

bilateral carpal tunnel syndrome, bilateral Guyon's canal syndrome and traumatic arthritis of the right patella. She stopped work on April 26, 2011 and did not return. The employing establishment related that appellant had retired on disability effective April 26, 2011 and that she had an accepted employment-related knee injury while working for another federal agency.² OWCP accepted the claim for bilateral wrist tendinitis, bilateral carpal tunnel syndrome, bilateral Guyon's canal syndrome, ulnar nerve impairment, arthritis of the right knee and patella and ligament laxity of the right knee.

On April 11, 2012 appellant underwent a right knee arthroscopy with a partial medial meniscectomy, chondroplasty of the patellofemoral and medial compartment and removal of loose bodies.

An electromyogram and nerve conduction velocity studies obtained on September 14, 2012 were normal.

In an impairment evaluation dated December 13, 2012, Dr. John W. Ellis, Board-certified in family practice, diagnosed bilateral wrist tendinitis, bilateral carpal tunnel syndrome, bilateral Guyon's canal syndrome, a medial meniscus tear of the right knee, ligament laxity of the right knee and traumatic arthritis of the right patella and knee with chondromalacia following surgery. On examination, he found a positive Tinel's sign over the cubital and radial nerves of both elbows with reduced elbow motion, a positive Tinel's sign over the medial and ulnar nerves of the wrists bilaterally with loss of motion, swelling and tendinitis, and 4/4 grip strength of both hands. Dr. Ellis further found crepitation and moderate laxity of the anterior cruciate ligament of the right knee, an antalgic gait, and mild laxity of the lateral and medial collateral ligaments. Citing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009), Dr. Ellis found that appellant had a 2 percent impairment due to bilateral wrist tendinitis according to Table 15-3 on page 395 and a 9 percent impairment due to bilateral entrapment neuropathy according to Table 15-23 on page 449, for a total impairment of 11 percent for each upper extremity. For the right lower extremity, he determined that she had a 3 percent impairment due to her partial medial meniscectomy and a 19 percent impairment due to laxity of the anterior cruciate, medial and lateral ligaments according to Table 16-3 on page 509, for a total right lower extremity impairment of 21 percent.

On December 27, 2012 appellant filed a claim for a schedule award.

By letter dated January 2, 2013, OWCP advised appellant that it had received the December 13, 2012 report from Dr. Ellis. It informed her of the requirements for an impairment evaluation and asked that she obtain an opinion from her physician which met the requirements. In a January 15, 2013 response, appellant requested that OWCP process her schedule award using Dr. Ellis' December 13, 2012 report.

On March 10, 2013 Dr. Daniel D. Zimmerman, a Board-certified internist and OWCP medical adviser, reviewed the medical evidence of record, including Dr. Ellis' report. He related that Dr. Ellis used two grid diagnosis in rating the right knee impairment even though the

² Appellant had a prior claim, assigned file number xxxxxx368, accepted for left knee sprain and left knee osteoarthritis due to an August 12, 2002 work injury.

A.M.A., *Guides* provided that only one grid diagnosis could be utilized.³ Dr. Zimmerman further indicated that Dr. Ellis improperly used Table 15-23 on page 449 because appellant did not have positive electrodiagnostic studies demonstrating carpal tunnel syndrome. Consequently, he concluded that OWCP could not base a schedule award on Dr. Ellis' impairment rating and recommended referring her for a second opinion examination.

