United States Department of Labor
Employees' Compensation Appeals Board

M.K., Appellant	)	
and	)	**Docket No. 15-0038**
	)	**Issued: March 10, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Margate, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 6, 2014 appellant, through counsel, filed a timely appeal from a July 7, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

ISSUE

The issue is whether appellant has more than one percent permanent impairment of the left upper extremity for which he received a schedule award.

On appeal counsel asserts that the referee physician's report is vague, speculative, and incomplete, that OWCP erred in its factual basis for finding a conflict, and that the referee was improperly selected under the Physicians Directory System (PDS).

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 11, 2005 appellant, then a 48-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that employment duties caused a pinched nerve in his left upper extremity. He had stopped work on May 6, 2005.

A May 5, 2005 electrodiagnostic study showed evidence of ulnar neuropathy at the left elbow (cubital tunnel syndrome), but no evidence of left hand carpal tunnel syndrome. The claim was accepted for lesion of ulnar nerve, left. A report of February 21, 2006 electrodiagnostic testing showed bilateral ulnar nerve neuropathies at the elbow, very significant on the left, and mild compromise of the left ulnar nerve at the wrist, bilateral median nerve neuropathies at the wrist, bilateral symmetric and significant radial nerve neuropathy, and mild right upper brachial plexus post-ganglionic sensory component compromise. Appellant returned to part-time work in October 2006, following back surgery.[2] On September 25, 2007 Dr. Scott M. Fried, a Board-certified osteopath specializing in orthopedic surgery, performed a transposition of the ulnar nerve of the left arm.

In December 2007, appellant was referred to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for a second opinion. In reports dated January 10, 2008, Dr. Stark reviewed appellant's medical and surgical history. He found no findings or pathology relating to the ulnar nerve on physical examination, including no weakness or sensory deficit. Dr. Stark advised that appellant could return to work without restriction.[3]

On November 17, 2008 appellant requested a schedule award and submitted an August 5, 2008 report from Dr. Steven M. Allon, an orthopedic surgeon. Dr. Allon advised that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[4] appellant had 48 percent impairment of the left arm.

In a March 18, 2009 report, Dr. Henry J. Magliato, a Board-certified orthopedist and OWCP medical adviser, disagreed with Dr. Allon's finding that appellant had 48 percent left arm impairment due to the accepted condition.

On April 4, 2009 Dr. Andrew A. Merola, also a Board-certified orthopedist and OWCP medical adviser, noted that there were significant discrepancies between the opinions of Dr. Stark and Dr. Allon, as Dr. Stark found that appellant's condition had resolved while Dr. Allon found that it resulted in permanent impairment. He recommended an impartial evaluation. Dr. Fried continued to treat appellant through 2008.

[2] Appellant has a claim for a back condition that OWCP has adjudicated under a separate claim. It is not before the Board on the present appeal.

[3] On March 4, 2008 OWCP terminated appellant's wage loss and medical benefits. Appellant returned to regular duty in March 2008. On August 18, 2008 an OWCP hearing representative affirmed the March 4, 2008 decision. In a May 29, 2009 decision, OWCP denied modification of the termination of compensation benefits.

[4] A.M.A., *Guides* (5th ed. 2001).

OWCP determined that a conflict in medical evidence had been created between Dr. Stark and Dr. Allon regarding whether appellant had any impairment of the left upper extremity due to the accepted condition, and in June 2009 referred him to Dr. Frederick G. Dalzell, a Board-certified orthopedic surgeon, for an impartial evaluation. In a July 22, 2009 report, Dr. Dalzell noted appellant's medical, surgical, and work history and his complaint of weakness and hypersensitivity at the surgical site of his left upper extremity. He reviewed the medical record including 2005 and 2006 electrodiagnostic studies and upper extremity x-ray studies. Left upper extremity physical examination demonstrated intact sensation and 16 percent deficit in lateral pinch on grip testing. Dr. Dalzell concluded that appellant had 10 percent left upper extremity impairment.

In a September 28, 2009 report, Dr. Merola, an OWCP medical adviser, reviewed Dr. Dalzell's report. He indicated that Dr. Dalzell did not provide any calculations upon which to make appropriate impairment recommendations and did not utilize the A.M.A., *Guides*. Dr. Merola asked that a supplemental report be obtained. Dr. Dalzell did not respond to OWCP's request.

