United States Department of Labor
Employees' Compensation Appeals Board

A.M., Appellant	)	
and	)	**Docket No. 16-0848**
	)	**Issued: November 9, 2016**
DEPARTMENT OF DEFENSE, DEFENSE SUPPLY CENTER, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 21, 2016 appellant, through counsel, filed a timely appeal from a November 16, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 met her burden of proof to establish left upper extremity permanent impairment due to the accepted work-related conditions.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel asserts that the opinion of OWCP's referral physician Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, is insufficiently rationalized to carry the weight of the medical evidence and, as such, a conflict in medical opinion evidence has been created.

FACTUAL HISTORY

On February 18, 1998 appellant, then a 39-year-old equipment specialist, filed an occupational disease claim (Form CA-2) alleging that repetitive computer use caused entrapment of the median and ulnar nerves at the wrist and elbow. This claim was adjudicated by OWCP under File No. xxxxxx582. On May 20, 1998 OWCP accepted right carpal tunnel syndrome under that claim. Appellant had right carpal tunnel release on June 11, 1998.

On July 21, 2000 appellant filed a second occupational disease claim (Form CA-2), alleging that repetitive computer work caused injury to both elbows. This claim was adjudicated by OWCP under File No. xxxxxx945. Appellant previously had left anterior ulnar nerve transposition at the cubital tunnel on June 1, 2000. On November 22, 2000 OWCP denied the July 2000 occupational disease claim. On June 14, 2001 an OWCP hearing representative affirmed the November 22, 2000 decision.[3] On January 25, 2002 appellant underwent right anterior ulnar nerve transposition at the cubital tunnel. Following further development, on October 30, 2006 OWCP accepted bilateral cubital tunnel syndrome.

On February 13, 2008 appellant filed a schedule award claim (Form CA-7). In a January 3, 2008 report, Dr. David Weiss, an osteopath, provided results on examination and impairment ratings for each arm. He diagnosed cumulative and repetitive trauma disorder, bilateral carpal tunnel syndrome, bilateral brachial plexopathy, right greater than left, bilateral ulnar nerve neuropathy at the cubital tunnel, occupational cervical spine syndrome superimposed upon preexisting cervical pathology (motor vehicle accident June 1995 with herniated nucleus pulposus), and status post left ulnar nerve transposition. Regarding the left upper extremity, a *Quick*DASH score of 70 was reported. Dr. Weiss advised that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides* hereinafter),[4] appellant had 40 percent left arm impairment. On March 21, 2008 Dr. John J. Park, Board-certified in anesthesiology and pain medicine, agreed with Dr. Weiss' conclusions.

In a July 11, 2008 report, Dr. Arnold T. Berman, an OWCP medical adviser and a Board-certified orthopedic surgeon, noted his review of the record and Dr. Weiss' January 3, 2008 report. The medical adviser concluded that, for a diagnosis of bilateral cubital tunnel syndrome, under Table 16-10 and Table 16-15 of the fifth edition of the A.M.A., *Guides*, appellant had four percent impairment of each upper extremity due to ulnar nerve sensory impairment, with maximum medical improvement reached on January 3, 2008.

[3] Appellant thereafter filed an appeal with the Board. In an Order dated November 19, 2001, the Board dismissed the appeal, at counsel's request. Docket No. 01-2290 (issued November 19, 2001).

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

On April 28, 2009 Dr. Berman advised that under Table 16-15 and Table 16-10, for a diagnosis of right carpal tunnel syndrome, appellant had 23 percent impairment of the median nerve which, when combined with the previous 4 percent impairment of the ulnar nerve, yielded 26 percent right upper extremity impairment, with January 3, 2008 the date of maximum medical improvement.

