

delayed conduction velocity and reduced amplitude of the left ulnar motor and sensory nerves across the elbow segment, indicating tardy ulnar entrapment neuropathy. A July 26, 2000 magnetic resonance imaging scan obtained by Dr. Jack L. Baldassare, a Board-certified diagnostic radiologist, showed mild osteoarthritic changes of the left upper extremity joint. On September 17, 2000 appellant underwent left ulnar nerve transposition. In a March 1, 2001 nerve conduction study, Dr. Cho noted that the ulnar entrapment neuropathy was more proximal than previously reported. Appellant subsequently underwent left ulnar nerve transposition revision on May 11, 2001.² OWCP accepted an occupational disease claim for left wrist and thumb tendinitis.³

Appellant filed a claim for a schedule award on March 30, 2009 and submitted medical evidence. In an amended February 16, 2009 report,⁴ Dr. Arthur F. Becan, an orthopedic surgeon, remarked that appellant complained of intermittent left wrist and elbow symptoms related to repetitive data entry duties. Appellant's condition limited her ability to drive, sleep, complete household work and perform other activities of daily living.⁵ Dr. Becan examined her left elbow and observed a 17 centimeter hypertrophic surgical scar along the posterior medial aspect, medial epicondyle tenderness and restricted joint flexion, pronation and supination. On inspection of the left wrist, he observed tenderness of the carpi extensor ulnaris and the first extensor compartment at the dorsal radial aspect, limited dorsiflexion, palmar flexion and ulnar deviation and a positive Finkelstein's test. Semmes-Weinstein monofilament testing also revealed a threshold of 6.1 grams of force. Following a review of the April 23, 2009 statement of accepted facts and medical file, Dr. Becan diagnosed cumulative and repetitive trauma disorder, left ulnar neuropathy, recurrent left ulnar neuropathy, status post ulnar nerve transposition, status post repeat ulnar nerve decompression, de Quervain's disease and extensor carpi ulnaris tendinitis. He applied Chapter 15 (The Upper Extremities), section 15.4e (Peripheral Nerve and Brachial Plexus Impairment) of the A.M.A., *Guides*.⁶ Based on the physical examination findings, Dr. Becan selected a sensory deficit level of 3.⁷ He assigned an impairment class diagnosed condition (CDX) of 1 with a default grade of C, amounting to a five percent impairment rating for severe ulnar sensory deficit above midforearm.⁸ Dr. Becan

² OWCP authorized the revision surgery in an April 23, 2001 letter.

³ The foregoing information was incorporated into April 23, 2009 and September 30, 2010 statements of accepted facts.

⁴ In his original report, Dr. Becan used the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*) and calculated a 26 percent permanent impairment of the left upper extremity. See *infra* note 6 (5th ed. 2001). OWCP advised Dr. Becan in an August 25, 2009 letter that impairment ratings must be based on the sixth edition of the A.M.A., *Guides* effective May 1, 2009. The case record also contains an April 25, 2009 report from Dr. Morley Slutsky, a Board-certified occupational physician and OWCP's medical adviser, in which he presented an impairment rating of three percent based on the fifth edition.

⁵ Dr. Becan added that appellant scored 63 on the shortened version of the "Disabilities of the Arm, Shoulder and Hand" (*QuickDASH*) questionnaire.

⁶ A.M.A., *Guides* (6th ed. 2008), 429-32, 434-44.

⁷ *Id.* at 425 (Table 15-14) (Sensory and Motor Severity).

⁸ *Id.* at 443 (Table 15-21) (Peripheral Nerve Impairment: Upper Extremity Impairments).

identified a grade modifier value of 2 for Functional History (GMFH), citing appellant's symptoms while performing normal activities.⁹ In addition, he chose a grade modifier value of 1 for Clinical Studies (GMCS) as electrodiagnostic studies exhibited ongoing ulnar abnormalities.¹⁰ Using the net adjustment formula of (GMFH -- CDX) + (GMCS -- CDX) or (2 - 1) + (1 - 1), Dr. Becan calculated a net adjustment of 1 and concluded that appellant sustained a five percent permanent impairment of the left upper extremity.¹¹ He listed February 16, 2009 as the date of maximum medical improvement.

On December 23, 2009 Dr. Henry J. Magliato, OWCP's medical adviser and a Board-certified orthopedic surgeon, reviewed the April 23, 2009 statement of accepted facts and Dr. Becan's report. He stated that the five percent impairment rating was suitable only if OWCP authorized ulnar nerve surgery. After he received a February 4, 2010 letter from OWCP stating that it only accepted left wrist and thumb tenosynovitis, Dr. Magliato found in a February 22, 2010 report that Dr. Becan's report failed to address an accepted condition.