In February 2010 OWCP referred appellant to Dr. Jonathan Fox, a Board-certified orthopedic surgeon, for an impartial medical evaluation. In a February 23, 2010 report, Dr. Fox noted his review of the record. Examination of the left arm showed no neurologic deficits. Tinel's sign was negative, pin sensation, grip strength, and range of motion were no normal. There were no signs of muscle atrophy, and muscle strength versus resistance was normal. Dr. Fox indicated that maximum medical improvement had been reached, the examination was normal, and appellant had no left arm impairment. On June 7, 2010 Dr. Magliato, an OWCP medical adviser, reported that, based on Dr. Fox's opinion, had zero percent left upper extremity impairment.

By decision dated June 22, 2010, OWCP denied appellant's claim for a left arm schedule award based on the opinion of Dr. Fox. A hearing was held on October 13, 2010. In a December 23, 2009 report, Dr. Allon updated his August 5, 2008 report to conform with the sixth edition of the A.M.A., *Guides*.[5] He did not re-examine appellant. Dr. Allon stated that maximum medical improvement was reached on August 5, 2008. He advised that, in accordance with Table 15-23 of the sixth edition of the A.M.A., *Guides*, appellant had four percent impairment due to entrapment neuropathy of the left ulnar nerve at the elbow and two percent impairment for entrapment neuropathy of the left median nerve at the wrist, for a total left upper extremity impairment of six percent.[6]

On January 12, 2011 the hearing representative remanded the case to OWCP to obtain a supplemental report from Dr. Fox providing a clear explanation as to how he used the A.M.A., *Guides*. On February 1, 2011 OWCP asked Dr. Fox to submit a supplemental report. On

[5] *Id.* at (6th ed. 2008).

[6] Regarding elbow neuropathy, Dr. Allon found modifiers of one for test findings, three for history and two for physical examination; for wrist neuropathy he found modifiers of two for test findings, zero for history and three for physical examination.

February 23, 2011 Dr. Fox advised OWCP that he did not have the sixth edition of the A.M.A., *Guides* and recommended referral to a hand surgeon.

On March 21, 2011 OWCP referred appellant to Dr. George P. Glenn, a Board-certified orthopedic surgeon, for an impartial evaluation. In a May 12, 2011 report, Dr. Glenn reviewed appellant's history and described physical examination findings. Range of motion of the shoulders, elbows, wrists, and fingers was normal with complaints of soreness of the thumb on the left, no swelling, redness, or heat, and soreness to firm palpation through the ulnar groove on the left. Muscle tone was excellent, and upper and forearm circumferences were equal, with no atrophy. Grip and key pinch were normal, and reflexes were brisk. Sensory was well preserved except for a complaint of a stocking-type distribution on the left. Two-point discrimination, vibratory, and position sense were preserved. Phalen's and reverse Phalen's produced complaints of shoulder discomfort on the left. Tinel's sign was negative bilaterally. Dr. Glenn diagnosed ulnar nerve compression syndrome, left (cubital tunnel syndrome), status post transposition of the ulnar nerve with complete recovery, and no residual symptoms or signs. He recommended a left elbow x-ray. In a May 4, 2011 work capacity evaluation, Dr. Glenn indicated that appellant could perform his usual job with no restrictions. A July 1, 2011 bilateral elbow x-ray demonstrated surgical changes on the left.

In an August 24, 2011 decision, OWCP found that appellant had no left arm impairment based on Dr. Glenn's opinion. On November 21, 2011 the hearing representative remanded the case for an OWCP medical adviser to review Dr. Glenn's report.

In a January 2, 2012 report, Dr. Merola, an OWCP medical adviser, reviewed Dr. Glenn's report and found that appellant had no left arm impairment. On January 17, 2012 OWCP again found that appellant had no left arm impairment and denied his schedule award claim. On June 24, 2012 the hearing representative remanded the case for OWCP to obtain a supplemental report from Dr. Glenn that provided elbow range of motion findings in degrees and discussed electrodiagnostic test results in accordance with the A.M.A., *Guides*.

