

**United States Department of Labor  
Employees' Compensation Appeals Board**

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C.A., Appellant )

and )

U.S. POSTAL SERVICE, POST OFFICE, )  
Boston, MA, Employer )

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**Docket No. 17-0665  
Issued: November 8, 2017**

*Appearances:*

*John L. Whitehouse, Esq., for the appellant<sup>1</sup>*

*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  
VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On February 2, 2017 appellant, through counsel, filed a timely appeal from a November 8, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

**ISSUE**

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

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<sup>1</sup> 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.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

## **FACTUAL HISTORY**

On August 20, 2009 appellant, then a 58-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on August 20, 2009 his left hand and arm were numb and painful after he moved a steel postal cage that struck a dock plate. He stopped work on August 20, 2009.

OWCP accepted appellant's claim for left cubital tunnel syndrome. It paid continuation of pay (COP) and wage-loss compensation.

On November 20, 2009 appellant underwent authorized left carpal tunnel release surgery and stopped work. OWCP paid wage-loss compensation until January 7, 2010. On January 8, 2010 appellant returned to full duty.

Appellant underwent a left hand electromyography (EMG) and nerve conduction velocity (NCV) study on July 5, 2012 by Dr. Albert L. Fullerton, a neurologist. Dr. Fullerton noted evidence of a significant residual left ulnar neuropathy at the elbow, affecting sensory and motor components, and a mild residual left medial neuropathy at the wrist affecting motor components.

On January 31, 2013 appellant filed a claim for a schedule award (Form CA-7).

By letter dated February 15, 2013, OWCP requested that appellant provide a medical report from his treating physician with an opinion on whether he had reached maximum medical improvement (MMI) and whether he had a permanent impairment rating utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).<sup>3</sup> Appellant was afforded 30 days to submit the additional evidence.

Appellant submitted reports by Dr. Benjamin P. Levine, a Board-certified orthopedic hand surgeon, dated January 18, 2012 to March 5, 2013. Dr. Levine noted appellant's history of left hand cubital tunnel syndrome. He related appellant's complaints of localized pain on the palmar side of his hand with worsening symptoms with pressure. Dr. Levine indicated that the left hand EMG study on July 5, 2012 showed a significant residual left ulnar neuropathy at the elbow and a mild residual left medial neuropathy at the wrist, with no evidence of cervical radiculopathy. He reviewed appellant's history and conducted a physical examination of appellant's left elbow. Dr. Levine noted no swelling, ecchymosis, or erythema. Range of motion was active and normal. Dr. Levine reported that sensory examination showed decreased sensation in the ulnar nerve distribution. Tinel's test was positive for cubital tunnel syndrome. Dr. Levine diagnosed cubital tunnel syndrome.

In a letter dated March 5, 2013, appellant informed OWCP that Dr. Levine was unable to provide a report because he had recommended additional surgery.

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<sup>3</sup> 6<sup>th</sup> ed. 2009.

By letter dated April 16, 2013, appellant informed OWCP that he cancelled his surgery with Dr. Levine and wished to proceed with his schedule award claim. He noted that he had asked Dr. Levine more than once for a narrative report.

Dr. Levine related in a June 21, 2013 report that he first treated appellant on August 25, 2009. He noted that appellant underwent EMG testing, which showed symptoms of possible ulnar tunnel and cubital tunnel of appellant's left wrist and ulnar nerve. Dr. Levine indicated that, based on the EMG results, surgery was performed on November 20, 2009. He related that he examined appellant again on January 7, 2010 and noted that appellant was doing great so he authorized appellant to return to work.

Dr. Levine reported that he examined appellant on January 18, 2012 because of complaints of pain on the palmer side of his left hand and problems holding objects. He indicated that appellant's examination was consistent with cubital tunnel syndrome. Dr. Levine opined that he was not sure whether or not appellant had reached MMI. He explained that, if appellant decided not to have any surgical intervention then he was at MMI, but a repeat surgery of this nature would not ensure a normal hand since appellant had residual symptoms after the first surgery. Dr. Levine diagnosed carpal tunnel and cubital tunnel syndrome. He reported that appellant continued to have difficulty grabbing and performing fine manipulation. Dr. Levine advised that appellant refrain from repetitive elbow flexion. He indicated that he was not comfortable giving appellant a rating based on the sixth edition of the A.M.A., *Guides* because he had not properly measured all of appellant's functionality in terms of motor and range of motion. Dr. Levine recommended surgical intervention.