On March 26, 2013 OWCP referred appellant to Dr. Kala Danushkodi, a Board-certified physiatrist, for a second opinion examination. In a report dated April 11, 2013, Dr. Danushkodi discussed her complaints of right knee pain, bilateral intermittent hand numbness with loss of grip strength and wrist pain and difficulty walking or standing. On examination, he found no atrophy and normal range of motion of the wrists bilaterally. Dr. Danushkodi further found mild bilateral wrist tenderness and pain with extension and flexion, a negative Tinel's sign and Phalen's test and inconsistent sensory examination. For the right knee, he found moderate swelling, tenderness of the anterior patella and crepitus with motion. Dr. Danushkodi measured knee flexion of 90 degrees, normal extension and an antalgic gait. He diagnosed right knee pain, bilateral wrist pain with tendinitis and bilateral hand pain. Dr. Danushkodi used Table 16-3 on page 509, the knee regional grid, and identified the diagnosis as a class 1 partial medial meniscectomy, which yielded a default value of two percent. He applied a grade modifier of 2 for functional history due to appellant's antalgic gait and use of a cane, a grade modifier of 2 for moderate tenderness on physical examination and a grade modifier of 2 for a moderate problem on clinical studies. Applying the net adjustment formula moved the adjustment to class 1, grade E, which yielded a three percent lower extremity impairment. Dr. Danushkodi found no impairment due to bilateral carpal tunnel syndrome or bilateral ulnar entrapment at the Guyons' canal due to the normal results on electrodiagnostic testing. He identified the diagnosis as class 1 nonspecific hand pain bilaterally using Table 15-2, the digit regulation grid, which yielded a default value of one percent. Dr. Danushkodi applied grade modifiers of 1 for functional history and physical examination and found that clinical studies were not applicable. He utilized the net adjustment formula to find no movement from the default value of one percent impairment for each upper extremity. Dr. Danushkodi further found that appellant had class 1 impairment due to bilateral wrist tendinitis using Table 15-3 on page 395, the wrist regional grid, for a default value of one percent. He applied grade modifiers 1 for functional history and physical examination and found that a grade modifier for clinical studies was not applicable. Dr. Danushkodi concluded that appellant had a three percent right lower extremity impairment, a one percent impairment of each upper extremity due to wrist tendinitis, and a one percent permanent impairment of each upper extremity due to hand pain.

On April 23, 2013 Dr. Zimmerman reviewed Dr. Danushkodi's report. He noted that Dr. Danushkodi explained how he arrived at the ratings using the sixth edition of the A.M.A., *Guides*. Dr. Zimmerman found that Dr. Danushkodi determined that appellant had a one percent impairment of the right upper extremity, a one percent impairment of the left upper extremity and a three percent impairment of the right lower extremity. He concurred with Dr. Danushkodi's findings.

³ A.M.A., *Guides* 497.

By decision dated May 13, 2013, OWCP granted appellant a schedule award for a three percent permanent impairment of the right lower extremity and a one percent permanent impairment of each upper extremity.⁴ The period of the award ran for 14.88 weeks from April 11 to July 24, 2013.

In a report dated June 12, 2013, Dr. Ellis found a positive Tinel's sign over the median and ulnar nerves of the wrists bilaterally with loss of motion and atrophy of the thenar and meniscectomy eminence. He further found a positive Tinel's sign over the elbows bilaterally with loss of motion and hypertrophy of the medial epicondyle and mild laxity of medial and collateral ligaments of the right knee with crepitation and loss of motion. Dr. Ellis determined that appellant had a 2 percent permanent impairment due to bilateral wrist tendinitis using Table 15-3 on page 395 of the A.M.A., *Guides* and a 12 percent impairment due to peripheral nerve impairments of the medial and ulnar nerve bilaterally using Table 15-21 on page 438. He further found a nine percent impairment for carpal and cubital tunnel syndrome. Dr. Ellis noted that the medical adviser related that entrapment neuropathy could not be used given the negative diagnostic studies. He related that the 12 percent peripheral nerve impairment was "a little high for the hand" and thus combined the 2 percent impairment due to wrist tendinitis and the 9 percent impairment due to carpal tunnel syndrome, which yielded an 11 percent impairment. Alternatively, Dr. Ellis found an 11 percent permanent impairment of each upper extremity due to loss of motion of the wrist using Table 15-32 on page 473.

For the right lower extremity, Dr. Ellis determined that appellant had a 3 percent impairment due to a medial meniscal tear and surgery and a 13 percent impairment due to mild medial and lateral collateral ligament laxity using Table 16-3 on page 509 and 510, for a combined 16 percent impairment of the right lower extremity. He explained that he combined the impairments due to the meniscal tear and ligament laxity as removal of the meniscus and other tissue caused increased laxity of the ligaments. Dr. Ellis also opined that appellant had a 32 percent impairment due to loss of motion of the right knee using Table 16-23 on page 549.