In an August 23, 2012 report, Dr. Glenn stated that he had asked appellant to return to his office so that he could specifically remeasure elbow range of motion.[7] He explained that section 15.4f of the A.M.A., *Guides* should be used to evaluate entrapment neuropathy. Dr. Glenn indicated that appellant had a functional history modifier of zero, as there was no demonstrable interference with function but noted that, in the interest of fairness as a consequence of appellant's subjective complaints, one could accept a functional history modifier of one. He further found that, although appellant did not fulfill all the criteria listed, Dr. Glenn could assign a grade modifier of one for physical examination. Finally, Dr. Glenn indicated that May 5, 2005 electrodiagnostic studies would equate a grade modifier of one. He applied the net adjustment formula and concluded that appellant had one percent left arm impairment.

In September 2012 appellant moved from New Jersey to Maine. On October 8, 2012 Dr. Merola concurred that appellant had one percent left arm impairment. On October 23, 2012 appellant was granted a schedule award for one percent impairment of the left arm. The award

[7] Although not specifically stated by Dr. Glenn, a reading of his report indicates that appellant did not return for further evaluation.

ran from August 23 to September 13, 2012. Counsel requested a hearing, which was held on February 5, 2013. In a March 14, 2013 decision, the hearing representative found that Dr. Glenn's report was incomplete because appellant did not return to his office for further measurement. The case was remanded to OWCP to obtain a new impartial evaluation, to include elbow range of motion measurements, to be followed by a *de novo* decision.

Upon remand, OWCP prepared a new statement of accepted facts and set of questions. On May 15, 2013 it referred appellant to Dr. David N. Markellos, a Board-certified orthopedic surgeon. With regard to Dr. Markellos' selection, the record contains an April 29, 2013 iFECS Report: ME023 Appointment Schedule Notification referring appellant to Dr. Markellos for an impartial evaluation. The record additionally contains a bypass history and a number of screen shots, including that no appropriate specialists were found within a 25, 50, 75, 100, 125, 150, and 175 mile radius.[8]

In a May 29, 2013 report, Dr. Markellos noted his review of an extensive medical record, a statement of accepted facts, a set of questions, a position description, appellant's description of his employment and medical history, and his complaint that his left elbow was a more sore than usual due to the five-hour drive to the examination. Left arm examination demonstrated no visible asymmetry or atrophy of the paraspinous, periscapular, shoulder girdle, deltoid, either arm or forearm, when compared to the right side. Circumferential measurements of the forearm and arm were equal bilaterally, indicating no measurable disuse atrophy. Appellant had full unrestricted and painless range of motion of the neck and both shoulders and equal range of motion of both elbows, from full extension to 140 degrees of flexion; full and equal 90 degrees of supination; and 80 degrees of pronation. A well-healed medial elbow scar was slightly tender to palpation. Tinel's sign was negative along the course of the expected position of the transposed ulnar nerve. There was no visible or measurable atrophy of the forearm and no visible atrophy with intrinsics of the hands. Strength was equal and +5/+5 of the upper arm, forearm, and intrinsics bilaterally. Froman's test for ulnar intrinsic weakness was negative with no hypothenar atrophy. Appellant reported subjective decreased sensation of the fifth finger only. Two-point discrimination was four millimeters in both the ulnar and median side of the hand, indicating no residual sensory deficit. Grip strength on the right was a consistent 56 to 57 kilograms but, because it varied from 10 to 38 kilograms on the left, this inconsistent and varied reading was not ratable. X-rays that day revealed two medial epicondylar anchors in place and no early osteoarthritis, soft tissue calcifications, or other abnormality. Dr. Markellos diagnosed history of left ulnar nerve entrapment neuropathy, status post ulnar nerve decompression and anterior submuscular transposition, with excellent clinical result and no objective evidence of residual neuropathy, weakness, or limited mobility. He indicated that, under the sixth edition of the A.M.A., *Guides*, for a diagnosis of entrapment neuropathy of the left upper extremity, section 15.4f was applicable, which indicated that grade modifiers should be determined for the purposes of calculating impairment. Dr. Markellos advised that appellant's clinical history was consistent with mild, intermittent symptoms with tingling and no objective restriction from current activities of daily living. His physical examination revealed full unrestricted range of motion of the elbow, a well-healed surgical incision, two-point discrimination in the normal range, and no

[8] The bypass history documents that 17 physicians were bypassed before Dr. Markellos' name was reached. The reasons given included telephone out of service, did not accept OWCP patients, and did not treat hands.

objective clinical atrophy. Grip testing was variable, inconsistent, and therefore unratable. Dr. Markellos advised that at some point, to truly define objective impairment, appellant could be referred for electrodiagnostic studies but that, at present, his clinical findings were normal with no objective motor or sensory deficit, and with full left elbow range of motion. He concluded that appellant had a class 0 rating for nerve entrapment, for zero percent left upper extremity permanent impairment and that maximum medical improvement was attained by the time of Dr. Allon's August 2008 assessment, approximately one year following surgery.