By decision dated May 1, 2009, OWCP granted appellant schedule awards for 26 percent permanent right arm impairment. Appellant, through counsel, timely requested a hearing, that was held before an OWCP hearing representative on September 8, 2009. In a November 3, 2009 decision, an OWCP hearing representative found that OWCP should combine File Nos. xxxxxx582 and xxxxxx945, prepare a statement of accepted facts (SOAF), and refer appellant for a second-opinion evaluation and impairment assessment of both upper extremities, in accordance with the sixth edition of the A.M.A., *Guides*.[5]

Following remand, OWCP prepared an amended SOAF and referred appellant to Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon, for a second-opinion evaluation and impairment assessment. In a February 5, 2010 report, Dr. Didizian, however, merely provided an impairment rating for her right arm. He concluded that appellant had 17 percent right upper extremity impairment due to carpal tunnel syndrome.

By decision dated March 4, 2010, issued under File No. xxxxxx945, OWCP found that appellant had not established more than 26 percent permanent impairment for the right arm.[6]

In a July 29, 2010 decision, issued under File No. xxxxxx582, OWCP also found that appellant had not established more than the 26 percent previously awarded. Appellant, through counsel, timely requested a hearing.

In a September 20, 2010 decision, issued under File No. xxxxxx945, an OWCP hearing representative set aside the March 4, 2010 decision, issued under that file, and remanded the case to OWCP. On remand, OWCP was to combine all of appellant's claims and prepare a SOAF that incorporated information from all her claims. Appellant was then to be referred to an appropriate specialist for a second-opinion evaluation and impairment assessment in accordance with the sixth edition of the A.M.A., *Guides*, to be followed by a *de novo* schedule award decision.

On November 12, 2010 OWCP prepared an amended SOAF under File No. xxxxxx945. It noted that File No. xxxxxx582 had been doubled with File No. xxxxxx945, and that appellant had two additional claims, File Nos. xxxxxx605 and xxxxxx741, both of which were lower extremity claims. All prior SOAF for File Nos. xxxxxx945 and xxxxxx582 were incorporated into the November 12, 2010 SOAF. On November 17, 2010 OWCP referred appellant to Dr. Samuel E. Epstein, a Board-certified osteopath specializing in orthopedic surgery, for a second-opinion report.

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

[6] Dr. Didizian's report was reviewed by Dr. Berman. Both Dr. Didizian and Dr. Berman provided impairment evaluation for left carpal tunnel syndrome. This, however, is not an accepted condition.

Appellant forwarded a June 11, 2010 report, in which Dr. Weiss had updated his January 3, 2008 report to conform to the sixth edition of the A.M.A., *Guides*. He did not reexamine appellant. Dr. Weiss concluded that appellant had a total 29 percent right upper extremity impairment. With regard to the left upper extremity, he advised that under Table 15-23, for entrapment neuropathy of the left median nerve at the wrist, she had total left upper extremity impairment of six percent.

Under File No. xxxxxx582, a hearing was held on December 6, 2010. The hearing representative issued a summary decision, finding that, based on the September 20, 2010 hearing representative decision remanding File No. xxxxxx945 to OWCP for doubling with File No. xxxxxx582, further development should be conducted under File No. xxxxxx945, the master file. The hearing representative memorialized this finding in correspondence dated December 21, 2010.

In a January 17, 2011 report, Dr. Epstein noted appellant's past medical and surgical history and his review of the medical record, including electrodiagnostic studies. He noted prior motor vehicle accidents in 1987 and 1995 with clavicle, neck, and shoulder injuries. With regard to an impairment rating, Dr. Epstein advised that since appellant had no significant objective abnormal findings for impingement syndrome, she would fall into a class 0 and had no rating for impingement syndrome. He further found that since she had no significant diminished sensation or motor function in the ulnar nerve distribution of either hand or forearm, and she had no significant pain in either elbow, or in the ulnar nerve distribution distal to the elbows, she fell into class 0 for the cubital tunnel syndrome, which had resolved postoperatively, and that she had no impairment due to cubital tunnel syndrome or its surgery. Regarding right carpal tunnel syndrome, Dr. Epstein concluded that appellant had nine percent impairment due to right carpal tunnel syndrome.[7] In an attached work capacity evaluation (OWCP Form 5c), he advised that she could perform her usual job.