Appellant was referred for a second opinion examination to Dr. Jeffrey F. Lakin, a Board-certified orthopedic surgeon. In an April 21, 2010 report, Dr. Lakin noted appellant's complaints of hand numbness and reviewed the medical file. On neurological examination, he recorded two-point discrimination above seven millimeters and elicited pain during resistive wrist extension, flexion, supination and pronation. Dr. Lakin concluded that appellant did not sustain an impairment of the left arm because she no longer experienced symptoms of her accepted left wrist or thumb tendinitis. He listed April 21, 2010 as the date of maximum medical improvement. On June 13, 2010 Dr. Andrew A. Merola, OWCP's medical adviser and a Board-certified orthopedic surgeon, agreed with Dr. Lakin's opinion.

By decision dated August 4, 2010, OWCP denied appellant's claim for a schedule award, finding the medical evidence insufficient to demonstrate that she sustained a measurable impairment of a scheduled member due to an accepted condition.

Appellant's attorney requested reconsideration on August 16, 2010. He argued that appellant's occupational disease claim should be accepted to include her left elbow because OWCP authorized the September 17, 2000 left ulnar nerve transposition surgery. Counsel also pointed out that Dr. Magliato agreed with Dr. Becan's five percent impairment rating on the condition that OWCP authorized this surgery.

A September 30, 2010 statement of accepted facts related that OWCP accepted left ulnar nerve entrapment neuropathy. In a September 30, 2010 letter, OWCP asked Dr. Lakin for a supplemental report in view of this revised statement of accepted facts.

In a November 8, 2010 supplemental report, Dr. Lakin applied Chapter 15, section 15.4f (Entrapment Neuropathy) of the A.M.A., *Guides*, in particular Table 15-23

⁹ *Id.* at 406 (Table 15-7) (Functional History Adjustment: Upper Extremities).

¹⁰ *Id.* at 410-11 (Table 15-9) (Clinical Studies Adjustment: Upper Extremities).

¹¹ Dr. Becan pointed out that a grade modifier for Physical Examination (GMPE) was unnecessary because these findings were already used to determine CDX. *Id.* at 407.

(Entrapment/Compression Neuropathy Impairment).¹² Based on appellant's mild hand symptoms, diminished sensation and delayed conduction velocity, he found grade modifier values of 1 for history, 2 for physical findings and 1 for test findings, respectively. Dr. Lakin averaged these values to arrive at 1.33, which rounded down to 1 and assigned a grade of 1. The *QuickDASH* modifier value was 1. Dr. Lakin concluded that appellant sustained a default two percent permanent impairment for ulnar nerve entrapment neuropathy.

In a November 29, 2010 report, Dr. Magliato reviewed Dr. Lakin's November 8, 2010 report and agreed with the two percent impairment rating. He identified February 16, 2009 as the date of maximum medical improvement.

On December 15, 2010 OWCP granted a schedule award for two percent permanent impairment of the left upper extremity for the period February 16 to March 31, 2009.

Counsel requested reconsideration on January 4, 2011 and asserted that Dr. Becan's amended February 16, 2009 report constituted the weight of the medical evidence.

On June 29, 2011 OWCP denied modification of the December 15, 2010 decision.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss of or loss of use of scheduled members or functions of the body.¹³ 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 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 regulation as the appropriate standard for evaluating schedule losses.¹⁴

The A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF). Generally, for upper extremity impairments, the evaluator identifies the impairment class for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS. The net adjustment formula is (GMFH -- CDX) + (GMPE -- CDX) + (GMCS -- CDX).¹⁵ Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.¹⁶

¹² *Id.* 432-33, 445-50.

¹³ 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

¹⁴ *K.H.*, Docket No. 09-341 (issued December 30, 2011).

¹⁵ *R.Z.*, Docket No. 10-1915 (issued May 19, 2011).

¹⁶ *J.W.*, Docket No. 11-289 (issued September 12, 2011).

The method used to calculate impairment on account of entrapment neuropathies deviates slightly from the diagnosis-based method.¹⁷ When the diagnosis of entrapment neuropathy has already been established, only grade modifiers need to be determined for the purposes of calculating the impairment rating.¹⁸ Grade modifiers are described for test findings, history and physical findings. Once the appropriate values for these modifiers are determined, the average of these values is taken and rounded to the nearest integer to determine the grade.¹⁹ Next, the evaluator looks at the “Upper Extremity Impairments” row at the bottom of Table 15-23, which contains the range of impairment values for the grade selected. The middle value is the default impairment percentage for the grade. Finally, the default percentage is modified based on the functional scale grade, which is indicated by the shortened version of the *QuickDASH*. If the functional scale grade is equal to the grade assigned for the condition, the default percentage is the appropriate rating. If the functional scale grade is lower or higher than the grade assigned to the condition, the lower or higher percentage, respectively, is the appropriate impairment rating.²⁰

ANALYSIS

OWCP accepted appellant’s occupational disease claim for left wrist and thumb tendinitis and later expanded it to include left ulnar nerve entrapment neuropathy. The case record indicates that the former has resolved while the latter forms the basis for the present schedule award claim.