On September 5, 2013 Dr. Hormozan Aprin, a Board-certified orthopedic surgeon and an OWCP medical adviser, reviewed the record, including Dr. Markellos' report. He indicated that the referee physician correctly applied the A.M.A., *Guides*, as defined in section 15.4f. Dr. Aprin concluded that the most probable date appellant reached maximum medical improvement was when appellant was last evaluated by Dr. Fried.

In an October 28, 2013 decision, OWCP denied appellant's claim for an additional schedule award, finding that the weight of the medical evidence rested with Dr. Markellos, as appropriately reviewed by the OWCP medical adviser. Counsel requested a hearing that was held on April 14, 2014. He asserted that there was no actual conflict because Dr. Stark was not asked about impairment in his second opinion examination and therefore could not create a conflict. Moreover, counsel asserted that Dr. Markellos was improperly selected as an impartial examiner.

Subsequent to the hearing, appellant submitted an April 18, 2014 report from Dr. David Weiss, an osteopath and associate of Dr. Allon. Dr. Weiss noted his review of Dr. Allon's reports dated August 5, 2008 and December 23, 2009, the May 29, 2013 report from Dr. Markellos, and the September 5, 2013 report from Dr. Aprin. He disagreed with Dr. Markellos' impairment analysis, asserting that, based on appellant's August 2008 examination findings, he had four percent left arm impairment due to left ulnar nerve entrapment at the elbow and two percent impairment for entrapment of the median nerve, for a total six percent left arm impairment.

By decision dated July 7, 2014, the hearing representative found that the weight of the medical evidence rested with the opinion of Dr. Markellos and affirmed the October 28, 2013 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing federal regulations[10] 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

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[11] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

The sixth edition of 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).[13] Section 15.4f provides the framework for evaluating entrapment neuropathy.[14] Impairment due to carpal tunnel and cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[15] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[16] The A.M.A., *Guides* specifically indicate that, if multiple simultaneous neuropathies occur in the same limb, both impairments may be rated and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller impairment is rated at 50 percent.[17] The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise,[18] and Appendix 15-B provides further guidance regarding electrodiagnostic evaluation of entrapment syndromes.[19]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[20] The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[21] When there exist opposing medical reports of virtually equal weight

[11] *Id*. at § 10.404(a).

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[13] A.M.A., *Guides*, *supra* note 4 at 3, section 1.3, "ICF: A Contemporary Model of Disablement."

[14] *Id*. at 432-50.

[15] *Id*. at 449.

[16] *Id*. at 448-50.

[17] *Id*. at 448.

[18] *Id*.

[19] *Id*. at 487-90.

[20] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[21] 20 C.F.R. § 10.321.

and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[22]

OWCP procedures further provide that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and not that of the medical adviser. The medical adviser should not resolve the conflict of medical opinion or attempt to clarify or expand the opinion of the medical referee. If clarification is necessary, a supplemental report should be obtained from the referee specialist.[23]

A physician selected by OWCP to serve as an impartial medical specialist should be one wholly free to make a completely independent evaluation and judgment. In order to achieve this, OWCP has developed specific procedures for the selection of the impartial medical specialist designed to provide adequate safeguards against any possible appearance that the selected physician's opinion was biased or prejudiced. The procedures contemplate that the impartial medical specialist will be selected on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and OWCP.[24]

The medical management application (MMA), which replaced the PDS, allows users to access a database of Board-certified specialist physician, and is used by OWCP to schedule referee examinations. The application contains an automatic, and strict rotational scheduling feature to provide for consistent rotation among physicians and to record the information needed to document the selection of the physician.[25]

The claims examiner is not able to determine which physician serves as the impartial medical specialist. A medical scheduler inputs the claim number into the application, from which the claimant's home zip code is loaded. The scheduler chooses the type of examination to be performed (second opinion or impartial referee) and the applicable medical specialty. The next physician in the roster appears on the screen and remains until an appointment is scheduled or the physician is bypassed. If the physician agrees to the appointment, the date and time are entered into the application. Upon entry of the appointment information, the application prompts the medical scheduler to prepare an ME023 appointment notification report for imaging into the case file. Once an appointment with a medical referee is scheduled, the claimant and any authorized representative are to be notified.[26]

[22] *V.G.*, 59 ECAB 635 (2008).

