United States Department of Labor
Employees' Compensation Appeals Board

M.H., Appellant	)	
and	)	**Docket No. 13-1825**
	)	**Issued: January 30, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Parsons, KS, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 1, 2013 appellant filed a timely appeal from a March 8, 2013 Office of Workers' Compensation Programs' (OWCP) decision regarding his schedule award claim. He also appealed an April 23, 2013 OWCP decision that denied his request for reconsideration. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 two percent impairment of his right arm for which he received a schedule award; and (2) whether OWCP properly denied his request for reconsideration.

FACTUAL HISTORY

On June 19, 2009 appellant, then a 35-year-old distribution process worker, filed an occupational disease claim for a right elbow injury due to performing repetitive job duties.

[1] 5 U.S.C. §§ 8101-8193.

OWCP accepted the claim for mononeuritis of the right elbow and later expanded his claim to include right cubital tunnel syndrome. It authorized a right ulnar nerve transposition which was performed on May 22, 2009 and a revision of the right ulnar nerve transposition on May 6, 2010. Appellant received appropriate compensation benefits.[2]

Appellant was treated by Dr. Brad Meister, a Board-certified orthopedist, on May 11, 2009 for right medial elbow tenderness. Dr. Meister diagnosed refractory cubital tunnel syndrome. On May 22, 2009 he performed an ulnar nerve transposition of the right elbow and diagnosed right ulnar nerve entrapment at the elbow. An April 28, 2009 electromyogram (EMG) revealed right focal sensorimotor ulnar mononeuropathy consistent with epicondylar groove and cubital tunnel.

Appellant filed a claim for a schedule award. On April 6, 2010 OWCP advised him that the medical evidence was insufficient to support his claim because the evidence did not show that he had reached maximum medical improvement.

Appellant came under the treatment of Dr. Erich J. Lingenfelter, a Board-certified orthopedist, from April 2 to December 8, 2010 for pain status post subcutaneous ulnar nerve transposition. Dr. Lingenfelter diagnosed ulnar neuritis, status post subcutaneous ulnar nerve transposition with subluxing ulnar nerve and recommended right submuscular ulnar nerve transposition. On May 6, 2010 he performed a right revision, ulnar nerve transposition with submuscular ulnar nerve transposition and neurolysis. Dr. Lingenfelter diagnosed continued ulnar neuritis, status post subcutaneous ulnar nerve transposition with severe pain and ulnar neuritis. In reports dated May 10 to December 18, 2010, he noted that appellant continued to have numbness and tingling in his ulnar two digits with intermittent mild sharp pain. Dr. Ligenfelter released appellant to work with permanent restrictions and noted that it would take time, up to a year and a half, for his symptoms to completely calm down. A January 26, 2010 x-ray of the right elbow revealed no abnormalities.

On May 11, 2011 appellant filed a claim for a schedule award. On June 13, 2011 OWCP advised that the medical evidence did not indicate that appellant had reached maximum medical improvement. Appellant renewed his schedule award request in 2012.

By letter dated August 10, 2012, OWCP referred appellant for a second opinion to Dr. Michael S. Clarke, a Board-certified orthopedic surgeon, regarding whether he had permanent impairment due to his work injury.

In an August 27, 2012 report, Dr. Clarke noted appellant's history of injury and medical treatment. On examination appellant had a 35-degree loss of full extension of the right elbow, irritability in the scar posterior to the medial malleolus, positive Tinel's sign and full flexion of the right elbow. Sensory examination with the pinwheel showed near complete anesthesia of the

[2] Appellant injured his right finger on June 23, 2006 which was accepted for right index finger sprain, claim number xxxxxx886. On March 20, 2010 he injured his right arm which was accepted for right arm/elbow strain, claim number xxxxxx197. On October 20, 2010 appellant injured his left arm which was denied, claim number xxxxxx540. These claims were consolidated with the current claim before the Board.

little finger and half the right finger and up to the ulnar border of the right hand there was decreased sensory perception. Minimal intrinsic atrophy was noted. Appellant had profundus function to the little and ring fingers equal bilaterally. He also had sweating of the ulnar nerve distribution bilaterally with decreased two-point perception in the ulnar nerve distribution. Dr. Clarke diagnosed partial sensory ulnar neuropathy status post ulnar neurolysis for cubital canal syndrome.