The Board finds that Dr. Lakin’s November 8, 2010 report constitutes the weight of the medical evidence. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician’s opinion.²¹ Appellant submitted two impairment rating reports from Dr. Becan, both of which were dated February 16, 2009. The original report calculated a 26 percent permanent impairment of the left upper extremity based on the fifth edition of the A.M.A., *Guides*. The Board has held that the fifth edition applies to schedule award decisions issued between February 1, 2001 and April 30, 2009 while the sixth edition applies to decisions issued on or after May 1, 2009.²² Here, OWCP issued its decision on August 4, 2010. Since Dr. Becan did not utilize the proper edition of the A.M.A., *Guides*, this report was of diminished probative value.²³

¹⁷ See generally *supra* note 6 at 432-33, 445-50.

¹⁸ *Id.* at 433.

¹⁹ *Id.* at 433, 445-448.

²⁰ *Id.* at 448-49.

²¹ *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *James Mack*, 43 ECAB 321, 329 (1991).

²² *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

²³ *A.B.*, Docket No. 10-2142 (issued August 10, 2011). See also *James Kennedy, Jr.*, 40 ECAB 620, 627 (1989) (an opinion that is not based upon standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of permanent impairment).

After OWCP instructed him to use the sixth edition of the A.M.A., *Guides*, Dr. Becan amended his February 16, 2009 report. He diagnosed cumulative and repetitive trauma disorder and left ulnar neuropathy, *inter alia*, applied Chapter 15, section 15.4e of the A.M.A., *Guides*, and calculated a five percent impairment rating for severe ulnar sensory deficit above midforearm. As noted, however, OWCP specifically accepted left ulnar nerve entrapment neuropathy and the A.M.A., *Guides* sets forth a distinct scheme for rating entrapment neuropathies. The prologue of section 15.4 states, “Nerve entrapments (*e.g.*, carpal tunnel syndrome, cubital tunnel syndrome and other entrapments) are not isolated traumatic events and are dealt with in section 15.4f, Entrapment Neuropathy.”²⁴ This caveat is reiterated at the beginning of section 15.4e: “Impairment from traumatic injury to peripheral nerves is defined by the specific nerves involved, and the associated severity of sensory and motor deficits. [Section 15.4e] is *not* used for nerve entrapments since nerve entrapments are not isolated traumatic events; nerve entrapments are rated in section 15.4f.”²⁵ Because Dr. Becan used the wrong rating scheme, his amended report is of limited probative value on the extent of appellant’s left upper extremity impairment.

Dr. Lakin applied section 15.4f in his November 8, 2010 report. Citing appellant’s complaints of mild hand symptoms, a neurological examination exhibiting decreased sensation, and nerve conduction studies revealing delayed conduction velocity, he assigned grade modifier values of 1 for history, 2 for physical findings and 1 for test findings, respectively. Dr. Lakin obtained the average of these values, $(1 + 2 + 1) / 3$ or 1.33 and rounded to the nearest integer to establish a grade modifier of 1. Based on the “Upper Extremity Impairments” row at the bottom of Table 15-23, he observed that the default impairment rating for grade modifier of 1 was two percent. Since the *QuickDASH* modifier value was also 1, Dr. Lakin opined that appellant sustained a two percent permanent impairment for ulnar nerve neuropathy. Dr. Merola, OWCP’s medical adviser, reviewed the report and agreed with the rating. In view of Dr. Lakin’s rationalized medical opinion, the Board finds that OWCP properly granted a schedule award for two percent permanent impairment of the left upper extremity.

Counsel contends on appeal that Dr. Becan’s February 16, 2009 reports should have constituted the weight of the medical evidence. The Board has already addressed the deficiencies of these reports. Alternatively, counsel argues that there is a medical conflict between Drs. Becan and Lakin necessitating a referral for a referee examination.²⁶ A simple disagreement between two physicians does not, of itself, establish a conflict. A conflict only exists only when there are opposing medical reports of virtually equal weight and rationale.²⁷ Given that the reports of Drs. Becan and Lakin are not of equivalent probative value, a referee examination is unnecessary.

²⁴ *Supra* note 6 at 423.

²⁵ *Id.* at 429 (Emphasis in original.). *See also id.* at 433 (“Entrapment neuropathy is determined using the methods described in [section 15.4f] alone”).

²⁶ *See* 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321; *R.H.*, 59 ECAB 382, 386-87 (2008).

²⁷ *John D. Jackson*, 55 ECAB 465 (2004).

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

CONCLUSION

The Board finds that appellant did not sustain more than a two percent permanent impairment of the left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the June 29, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 2, 2012
Washington, DC

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

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

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