By letter dated October 31, 2013, counsel advised OWCP that it was enclosing Dr. Levine's response to the February 15, 2013 development letter. He submitted an October 29, 2013 report by Dr. Levine. In this report Dr. Levine related that appellant's left hand and elbow were problematic. Upon examination of appellant's left elbow, he observed no swelling, ecchymosis, or erythema. Range of motion was active and normal. Sensory examination showed decreased sensation in the ulnar nerve distribution. Dr. Levine reported that Tinel's test was positive for cubital tunnel. Elbow flexion was also positive. Dr. Levine diagnosed cubital tunnel syndrome. He opined that, according to Table 15-21, page 443 of the A.M.A., *Guides*, appellant was a class 2, which resulted in 17 percent upper extremity impairment and 10 percent whole body impairment according to Table 15-11.

OWCP referred appellant, along with a statement of accepted facts (SOAF) and the record, to Dr. Frank A. Graf, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether appellant sustained any ratable impairment of his left upper extremity condition in accordance with the A.M.A., *Guides*.

In a February 11, 2014 report, Dr. Graf reviewed the SOAF and the evidence of record. He noted that appellant's claim was accepted for cubital tunnel syndrome and that appellant had also undergone left carpal tunnel release surgery. Dr. Graf indicated that an August 30, 2012 EMG study showed significant residual left ulnar neuropathy and residual median neuropathy. He related appellant's current complaints of continued numbness, tingling, and pain along the left ulnar border forearm and in all digits of the left hand. Upon physical examination, Dr. Graf reported positive Tinel's sign of appellant's right wrist and positive Tinel's sign of his right ulnar

cubital tunnel. Examination of appellant's left upper extremity revealed a thinning of the interosseous muscles diffusely present on the left and thenar atrophy. Dr. Graf reported that Phalen's test or carpal tunnel was negative on the left. He indicated that Tinel's test was positive at the left wrist and at the ulnar cubital tunnel.

Dr. Graf reported that appellant had reached MMI regarding his left and right upper extremities. He explained that appellant obtained little benefit from surgery and did not wish to have another surgery. Dr. Graf further recommended that appellant's claim be expanded to include right carpal tunnel and right ulnar cubital tunnel dysfunction. He referenced Table 15-21, page 443, of the A.M.A., *Guides* and indicated that appellant was a class 2, grade C for ulnar nerve above forearm, which equaled 17 percent left upper extremity impairment. Dr. Graf also referred to Table 15-21, page 438 for median nerve below mid forearm entire nerve with moderate sensory deficit and noted that appellant was a class 2, grade C which equaled 17 percent left upper extremity impairment. He applied the net adjustment formula to the default ratings for each condition and noted grade modifiers of 2 for Functional History (GMFH), 2 for Physical Examination (GMPE), and 2 for Clinical Studies (GMCS). Utilizing the Combined Values Chart, Dr. Graf indicated that appellant had combined 31 percent left upper extremity impairment.

In a March 4, 2014 addendum report, Dr. Graf related that his opinion was based upon history taken directly from the patient, patient examination, and with reference to the sixth edition of the A.M.A., *Guides*. He indicated that the ratings submitted would not be recalculated since they represented his opinion of appellant's permanent impairment.

In a May 4, 2014 report, Dr. David I. Krohn, a Board-certified internist and OWCP medical adviser, noted that he had reviewed Dr. Graf's February 11, 2014 report. He indicated that Dr. Graf combined appellant's impairment for carpal tunnel syndrome and for ulnar nerve impairment to obtain appellant's final impairment rating, but the SOAF did not include carpal tunnel syndrome as an accepted work-related condition. Dr. Krohn also related that Dr. Graf assigned a grade modifier of 2 for clinical studies, but he would have assigned a grade modifier of 1 because appellant did not have a second left ulnar nerve transposition in June 2013 as Dr. Graf noted. He assigned a MMI date of February 11, 2014. Dr. Graf referenced Table 15-21, page 443, of the A.M.A., *Guides*, for ulnar nerve injury and related that appellant was a class 2 for moderate motor deficit, which equaled 17 percent permanent impairment of the left upper extremity. Dr. Krohn reported grade modifiers of 2 for GMFH, 2 for GMPE, and 1 for GMCS. After applying the net adjustment formula, he calculated that appellant had 15 percent left upper extremity permanent impairment.