On September 1, 2013 appellant requested reconsideration. She argued that OWCP should have requested a supplemental report from Dr. Ellis in accordance with its procedures if it found his report insufficient. Appellant also contended that a conflict existed between her physician and the second opinion physician. She maintained that Dr. Danushkodi did not measure her right knee, hands or arms with a measuring instrument, failed to date his report and did not refer to the pages of the A.M.A., *Guides*.

On October 15, 2013 Dr. Zimmerman reviewed the December 13, 2012 and June 12, 2013 reports from Dr. Ellis. He found that Dr. Ellis should not have provided an impairment rating for carpal tunnel syndrome and Guyon's canal syndrome. Dr. Zimmerman determined that Dr. Ellis used multiple diagnoses in rating the lower extremity impairment which was precluded by the A.M.A., *Guides*. He advised that the impairment rating was unchanged.

⁴ OWCP indicated that it was awarding appellant a schedule award for a one percent permanent impairment of the right leg. However, this is a typographical error. The number of weeks of the schedule award, 14.88, demonstrates that OWCP found a schedule award for a three percent permanent impairment of the right lower extremity and a one percent permanent impairment of each upper extremity.

By decision dated November 14, 2013, OWCP denied modification of its May 13, 2013 decision. It noted that it had advised appellant on January 2, 2013 that the December 13, 2012 report from Dr. Ellis was insufficient. OWCP indicated that Dr. Danushkodi provided measurements and that there was no requirement to provide the page numbers of the A.M.A., *Guides*. It further noted that the medical adviser reviewed the June 12, 2013 report from Dr. Ellis and found that it was insufficient as it provided more than one diagnosis, which was not allowed under the sixth edition of A.M.A., *Guides*.

On appeal, appellant argues that OWCP did not request an additional report from Dr. Ellis. She also contends that the medical adviser incorrectly found that she reached maximum medical improvement on April 11, 2013 rather than June 12, 2014 and so she was entitled to a longer award. Appellant questions why OWCP found that Dr. Ellis' report was not sufficient and why it used the same OWCP medical adviser on reconsideration. She maintains that Dr. Danushkodi did not measure her right knee or used instruments on her extremities. Appellant maintains that she should have been sent for an impartial medical examination.

LEGAL PRECEDENT

The schedule award provision of FECA⁵ and its implementing federal regulations,⁶ 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.⁷ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁸

The upper limb is divided into four regions: digits/hand, wrist, elbow, and shoulder. An impairment for each region is defined by class and grade. The final impairment grade within the class is calculated using the grade modifiers.⁹

The sixth edition requires identifying the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).¹⁰ The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ *Id.* at § 10.404(a).

⁸ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁹ A.M.A., *Guides*, 387 Chapter 15.2.

¹⁰ *Id.* at 494-531.

ANALYSIS

OWCP accepted that appellant sustained bilateral wrist tendinitis, bilateral carpal tunnel syndrome, bilateral Guyon's canal syndrome, ulnar nerve impairment, arthritis of the right knee and patella and ligament laxity of the right knee due to factors of her federal employment. On April 11, 2012 appellant underwent a partial medial meniscectomy, chondroplasty of the patellofemoral, and medial compartment, and removal of loose bodies of the right knee.

Regarding the upper extremity impairments, in the December 13, 2012 impairment evaluation, Dr. Ellis determined that appellant had a 9 percent impairment of each upper extremity due to entrapment neuropathy and a 2 percent impairment of each upper extremity due to wrist tendinitis, for a total impairment of each upper extremity of 11 percent.¹¹ On March 10, 2013 Dr. Zimmerman reviewed Dr. Ellis' December 13, 2012 report. He opined that it was insufficient to support a schedule award as he did not properly apply the A.M.A., *Guides* in rating the impairment for entrapment neuropathy. The A.M.A., *Guides* indicate that section 15.4f, entrapment neuropathy, should not be used in rating impairment if electrodiagnostic testing is normal.¹² Consequently, Dr. Ellis' rating of upper extremities did not conform to the provisions of the A.M.A., *Guides* and is thus of little probative value.

