had 35 percent impairment of the left upper extremity and 35 percent impairment of the right upper extremity "based on a shoulder impairment of 3 percent (Fig[ure] 16-40, p.476), loss of grip impairment of 20 percent (Table 16-32 and 16-34, p.509), brachial plexus impairment of 5 percent (Table16-10, p.482 and 16-14, p.490), a median nerve impairment of 5 percent and a radial nerve impairment of 2 percent (Table 16-15, p.492 and 16-10, p.482)."

The Office referred Dr. Mandel's report to the Office medical adviser. Dr. Slutsky reviewed the evidence on July 7, 2007 and found that based on Dr. Mandel's report appellant had no clinical evidence of carpal tunnel syndrome. He disagreed with Dr. Mandel's grip strength assessments as he did not identify the pathologic basis for appellant's strength loss, did not discuss how he performed the grip strength testing and did not show his calculations which led to the 20 percent impairment rating. Dr. Slutsky also found that he could not confirm Dr. Mandel's impairment for brachial plexopathy as he did not document testing for light touch, two point discrimination and protective sensibility. He disagreed with Dr. Mandel's rating for radial nerve deficits as he failed to document physical examination testing for radial nerve dysfunction. Dr. Slutsky found that appellant had two percent impairment bilaterally due to ulnar nerve impairment and one percent due to loss of shoulder abduction for a total impairment rating of three percent bilaterally. By decision dated July 10, 2007, the Office denied modification of its prior decision.

Appellant requested reconsideration on July 24, 2007. She submitted a report dated August 13, 2007 from her attending physician Dr. Scott Fried, an osteopath, reporting his findings on examination including positive Phalen's testing from dysesthesias in the median nerve distribution bilaterally, positive Tinel's signs in the medial, ulnar and radial nerves as well as sympathetic reactivity with color changes in the hands and vascular instability. Dr. Fried also reported positive Roos and Hunter testing indicating inflammation and scarring about the nerves of the brachial plexus at the thoracic outlet level. He diagnosed radial neuropathy on the right, medial neuropathy bilaterally, ulnar neuropathy left and radial neuropathy on the left as well as brachial plexopathy/cervical radiculopathy, Budd Chiari malformation of the cervical spine, sympathetically mediated pain syndrome and capsulitis of the left shoulder. By decision dated February 4, 2008, the Office denied appellant's request for reconsideration on the grounds that she failed to submit relevant new evidence addressing her permanent impairment for schedule award purposes.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[4] and its implementing regulations[5] 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

implementing regulations as the appropriate standard for evaluating schedule losses.[6] Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[7]

A schedule award is not payable for a member, function or organ of the body not specified in the Act or in the implementing regulations. As neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back, no claimant is entitled to such an award.[8] However, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[9]

ANALYSIS -- ISSUE 1

The Office has accepted appellant's claim for bilateral carpal tunnel syndrome and bilateral carpal tunnel releases, bilateral brachial plexus lesions, lesion of the ulnar nerve on the left and lesion of the radial nerve on the right and left. The record also establishes that appellant has a preexisting congenital cervical condition of Budd Chiari malformation of the cervical spine. Appellant has received schedule awards totaling 24 percent impairment of the upper extremities due to these conditions.

On June 26, 2003 Dr. Mandel, a Board-certified orthopedic surgeon, found that appellant had 10 percent impairment due to carpal tunnel syndrome, 2 percent due to ulnar neuropathy and 1 percent impairment of each upper extremity due to loss of range of motion. Dr. Slutsky found that appellant had 12 percent impairment of each upper extremity due to bilateral carpal tunnel syndrome and ulnar neuropathy. He concluded that appellant's loss of range of motion of the shoulders was not related to an accepted condition.

In a report dated March 15, 2007, Dr. Slutsky opined that appellant had no additional permanent impairment due to her brachial plexopathy. He found that the record did not contain consistent physical evidence of clinically significant brachial plexopathy and that appellant was not entitled to an impairment rating for this condition. Dr. Slutsky explained that there would have to be consistent physical evidence of deficits to multiple cervical nerve roots as this would reflect clinical support of the presence of significant brachial plexopathy.