On March 4, 2011 Dr. Christopher R. Brigham, an OWCP medical adviser who is Board-certified in family and occupational medicine, agreed with Dr. Epstein's right upper extremity impairment of nine percent.[8]

In a March 7, 2011 decision, OWCP found that appellant had established no more than the 26 percent previously awarded for right upper extremity. Appellant, through counsel, timely requested a hearing. On August 1, 2011 counsel requested that the hearing be converted to a review of the written record. Appellant resubmitted Dr. Weiss' June 11, 2010 report.

By decision dated October 18, 2011, an OWCP hearing representative affirmed the March 7, 2011 decision, finding that appellant had established no more than 26 percent right upper extremity impairment. The hearing representative noted that upon return of the case record, OWCP was to address the left upper extremity.

[7] Dr. Epstein noted that, per the SOAF, left carpal tunnel syndrome had not been accepted. He nonetheless found one percent impairment for left carpal tunnel syndrome.

[8] Dr. Brigham also agreed with Dr. Epstein's left upper extremity impairment assessment, but noted that left carpal tunnel syndrome had not been accepted.

In a February 7, 2012 report, Dr. Henry J. Magliato, an OWCP medical adviser and a Board-certified orthopedic surgeon, reviewed both records (File Nos. xxxxxx945 and xxxxxx582) and Dr. Weiss' impairment rating. For the left arm, he noted that Dr. Weiss provided a rating for left carpal tunnel syndrome for median nerve entrapment, which was not an accepted condition and found that appellant had no impairment of the left arm. The medical adviser recommended an additional impairment evaluation as there were significant problems with Dr. Weiss' analysis under the sixth edition for both arms.

OWCP then referred appellant to Dr. Askin, for a second-opinion evaluation and impairment rating for the left arm. In an August 31, 2012 report, Dr. Askin noted his review of the SOAF and medical record, noting the accepted conditions of right carpal tunnel syndrome and bilateral ulnar nerve lesions, her past medical history, and her continued complaints of pain and numbness. Physical examination showed full range of motion of shoulders, elbows, forearms, wrists, fingers, and thumbs. Muscle function was intact bilaterally with forearm circumference of 25 centimeter (cm) on the right and 24 cm on the left. Dynamometer grip strength of the hand was 22/24 at 1 (right/left), 26/28 at 3, and 18/18 at 5. Dr. Askin advised that appellant reported two-point discrimination of more than 1 cm for the left long, ring, and small fingers, and more than 1 cm in the right thumb and small fingers, but was otherwise within normal limits. No atrophic or dystrophic changes were seen on inspection of both hands. Finkeistein's test for de Quervain's, Wartenberg's, Froment's, and cross-finger signs, and testing for the intersection syndrome were negative bilaterally, although appellant reported that right wrist motion caused discomfort. Inner function was intact. Phalen's, Tinel's, and percussion over the cubital tunnels were positive bilaterally. Percussion of Guyon's canal was negative on the right and positive on the left. Dr. Askin's testing revealed patency of the radial and ulnar arteries. He found that maximum medical improvement had been reached and that the only objective findings were surgical scars, noting no objective clinical indications such as atrophy or dystrophic change that would be consistent with a left arm impairment. Dr. Askin related that all imperfections described by appellant regarding her left arm were within her control, and that her complaints were entirely subjective and not objectively corroborated. He concluded that, in accordance with Table 15-23 of the sixth edition of the A.M.A., *Guides*, appellant had no impairment of the left upper extremity, noting no objective clinical findings such as atrophy or dystrophic change, normal range of motion, and normal strength with only subjective complaints present.

On April 9, 2013 counsel requested a copy of Dr. Askin's report and asked that OWCP issue a decision on appellant's schedule award claim.

On May 14, 2014 OWCP asked its medical adviser, Dr. Magliato, to review Dr. Askin's impairment evaluation. In a May 22, 2014 report, the medical adviser agreed with Dr. Askin that appellant had no left arm impairment, based on no objective findings relative to the left ulnar nerve and only subjective complaints.

By decision dated February 26, 2015, OWCP found that a schedule award for a left upper extremity impairment was not warranted as the medical evidence of record failed to demonstrate a measureable impairment.

