

initially accepted for right hand sprain and sprain of the right third finger and was later modified to include right carpal tunnel syndrome (CTS), right tenosynovitis and bilateral hand arthritis. Appellant underwent the following authorized surgeries: right thumb carpal metacarpal (CMC) interpositional arthroplasty with metatarsophalangeal (MP) joint capsulodesis on November 5, 2005; right thumb revision with CMC arthroplasty with ligament reconstruction and extensor pollicis brevis tendon transfer on April 6, 2006; and right thumb deep hardware removal, irrigation and debridement of the pin site wounds on June 27, 2006.

On March 7, 2007 appellant's treating physician, Dr. Sanjay K. Patari, a Board-certified orthopedic surgeon, opined that appellant was capable of performing sedentary work and placed her on permanent restrictions based on the results of a February 26, 2007 functional capacity evaluation. He stated that she had reached maximum medical improvement (MMI) and discharged her from his care.

On June 20, 2007 the Office referred appellant to Dr. Hythem P. Shadid, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion as to whether her accepted conditions had resolved and whether she was able to return to work. In a report dated August 1, 2007, Dr. Shadid noted definite grasp weakness in the right hand with a fused MP joint in the right thumb. Pinch strength was at 3/5. Motor and sensory responses were otherwise fully intact in both hands. There was no evidence of any swelling or pain with passive or active range of motion to either wrist and any digit. There was evidence of a significant laxity in the left thumb at the first metacarpophalangeal (MCP) joint with 50 degrees of laxity to radial deviation of the left thumb at the first MCP joint. There was no evidence of any carpal instability and no unusual tenderness exhibited over the extensor compartments of the wrist on either side. Overall musculature in both hands appeared symmetrical with no evidence of any significant atrophy of either the thenar or hypothenar eminences.

Dr. Shadid diagnosed arthritis of the right hand, as documented by x-ray. He opined that while arthritis involving the second and third fingers may have been aggravated by the initial injury in 2002, there was no connection between the diagnosis of arthritis in appellant's right thumb and the 2002 injury, as the thumb was not involved in that injury at all. Dr. Shadid opined that none of the current diagnoses continued to be medically connected with her accepted conditions. The diagnosis of sprain had resolved within three months. Any aggravation of a preexisting condition of arthritis would have been considered a temporary aggravation only and appellant should have reached MMI within three months of the injury. Dr. Shadid noted that the condition of arthritis in both hands could have been accelerated by the repetitive activities involved in being a mail carrier. He concluded that appellant had reached MMI from all conditions attributed to her work-related activities and that her residuals included loss of range of motion and weakness in her right thumb. Dr. Shadid opined that she was able to work at a sedentary level with permanent weight restrictions.

In an August 9, 2007 work capacity evaluation, Dr. Shadid stated that appellant lacked the hand strength to perform the duties of her usual job and should be restricted to lifting no more than 15 pounds, pushing no more than 35 pounds and pulling no more than 20 pounds.

On October 25, 2007 appellant returned to work as a modified carrier. On April 22, 2008 the Office found that the modified carrier position fairly and reasonably represented her wage-

earning capacity and reduced her compensation benefits to zero, as her actual earnings exceeded the current wages of the job held when injured.

On October 8, 2008 Dr. Patari found appellant's condition to be stable following her CMC interpositional arthroplasty. He diagnosed CMC arthritis of the right thumb. Examination revealed abduction -- 50 degrees; palmar abduction -- 45 degrees; and flexion to the distal palmar crease over the fifth finger with one centimeter (cm) tip-to-palm. Dr. Patari opined that appellant was able to work full time with permanent restrictions, which included lifting and carrying no more than 15 pounds and no driving.

On December 15, 2008 appellant requested a schedule award. In a letter dated December 24, 2008, the Office advised her to submit a detailed report from her treating physicians regarding the degree of permanent impairment resulting from her accepted injury, including an opinion as to impairment related to CTS. On January 9, 2009 Dr. Pantini stated that he was unable to provide an assessment on impairment related to CTS, as he had not treated appellant for that condition.

On March 27, 2009 the Office forwarded the case record to the district medical adviser (DMA) for review and an opinion as to the degree of permanent impairment to appellant's right upper extremity. In a report dated March 31, 2009, the DMA reviewed the statement of accepted facts and the medical evidence of record, including reports from Dr. Patari and Dr. Shadid. He noted Dr. Shadid's August 1, 2007 findings of decreased pinch strength in the right hand, but no neurologic deficit. The DMA referred to Dr. Patari's October 8, 2008 report, which found right thumb abduction and palmar adduction to be within normal limits. He inferred from the medical narrative that the thumb MP joint was fused in a position of function. Referencing the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), the DMA opined that appellant had a two percent permanent impairment of the right upper extremity as a result of her accepted conditions. Based on range of motion measurements, he concluded that she had a five percent impairment for MCP fusion (20 degrees) pursuant to Figure 16-15 on page 457, a zero percent impairment for abduction (50 degrees) pursuant to Table 16-8a on page 459 and a zero percent impairment for adduction pursuant to Table 16-8b on page 459, for a total right thumb impairment of five percent. Applying Table 16-1 on page 438 of the A.M.A., *Guides*, the DMA determined that appellant had a two percent impairment of the hand, which converted to a two percent impairment of the right upper extremity under Table 16-2 on page 439.¹ He stated that the date of MMI was August 1, 2007. The DMA noted that, according to page 508 of the A.M.A., *Guides*, decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities or absence of parts that prevent effective application of maximal force in the region being evaluated.