In an addendum report dated November 20, 1012, Dr. Clarke opined that appellant had four percent right upper extremity impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] He noted subjective sensory neuropathy presenting a decreased sensibility in the little finger and half the right finger. There was no loss of motion function and all muscles innervated by the right ulnar nerve were intact with no intrinsic muscle atrophy in the hand. Although Dr. Clarke noted that appellant had 30 to 35 degrees lack of full elbow extension, he found this "suspect" as it had been his experience, with similar conditions, that there is little or no decrease in elbow range of motion. He opined that this would likely correct with usual activities of daily living. Dr. Clarke noted that, pursuant to Table 15-8, sensory loss, and Figure 15.26, Table 15-33 for loss of motion of the elbow, appellant had four percent right upper extremity impairment. In a December 14, 2012 report, he noted that appellant underwent three surgeries of the right ulnar nerve at the elbow and the nerve was transposed with mild subjective ulnar sensory neuropathy possibly due to partial devascularization of the nerve at the time of the surgeries.

On December 31, 2012 an OWCP medical adviser requested that Dr. Clarke provide an impairment rating for the residuals of the accepted cubital tunnel syndrome which was found at Table 15-23, page 449 of the A.M.A., *Guides.* He noted that impairment ratings for entrapment neuropathy in the upper extremity is based on Table 15-23 of the A.M.A., *Guides* and requested that Dr. Clarke provide an impairment rating using Table 15-23 of the A.M.A., *Guides* and note grade modifiers as appropriate.

In a January 30, 2013 report, Dr. Clarke referred to Table 15-23, page 449 of the A.M.A., *Guides* for entrapment/compression neuropathy impairment and noted that test findings for the April 28, 2009 EMG and nerve conduction studies confirm conduction delays over the ulnar nerve distribution would correlate to a grade modifier of 1. Regarding a functional history adjustment, he noted mild intermittent symptoms, for a grade modifier of 1. Dr. Clarke noted that the physical examination adjustment corresponded to a grade modifier of 2 for decreased sensation. He noted the grade modifiers totaled 4 (1+1+2) and averaged 1.33 which rounded to 1. Dr. Clarke explained that grade modifier 1 was selected with a default value of two percent right arm impairment for residuals of right cubital tunnel syndrome.

In a February 24, 2013 report, an OWCP medical adviser reviewed appellant's history of injury and treatment. He determined that appellant reached maximum medical improvement on August 27, 2012. The medical adviser noted that Dr. Clarke provided signs and symptoms in conjunction with diagnostic studies to determine an impairment rating pursuant to Table 15-23 of A.M.A., *Guides.* He referred to Table 15-23 of the A.M.A., *Guides* and concurred with

[3] A.M.A., *Guides* (6th ed. 2008).

Dr. Clarke's determination that appellant had two percent impairment of the right upper extremity for residual of right cubital tunnel syndrome.

By decision dated March 8, 2013, OWCP issued appellant a schedule award for two percent permanent impairment of the right arm. The period of the award was from August 27 to October 9, 2012.

In an undated letter and in an appeal request form, both received by OWCP on April 14, 2013, appellant requested reconsideration. No additional information was submitted.

In an April 23, 2013 decision, OWCP denied appellant's requests for reconsideration on the grounds that the evidence submitted was insufficient to warrant a merit review.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[4] and its implementing federal 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, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[7] It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[8]

The A.M.A., *Guides* provide a specific rating process for entrapment neuropathies such as carpal tunnel or cubital tunnel.[9] This rating process requires that the diagnosis of a focal neuropathy syndrome be documented by sensory or motor nerve conduction studies or EMG. The A.M.A., *Guides* do not allow additional impairment values for decreased grip strength, loss of motion or pain.[10] Table 15-23 provides a compilation of the grade modifiers for test findings, history, physical findings which are averaged and rounded to the nearest whole number. This table also provides the range of impairment values as well as the function scale modifier which determines the impairment value within the impairment scale.[11]

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

[7] A.M.A., *Guides* (6th ed. 2009).

[8] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[9] A.M.A., *Guides* 432-50.

[10] *Id*. at 433.

[11] *See id*. at 449, 448-450.