OWCP referred appellant to Dr. Danushkodi for a second opinion evaluation regarding the extent of any permanent impairment. On examination of the upper extremities he found a negative Tinel's sign and Phalen's test, no atrophy and normal range of motion. Dr. Danushkodi advised that appellant had no impairment resulting from bilateral carpal tunnel syndrome or bilateral ulnar nerve entrapment at the Guyons' canal based on the normal results of objective testing. He determined that she had a one percent impairment of each upper extremity due to bilateral hand pain and a one percent impairment of each upper extremity due to bilateral wrist tendinitis.¹³

On April 23, 2013 Dr. Zimmerman reviewed Dr. Danushkodi's report and concurred with his finding of a one percent permanent impairment of each upper extremity. However, Dr. Danushkodi found a one percent impairment in two regions of the arm: bilateral wrist tendinitis and hand pain, using two different regional diagnosis-based impairment grids. Dr. Zimmerman did not explain why he counted only one of the regional ratings. Consequently, the Board will modify the November 14, 2013 decision to reflect an additional one percent permanent impairment of both the right and left upper extremity.¹⁴

On June 12, 2013 Dr. Ellis determined that appellant had a 2 percent impairment due to bilateral wrist tendinitis using Table 15-3 on page 395 and a 12 percent impairment due to

¹¹ *Id.* at 449, 395, Table 15-23, Table 15-3.

¹² *Id.* at 448.

¹³ *Id.* at 391, 395, Table 15-2, Table 15-3.

¹⁴ Using the A.M.A., *Guides*, where the upper extremity percentage includes more than one region, the Combined Values Chart is to be used. In this case, the one percent for hand pain and one percent for wrist tendinitis combined to equal two percent. A.M.A., *Guides* 387.

peripheral nerve impairments of the medial and ulnar nerve bilaterally under Table 15-21 on page 438. He further found a nine percent impairment for carpal and cubital tunnel syndrome. Dr. Ellis noted that the medical adviser determined that entrapment neuropathy could not be used with negative diagnostic studies. He found that the 12 percent peripheral nerve impairment was high and thus combined the 9 percent impairment for entrapment neuropathy with the 2 percent impairment due to wrist tendinitis to find an 11 percent impairment of each upper extremity. Dr. Ellis found, in the alternative, an 11 percent impairment due to reduced range of motion. On October 15, 2013 Dr. Zimmerman reviewed Dr. Ellis' June 12, 2013 report and noted that a rating for entrapment neuropathy could not be made under Table 15-23 due to the negative electrodiagnostic studies. He concluded that the impairment rating was unchanged. According to the A.M.A., *Guides*, when conduction testing has not been performed or does not meet this section's (15.4) diagnostic criteria, the case should be evaluated under the diagnosis-based impairments with the appropriate regional grid.¹⁵ The A.M.A., *Guides* further prohibits rating nerve entrapments under Table 15-21.¹⁶ Consequently, Dr. Ellis' impairment determination for peripheral neuropathy using Table 15-21 was not appropriate. Further, he did not indicate that he measured range of motion three times as required by the A.M.A., *Guides*.¹⁷ Consequently, Dr. Ellis' impairment rating of the upper extremities is not in accordance with the A.M.A., *Guides*.

Regarding the right lower extremity, the Board finds that appellant has no more than a three percent permanent impairment. In his December 13, 2012 report, Dr. Ellis determined that she had a 19 percent impairment of the right lower extremity due to laxity of the anterior cruciate, medial and lateral ligaments and a 3 percent impairment due to a partial medial meniscectomy.¹⁸ On March 10, 2013 Dr. Zimmerman noted that Dr. Ellis improperly used multiple grid diagnoses in rating appellant's right knee impairment. As found by the medical adviser, the A.M.A., *Guides*, provide that, when using the diagnosis-based regional grids, generally only one diagnosis is appropriate.¹⁹