On April 29, 2009 the Office granted appellant a schedule award for a two percent impairment of her right upper extremity. The period of the award ran from August 1 to September 13, 2007. The Office determined that the date of MMI was August 1, 2007.

¹ Table 16-1 provides for the conversion of impairment of the digits to impairment of the hand. Table 16-2 provides for the conversion of impairment of the hand to impairment of the upper extremity. A.M.A., *Guides* (5th ed. 2001) at 438, 439, Table 16-1 and 16-2.

On May 23, 2009 appellant requested reconsideration. She contended that the two percent schedule award did not adequately represent her impairment due to the accepted injury and that her involuntary reassignment, which was based on her inability to perform her preinjury job, was evidence of a greater impairment. Appellant also noted that she did not receive a copy of the medical adviser's calculations.

In a July 1, 2009 decision, the Office denied appellant's request for further review of the merits of her claim.

On appeal, appellant reiterated her belief that her right upper extremity impairment was greater than two percent, as evidenced by her involuntary reassignment due to her inability to perform her date-of-injury job duties.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act² and its implementing regulations³ 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 regulations as the appropriate standard for evaluating schedule losses.⁴

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.⁵

ANALYSIS -- ISSUE 1

Based on the medical evidence of record, the Office granted appellant a schedule award for a two percent right upper extremity impairment resulting from her accepted conditions. The Board finds that she has failed to meet her burden of proof to establish that she has more than a two percent right upper extremity impairment.

In support of her request for a schedule award, appellant submitted reports from her treating physician, Dr. Patari. On March 7, 2007 Dr. Patari opined that she was capable of performing sedentary work and placed her on permanent restrictions, based on the results of a

² 5 U.S.C. § 8107.

³ 20 C.F.R. § 10.404 (1999).

⁴ *Id.*

⁵ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

February 26, 2007 functional capacity evaluation. He stated that appellant had reached MMI and discharged her from his care. Dr. Patari did not, however, provide examination findings or offer an opinion as to the degree of permanent impairment. Therefore, his report is of limited probative value on the schedule award issue.

Dr. Patari's October 8, 2008 report does not support an additional schedule award. He found appellant's condition to be stable following her CMC interpositional arthroplasty; diagnosed CMC arthritis of the right thumb and opined that she was able to work full time with permanent restrictions. Examination revealed abduction -- 50 degrees; palmar abduction -- 45 degrees and flexion to the distal palmar crease over the fifth finger with one cm tip-to-palm. While Dr. Patari provided examination findings, he did not offer any opinion on permanent impairment. The Board notes that the DMA utilized Dr. Patari's measurements in calculating his impairment rating.

In his June 20, 2007 second opinion report, Dr. Shadid opined that appellant had reached MMI and that her residuals included loss of range of motion and weakness in her right thumb. He did not provide an impairment rating; he did, however, opine that the only residuals remaining due to her accepted injury were loss of range of motion and weakness in her right thumb. Nothing in the report supports the conclusion that appellant had more than a two percent impairment of her right upper extremity. Dr. Shadid noted definite grasp weakness in the right hand with a fused MP joint in the right thumb. Although pinch strength was at 3/5, motor and sensory responses were otherwise fully intact in both hands. Dr. Shadid found no evidence of any swelling or pain with passive or active range of motion to either wrist or any digit; no evidence of any carpal instability and no unusual tenderness over the extensor compartments of the wrist on either side. Overall musculature in both hands appeared symmetrical with no evidence of any significant atrophy of either the thenar or hypothenar eminences. Dr. Shadid opined that there was no connection between the diagnosis of arthritis in appellant's right thumb and the 2002 injury, as the thumb was not involved in that injury at all and that none of the current diagnoses continued to be medically connected with her accepted conditions.