Appellant, through counsel, timely requested a hearing, that was held on August 31, 2015. In an August 20, 2015 statement, she noted her disagreement with Dr. Askin's findings and conclusions. Counsel noted that the schedule award decision was issued over two years after Dr. Askin's evaluation and referred to the positive electrodiagnostic study in 2000. Appellant asserted that his conclusion of zero percent left upper extremity impairment was in conflict with his observations, noting positive cubital percussion and Guyon's canal tests, sensory deficit in the fingers, and that her left upper extremity measured smaller than the right. Counsel recommended that appellant be referred for a new impairment evaluation.

Following the hearing appellant resubmitted Dr. Weiss' January 3, 2008 report, which was updated on September 29, 2015. Dr. Weiss had not examined her since 2008. He had evaluated entrapment neuropathy of the left ulnar nerve at the elbow, rather than the median nerve at the wrist. Dr. Weiss' calculations under Table 15-23 were identical, and he again concluded that appellant had six percent left upper extremity impairment.

In a November 16, 2015 decision, an OWCP hearing representative found that Dr. Askin provided a well-discussed report in which he advised that appellant had no objective evidence on examination or testing to warrant a ratable impairment, noting that her complaints were not corroborated on examination. The hearing representative noted that Dr. Weiss' reports were flawed and that an OWCP medical adviser agreed with Dr. Askin's findings. She concluded that appellant had not provided sufficient medical discussion from an examining physician to establish a ratable left upper extremity impairment and affirmed the February 26, 2015 decision.

LEGAL PRECEDENT

The schedule award provision of FECA, and its implementing federal regulations,[9] 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.[10] For decisions issued after May 1, 2009, the sixth edition will be used.[11]

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).[12] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment class for the diagnosed condition Class of Diagnosis (CDX), which is

[9] 20 C.F.R. § 10.404.

[10] *Id*. at § 10.404(a).

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

[12] A.M.A., *Guides*, *supra* note 4 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14]

Impairment due to cubital tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text in section 15.4f of the A.M.A., *Guides*.[15] In Table 15-23, grade modifier 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]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[17]

ANALYSIS

The Board finds that appellant has failed to establish left upper extremity permanent impairment due to the accepted cubital tunnel syndrome.

The reports from Dr. Weiss updated June 11, 2010 and again updated September 29, 2015, while they applied the sixth edition of the A.M.A., *Guides*, were based on the findings from his January 3, 2008 examination. As these reports were not based on current findings, they are of diminished probative value.[18]

In his August 31, 2012 report, while Dr. Askin noted positive Phalen's, Tinel's, and percussion tests over appellant's cubital tunnels, he opined that all imperfections described by her regarding her left arm were within her control and that her complaints were entirely subjective and not objectively corroborated. He concluded that, in accordance with Table 15-23 of the sixth edition of the A.M.A., *Guides*, she had no impairment of the left arm, noting no objective clinical findings, such as atrophy or dystrophic change, normal range of motion, and normal strength with only subjective complaints present.

[13] *Id*. at 385-419.

[14] *Id*. at 411.

[15] *Id*. at 433-50.

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

[17] *See supra* note 12 at Chapter 2.808.6(f) (February 2013).

[18] *See J.M.*, Docket No. 14-888 (issued February 9, 2015).

Dr. Magliato, OWCP medical adviser, agreed with Dr. Askin's conclusion that appellant had no left upper extremity impairment, based on no objective findings relative to the left ulnar nerve and only subjective complaints.

There is no current medical evidence in conformance with the A.M.A., *Guides* showing any left upper extremity impairment causally related to the accepted condition. The Board finds that, as the medical adviser properly applied the A.M.A., *Guides* to Dr. Askin's clinical findings and agreed with his conclusions, their opinions represent the weight of the medical evidence.[19]

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 failed to meet her burden of proof to establish left upper extremity permanent impairment due to the accepted cubital tunnel syndrome.

ORDER

IT IS HEREBY ORDERED THAT the November 16, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 9, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[19] *See N.B.*, Docket No. 15-1390 (issued November 6, 2015).