In his April 11, 2013 report, Dr. Danushkodi identified the diagnosis as a class 1 partial medial meniscectomy using Table 16-3 on page 509, the knee regional grid, and found a default value of two percent. He applied a grade modifier 2 for functional history based on appellant's antalgic gait and use of a cane, a grade modifier 2 for moderate tenderness on physical examination and a grade modifier 2 for a moderate problem on clinical studies. Applying the net adjustment formula moved the adjustment to class 1, grade E, which yielded a three percent lower extremity impairment.²⁰ On April 23, 2013 Dr. Zimmerman concurred with

¹⁵ *Id.* at 445-46; *see also* *L.J.*, Docket No. 13-1654 (issued December 4, 2013).

¹⁶ Section 15.4e, including Table 15-21, is not used for nerve entrapments since nerve entrapments are not isolated traumatic events. A.M.A., *Guides* 429.

¹⁷ *Id.* at 464.

¹⁸ *Id.* at 509, Table 16-3.

¹⁹ *Id.* at 497.

²⁰ Utilizing the net adjustment formula discussed above, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), or 2-1) + (2-1) + (2-1) = 3, which moved the impairment all the way over to the right for a grade E, or three percent impairment.

Dr. Danushkodi's finding. The Board finds that there is no evidence conforming to the A.M.A., *Guides* showing a greater right lower extremity impairment.

On June 12, 2013 Dr. Ellis found that appellant had a 3 percent impairment due to her surgery to repair a torn medial meniscus and a 13 percent impairment due to mild medial and collateral ligament laxity using Table 16-3 on page 509 and 510. He indicated that he combined the impairment rating for a torn meniscus and laxity as the removal of the meniscus resulted in the laxity. However, Table 16-3 on page 510 provides that the diagnosis for a cruciate or collateral ligament injury is used only when surgery is not a rating factor. Consequently, Dr. Ellis improperly applied the A.M.A., *Guides* in finding a 13 percent impairment due to medial and collateral ligament laxity. He further found that appellant had a 32 percent permanent impairment due to loss of range of motion of the right knee using Table 16-23 on page 549. However, the A.M.A., *Guides* at section 16.2 provides, "Range of motion is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment."²¹ Dr. Ellis did not explain why he could not rate appellant's impairment using another method and thus his rating due to loss of range of motion is insufficient to support a schedule award.

On appeal, appellant argues that OWCP did not advise her that Dr. Ellis' report was insufficient. OWCP, however, informed her on January 2, 2013 of the requirements for an impairment evaluation. Appellant further maintains that OWCP should have found that she reached maximum medical improvement on April 11, 2013 rather than June 12, 2014 and thus the period of the schedule award should be longer. The determination of maximum medical improvement, however, is usually the date of the medical examination which determined the extent of the impairment.²² It has no effect on the length of the award.

Appellant contends that OWCP should have based her schedule award on Dr. Ellis' report and asserts that Dr. Danushkodi did not properly evaluate her impairment. She also alleges that OWCP should have sent her for an impartial medical examination. As discussed, however, Dr. Ellis' report does not conform to the provisions of the A.M.A., *Guides* and is thus insufficient to create of conflict or establish the extent of impairment.²³

Appellant additionally notes that the same OWCP medical adviser reviewed Dr. Ellis' report after her reconsideration request. OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.²⁴ The procedures further provide that if the case is referred for a referee examination, it should then be routed to a

²¹ A.M.A., *Guides* 497.

²² See *Richard Larry Enders*, 48 ECAB 184 (1996).

²³ See *Mary L. Henninger*, 52 ECAB 408 (2001).

²⁴ See *supra* note 8 at Chapter 2.808.6(f) (February 2013).

new medical adviser.²⁵ There is no provision for referring the case to a new medical adviser based on a reconsideration request.

CONCLUSION

The Board finds that appellant has established entitlement to one percent impairment due to hand pain and one percent impairment due to wrist tendinitis for both the right and left upper extremities. The Board further finds that she has no more than a three percent permanent impairment of the right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the November 14, 2013 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: December 10, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

²⁵ *Id.* at § 2.808.6(g).