The Office properly referred the case file to the DMA for an impairment rating in accordance with the A.M.A., *Guides*.⁶ In a report dated March 31, 2009, the DMA reviewed the statement of accepted facts and the medical evidence of record, including reports from Dr. Patari and Dr. Shadid. He noted Dr. Shadid's August 1, 2007 findings of decreased pinch strength in the right hand but no neurologic deficit. The DMA referred to Dr. Patari's October 8, 2008 report, which found right thumb abduction and palmar adduction to be within normal limits. He inferred from the medical narrative that the thumb MP joint was fused in a position of function. Referencing the fifth edition of the A.M.A., *Guides*, the DMA opined that appellant had a two percent permanent impairment of the right upper extremity as a result of her accepted conditions. Based on range of motion measurements, he concluded that she had a five percent impairment for MCP fusion (20 degrees) pursuant to Figure 16-15 on page 457, a zero percent impairment for abduction (50 degrees) pursuant to Table 16-8a on page 459 and a zero percent impairment for adduction pursuant to Table 16-8b on page 459, for a total right thumb impairment of five percent. Applying Table 16-1 on page 438 of the A.M.A., *Guides*, the DMA determined that

⁶ See *supra* note 5 and accompanying text.

appellant had a two percent impairment of the hand, which converted to a two percent impairment of the right upper extremity under Table 16-2 on page 439.⁷ He did not include an impairment rating for decreased strength, which he explained cannot be rated in the presence of decreased motion that prevents effective application of maximal force in the region being evaluated.⁸

It is well established that, when the treating physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. The Office may then rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the treating physician.⁹ The Board finds that the DMA correctly applied the A.M.A., *Guides* to the findings of Dr. Patari and Dr. Shadid in determining his impairment rating. The Office properly relied on his opinion in granting appellant a schedule award for a two percent impairment of her right upper extremity.

The Board finds that the Office medical adviser properly determined appellant's permanent impairment. There is no other medical evidence of record, consistent with the A.M.A., *Guides*, showing that she has greater than two percent impairment of the right upper extremity. Accordingly, the medical evidence establishes that appellant has no more than two percent right upper extremity impairment.

LEGAL PRECEDENT -- ISSUE 2

To require the Office to reopen a case for merit review under section 8128(a) of the Act,¹⁰ the Office 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.¹¹ 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.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

⁷ See *supra* note 1.

⁸ *Id.* at 508.

⁹ *Linda Beale*, 57 ECAB 429 (2006).

¹⁰ 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).

¹¹ 20 C.F.R. § 10.606(b)(2).

¹² *Id.* at § 10.607(a).

¹³ *Id.* at § 10.608(b).

ANALYSIS -- ISSUE 2

Appellant's January 5, 2009 request for reconsideration consisted of a letter contending that the two percent schedule award did not adequately represent her impairment due to the accepted injury. She argued that her involuntary reassignment, which was based on her inability to perform her preinjury job, was evidence of a greater impairment. Appellant's assertion, however, does not establish that the Office erroneously applied or interpreted a specific point of law or constitute a relevant legal argument not previously considered by the Office. Consequently, she is not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(2).¹⁴

Appellant did not submit relevant and pertinent new evidence not previously considered by the Office.¹⁵ In fact, she submitted no additional evidence in support of her request for reconsideration. Therefore, appellant is not entitled to a review of the merits based on the third above-noted requirement under section 10.606(b)(2). The Board notes that she indicated that she was enclosing a copy of an involuntary reassignment and a recent copy of "Claimant[s] eligible conditions" together with her letter requesting reconsideration; however, the record does not contain either of those documents.¹⁶

The Board finds that the Office properly determined that appellant was not entitled to further review of the merits pursuant to any of the three requirements under section 10.606(b)(2) and properly denied her request for reconsideration.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof to establish that she has more than a two percent right upper extremity impairment. The Board further finds that the Office properly refused to reopen her case for further review of the merits pursuant to 5 U.S.C. § 8128(a).

¹⁴ Appellant stated that she did not receive a copy of the medical adviser's calculations and contends that the April 29, 2009 decision did not adequately inform her as to how the schedule award was determined. The Board notes that the Office provided her with a copy of the medical adviser's calculations subsequent to its April 29, 2009 decision. Further, there is no evidence to rebut the presumption that the calculations were not attached to the April 29, 2009 schedule award, as indicated in the decision. *See Kenneth E. Harris*, 54 ECAB 502, 505 (2003). (In the absence of evidence to the contrary, it is presumed that a notice mailed in the ordinary course of business was received in due course by the intended recipient). Additionally, the decision advised appellant that the award was calculated according to the fifth edition of the A.M.A., *Guides*, based upon the medical findings provided by the examining physician. As indicated, appellant provided no medical evidence establishing any permanent impairment to the right upper extremity greater than two percent.

¹⁵ *Supra* note 11.

¹⁶ The Board notes that neither a notice of reassignment nor a statement of eligible conditions would be relevant to the issue at hand, which is medical in nature. *See E.M.*, 60 ECAB ___ (Docket No. 09-39, issued March 3, 2009) (where the Board held that new evidence submitted upon a reconsideration request that does not address the pertinent issue is not relevant evidence); *Freddie Mosley*, 54 ECAB 255 (2002).

ORDER

IT IS HEREBY ORDERED THAT the July 1 and April 29, 2009 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: September 7, 2010
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