Dr. Mandel completed a report on April 25, 2007 finding that appellant had 35 percent impairment of the left upper extremity and 35 percent impairment of the right upper extremity based on a shoulder impairment of 3 percent, loss of grip impairment of 20 percent, brachial plexus impairment of 5 percent, a median nerve impairment of 5 percent and a radial nerve impairment of 2 percent.

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[6] *Id.*

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

[8] *George E. Williams*, 44 ECAB 530, 533 (1993).

[9] *Id.*

Dr. Slutsky reviewed this report and found no clinical evidence of carpal tunnel syndrome. He found that Dr. Mandel did not identify the pathologic basis for appellant's strength loss, did not discuss how he performed the grip strength testing and did not show his calculations which led to the 20 percent impairment rating. Dr. Slutsky also found that he could not confirm Dr. Mandel's impairment for brachial plexopathy as he did not document testing for light touch, two point discrimination and protective sensibility. He disagreed with Dr. Mandel's rating for radial nerve deficits as he failed to document physical examination testing for radial nerve dysfunction. Dr. Slutsky found that appellant had two percent impairment bilaterally due to ulnar nerve impairment and one percent due to loss of shoulder abduction for a total impairment rating of three percent bilaterally.

It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides* his or her opinion is of diminished probative value in establishing the degree of permanent impairment and the Office may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the attending physician.[10] In this case, Dr. Mandel did not properly correlate his findings with the A.M.A., *Guides*. The Office, therefore, properly relied on the impairment rating of Dr. Slutsky, who explained the deficits in Dr. Mandel's report and offered his reasons for reaching an alternative impairment rating. Therefore, appellant has not met her burden of proof in establishing more than 24 percent impairment of her upper extremities.

LEGAL PRECEDENT -- ISSUE 2

To require the Office to reopen a case for merit review under section 8128(a) of the Act,[11] the Office's regulations provide that the evidence or argument submitted by 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.[12] 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 on the merits.[13]

ANALYSIS -- ISSUE 2

The Office denied appellant's claim for an additional schedule award finding that the weight of the medical opinion evidence rested with the detailed and well-reasoned report of Dr. Slutsky. Appellant disagreed with this decision and submitted a report dated August 13, 2007 from her attending physician Dr. Fried, an osteopath, who reported positive Phalen's testing from dysesthesias in the median nerve distribution bilaterally, positive Tinel's signs in the medial, ulnar and radial nerves as well as sympathetic reactivity with color changes in the hands and vascular instability. Dr. Fried also reported positive Roos and Hunter testing indicating

[10] *Linda Beale*, 57 ECAB 429, 434 (2006).

[11] 5 U.S.C. §§ 8101-8193, § 8128(a).

[12] 20 C.F.R. § 10.606(b)(2).

[13] *Id*. at § 10.608(b).

inflammation and scarring about the nerves of the brachial plexus at the thoracic outlet level. He diagnosed radial neuropathy on the right, medial neuropathy bilaterally, ulnar neuropathy left and radial neuropathy on the left as well as brachial plexopathy/cervical radiculopathy, Budd Chiari malformation of the cervical spine, sympathetically mediated pain syndrome and capsulitis of the left shoulder.

The Board finds, however, that this report is not relevant to the issue before the Office whether appellant has more than 12 percent impairment of each of her upper extremities. Dr. Fried did not provide an impairment rating and did not correlate his findings with the A.M.A., *Guides*. As this report does not address the central issue in the claim, the Office properly declined to reopen appellant's claim for consideration of the merits.

CONCLUSION

The Board finds that appellant has no more than 12 percent impairment of each of her upper extremities for which she has received a schedule award. The Board further finds that the Office properly declined to reopen appellant's claim for consideration of the merits on the grounds that she failed to submit, relevant and pertinent new evidence in support of her request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the February 4, 2008 and July 10, 2007 decision of the Office of Workers' Compensation Programs are affirmed.

Issued: September 15, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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