ANALYSIS -- ISSUE 1

On appeal, appellant contends that he is entitled to a s**c**hedule award greater than two percent permanent impairment of the right upper extremity. OWCP accepted his claim for mononeuritis of the right elbow and later expanded his claim to include right cubital tunnel syndrome. It authorized a right ulnar nerve transposition which was performed on May 22, 2009 and a revision of the right ulnar nerve transposition on May 6, 2010. On June 12, 2012 appellant filed a Form CA-7 claim for a schedule award. The Board finds that the medical evidence of record establishes no more than two percent of the right upper extremity.

Dr. Clarke and the medical adviser agreed as to the extent of appellant's impairment. They found that Table 15-23 (Entrapment/Compression Neuropathy Impairment)[12] was appropriate to rate appellant's cubital tunnel syndrome. Dr. Clarke and the medical adviser identified a grade modifier of 1 for EMG and nerve conduction testing findings on April 28, 2009 based upon conduction delays (sensory and/or motor).[13] For functional history, appellant had mild intermittent symptoms in the right upper extremity which corresponded to a grade modifier of 1. For physical findings, Dr. Clarke found a grade modifier of 2 for decreased sensation and the medical adviser concurred in this. The Board notes that, when grade modifier values were added, they resulted in a total of four. Dividing this value of four by the three modifier categories provided an average of 1.33 which was rounded to 1 which represented a default impairment rating of two percent.[14] In determining whether to modify the default value of two percent, the physicians considered the impact of appellant's condition on his activities of daily living, and found it was reasonable to select a grade 1, which resulted in the default two percent rating for grade modifier 1 in Table 15-23.

The Board finds that OWCP's medical adviser and second opinion physician properly applied the A.M.A., *Guides* to rate impairment to appellant's right upper extremity. They reviewed the medical evidence and determined that appellant had two percent impairment under the sixth edition of the A.M.A., *Guides*. There is no other medical evidence in conformance with the sixth edition of the A.M.A., *Guides* that supports any greater impairment.[15]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

[12] *See id.* at 449, Table 15-23.

[13] *Id.*

[14] *See id.* at 448-49.

[15] Although Dr. Clarke's November 20, 2012 report indicated that appellant had four percent impairment of the right arm for sensory loss and loss of motion, he did not clearly explain how this rating was derived from the A.M.A., *Guides.* Furthermore, Dr. Clarke questioned appellant's lack of elbow extension, noting that his decreased motion was "suspect." Thus, this report is insufficient to establish any greater impairment.

LEGAL PRECEDENT -- ISSUE 2

Under section 8128(a) of FECA,[16] OWCP has the discretion to reopen a case for review on the merits. It must exercise this discretion in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations, which provide 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 OWCP erroneously applied or interpreted a specific point of law; or
>
> "(ii) Advances a relevant legal argument not previously considered by OWCP; or
>
> "(iii) Constitutes relevant and pertinent new evidence not previously considered by OWCP."[17]

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 OWCP without review of the merits of the claim.[18]

ANALYSIS -- ISSUE 2

OWCP's most recent merit decision dated March 8, 2013 granted appellant a schedule award for two percent impairment of the right upper extremity. It denied his reconsideration request, without a merit review, and he appealed this decision to the Board.

The issue presented on appeal is whether appellant met any of the requirements of 20 C.F.R. § 10.606(b)(2), requiring OWCP to reopen the case for review of the merits of the claim. In his request for reconsideration, appellant did not show that OWCP erroneously applied or interpreted a specific point of law. He did not identify a specific point of law or show that it was erroneously applied or interpreted. Appellant did not advance a new and relevant legal argument.

The Board notes that the underlying issue in this case is whether appellant sustained permanent impairment of the right upper extremity greater than the two percent granted on March 8, 2013. That is a medical issue which must be addressed by relevant medical evidence.[19] A claimant may be also entitled to a merit review by submitting new and relevant evidence, but appellant did not submit any new and relevant medical evidence in support of his claim.

[16] 5 U.S.C. § 8128(a).

[17] 20 C.F.R. § 10.606(b)(2).

[18] *Id.* at § 10.608(b).

[19] *See Bobbie F. Cowart*, 55 ECAB 746 (2004).

The Board accordingly finds that appellant did not meet any of the requirements of 20 C.F.R. § 10.606(b)(2). Appellant did not show that OWCP erroneously applied or interpreted a specific point of law, advance a relevant legal argument not previously considered by OWCP, or submit relevant and pertinent evidence not previously considered. Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he has more than a two percent impairment of the right upper extremity. The Board further finds that OWCP properly denied appellant's request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the April 23 and March 8, 2013 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: January 30, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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