[23] *See* Federal (FECA) Procedure Manual, Part 2, *supra* note 12 at Chapter 2.808.6(g)(1,2) (February 2013).

[24] *Raymond J. Brown*, 52 ECAB 192 (2001).

[25] Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.5 (May 2013); *see also R.C.*, Docket No. 12-468 (issued October 25, 2012).

[26] *B.N.*, Docket No. 12-1394 (issued August 5, 2013).

If an appointment cannot be scheduled in a timely manner or cannot be scheduled for some other reason such as a conflict or the physician is of the wrong specialty, the scheduler will update the application with an appropriate bypass code. Upon the entering of a bypass code, the MMA will select the next physician in the rotation.[27]

ANALYSIS

OWCP accepted appellant's claim for lesion of the left ulnar nerve. In December 2007, it referred him to Dr. Stark for a second opinion evaluation, and on January 10, 2008 Dr. Stark found no pathology relating to the ulnar nerve of physical examination, including no weakness or sensory deficit. Dr. Stark advised that appellant could return to work without restriction. Appellant filed a schedule award claim on November 17, 2008 and submitted an August 5, 2008 report from Dr. Allon who found 48 percent permanent left arm impairment. OWCP found that a medical conflict was created between Dr. Stark and Dr. Allon regarding appellant's impairment and condition and first referred him to Dr. Dalzell, and then to Dr. Fox for an impartial evaluation. Following denial of the schedule award claim on June 22, 2010 based upon the medical opinion of Dr. Fox, appellant submitted a December 23, 2009 report from Dr. Allon who updated his August 2008 report now finding that appellant had six percent left arm impairment due to ulnar nerve entrapment at the elbow and wrist pursuant to the sixth edition of the A.M.A., *Guides*.

On January 12, 2011 the hearing representative remanded the case for a supplemental report from Dr. Fox, who recommended referral to a hand surgeon as he did not have a sixth edition of the A.M.A., *Guides*. OWCP then referred appellant to Dr. Glenn for an impartial evaluation. Dr. Glenn found no impairment. OWCP again denied appellant's schedule award claim on August 24, 2011. On November 21, 2011 it remanded the case for review by an OWCP medical adviser, who concluded that appellant had no left arm impairment, and on January 17, 2012, OWCP again denied the schedule award claim.

On June 24, 2012 the hearing representative remanded the case for OWCP to obtain a supplemental report from Dr. Glenn. In an August 23, 2012 report, he advised that appellant had a one percent left arm impairment. On October 23, 2012 appellant was granted a schedule award for one percent impairment of the left upper extremity.

On March 14, 2013 the hearing representative directed a new impartial evaluation regarding appellant's left arm impairment that was to include elbow range of motion measurements. OWCP then referred appellant to Dr. Markellos who provided a comprehensive report dated May 29, 2013 in which he found that appellant had no left arm impairment. On October 28, 2013 it denied an additional schedule award based on the opinion of Dr. Markellos.

Appellant requested a hearing and submitted an April 18, 2014 report from Dr. Weiss who maintained that that the physical examination findings from Dr. Allon in 2008 and his analysis in 2009 established that appellant had six percent impairment of the left upper extremity. On July 7, 2014 the hearing representative affirmed the October 28, 2013 decision.

[27] *Supra* note 25.

Counsel has asserted that Dr. Markellos was improperly selected as an impartial specialist. OWCP uses the MMA, as described above. This application replaced the PDS and allows users to access a database of Board-certified specialist physicians and is used to schedule examinations. The application contains an automatic and strict rotational scheduling feature to provide for consistent rotation among physicians and to record the information needed to document the selection of the physician.[28]

In the present case, the record contains an OWCP ME023 report documenting Dr. Markellos' selection under the MMA. Additionally, as required, the record contains a bypass history report certifying that the MMA was used to schedule appellant's appointment with Dr. Markellos. This report provides explanations for each physician bypassed until Dr. Markellos was reached.[29] This evidence, within the MMA system, indicates that all physicians were appropriately bypassed until Dr. Markellos was selected. The Board finds that OWCP provided sufficient documentation to establish that it properly utilized its MMA system in selecting Dr. Markellos as the impartial medical examiner. By doing so, OWCP has met its affirmative obligation to establish that it properly followed its selection procedures.[30] Thus, counsel's argument is without merit.

In his May 29, 2013 report, Dr. Markellos noted his review of the factual and medical record, and appellant's description of his employment and medical history and physical complaints. He fully described examination findings and diagnosed history of left ulnar nerve entrapment neuropathy, status post ulnar nerve decompression and anterior submuscular transposition, with excellent clinical result and no objective evidence of residual neuropathy, weakness, or limited mobility. Dr. Markellos indicated that, in accordance with section 15.4 of the A.M.A., *Guides*, for a diagnosis of entrapment neuropathy of the left arm, appellant's clinical history was consistent with mild, intermittent symptoms with tingling and no objective restriction from current activities of daily living. He noted that appellant's examination revealed full unrestricted range of motion of the elbow, a well-healed surgical incision, two-point discrimination in the normal range, and no objective clinical atrophy. Grip testing was variable, inconsistent, and therefore unratable. Dr. Markellos advised that appellant's clinical findings were normal with no objective motor or sensory deficit, and with full left elbow range of motion. He concluded that appellant had a class 0 rating for nerve entrapment, for zero percent left upper extremity impairment, and indicated that maximum medical improvement was attained approximately one year following surgery.

On September 5, 2013 Dr. Aprin, the OWCP medical adviser, reviewed the record, including Dr. Markellos' report. He determined that Dr. Markellos correctly applied the A.M.A., *Guides* as defined in section 15.4f and that appellant reached maximum medical improvement on July 17, 2008.

[28] *Supra* note 25; *see also L.H.*, Docket No. 14-1060 (issued October 1, 2014).

[29] *Supra* note 8.

[30] *See A.M.*, Docket No. 14-1275 (issued January 12, 2015).

The Board has carefully reviewed the opinion of Dr. Markellos and finds that it has reliability, probative value, and convincing quality with respect to its conclusions regarding the relevant issue in the present case.[31] Dr. Markellos' opinion is based on a proper factual and medical history, which he thoroughly reviewed. He accurately summarized the relevant medical evidence and provided medical rationale that appellant had a class 0 rating for ulnar nerve entrapment, for a zero left upper extremity impairment. This finding is in accordance with section 15.4f of the A.M.A., *Guides*.[32] When a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion, the opinion of such specialist, if sufficiently well rationalized and based on a proper background, must be given special weight.[33] Dr. Markellos' opinion is consequently entitled to special weight as the impairment medical examiner.[34] Appellant therefore did not meet his burden of proof to establish that he has impairment of the left upper extremity greater than the one percent previously awarded.

On appeal counsel asserts that the referee physician's report is vague, speculative, and incomplete, that the Office erred in its factual basis for finding a conflict, and that the referee was improperly selected under the PDS. The Board has previously found herein that the independent medical report of Dr. Markellos was well reasoned and entitled to the special weight as an independent medical examination. As has also been noted above, the findings of Dr. Stark who performed a second opinion in which he found no physical abnormalities relating to appellant's ulnar nerve were sufficient to create a conflict with the attending physician, Dr. Allon, who found ulnar nerve impairment and a resulting 48 percent permanent impairment rating. Finally, the Board has previously found herein that OWCP properly selected the independent medical examiner, Dr. Markellos, under the PDS system.

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.

CONCLUSION

The Board finds that appellant did not establish a left upper extremity impairment greater than one percent impairment for which he has received a schedule award.

[31] *See C.M.*, Docket No. 13-2107 (issued April 21, 2014).

[32] *Id*.

[33] *Supra* note 22.

[34] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the July 7, 2014 decision of the Office of Workers' Compensation Programs is affirmed.[35]

Issued: March 10, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

[35] James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.