OWCP found that a conflict in medical evidence existed between the opinions of Dr. Graf, the second opinion physician, and Dr. Krohn, OWCP's medical adviser, regarding the degree of appellant's permanent impairment of his left upper extremity. It referred appellant to Dr. Joseph Abate, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion to resolve the conflict in medical opinion evidence.

In a December 8, 2014 report, Dr. Abate reviewed the SOAF and appellant's history. Upon physical examination of appellant's left upper extremity, he observed a minimal visible scar at the right wrist with a mildly positive Tinel's and Phalen's test. Dr. Abate reported

weakness of grasp, 50 percent left as compared to right. He noted mild arthritic deformities of the DIP joints, index and long fingers, and minimal sensory loss to pin prick of thumb, index, and long finger. Examination of appellant's left elbow demonstrated positive Tinel's sign with tingling into the fourth and fifth fingers and positive elbow flexion test. Dr. Abate diagnosed status post left cubital tunnel syndrome postoperative with residual and left carpal tunnel syndrome postoperative.

Dr. Abate noted that Dr. Krohn disagreed with Dr. Graf's impairment rating because the SOAF did not include carpal tunnel syndrome as an accepted work-related condition. He related that the SOAF did include appellant's left carpal tunnel syndrome. Dr. Abate reported that including both impairments and based on his physical findings, appellant had 17 percent impairment left upper extremity. He referenced Table 15-21, page 443, of the A.M.A., *Guides* and noted that appellant had moderate motor deficit for a class 2, default 17 percent permanent impairment of the left upper extremity. Dr. Abate reported grade modifiers of 0 for GMPE and -1 for GMCS for conduction delay, no motor conduction block for a total of 15 percent left upper extremity impairment. He related that appellant also had 17 percent left upper impairment for nerve below mid forearm moderate sensory. Dr. Abate utilized the Combined Values Chart and concluded that appellant had a total of 29 percent left upper extremity impairment. He noted an MMI date of November 20, 2009.

OWCP referred appellant's schedule award claim to a second OWCP medical adviser. In a May 5, 2015 report, Dr. Henry J. Magliato, a Board-certified orthopedic surgeon, reviewed appellant's history and noted that his claim was accepted for left hand cubital tunnel syndrome. He indicated that he reviewed and disagreed with the December 8, 2014 impairment rating and report. Dr. Magliato explained that appellant's permanent impairment should have been rated under the peripheral nerve entrapment section on page 448, 449, and Table 15-23. He noted that when there are two entrapments in the same extremity, the second one was rated at only 50 percent and the two values are then combined for the total left upper extremity impairment. Dr. Magliato related that appellant's positive neurological findings should have been included in the GMPE, which would either increase or decrease the default value. He recommended that the impartial medical examiner use the correct methods as outlined above or get a new impartial medical examiner.

In a May 30, 2015 report, Dr. Abate noted that he received OWCP's request to provide a supplemental report with an impairment rating based on Table 15-23, page 448, for peripheral nerve entrapment. He indicated that based on the conditions of carpal tunnel and cubital tunnel syndrome status postsurgical release, appellant had a GMCS of one due to conduction delay, GMFH of one for mild intermittent symptoms, and a GMPE of two for decreased sensation. Dr. Abate related that appellant had an average of 1.3 for a default impairment of two percent upper extremity impairment. He explained that for ulnar nerve entrapment, appellant had GMCS of one for conduction delay, GMFH of two for significant intermittent symptoms, and GMPE of two for decreased sensation for an average of two. Dr. Abate noted that appellant had a default value of five percent upper extremity impairment. He related that he selected the lower value of four percent impairment for the ulnar nerve. Dr. Abate calculated that with the full four percent impairment combined with 50 percent of the rating of the second nerve at two percent, the combined value of four percent and one percent resulted in a total of five percent left upper extremity permanent impairment.

Dr. Magliato reviewed Dr. Abate's May 30, 2015 supplemental report in a July 24, 2015 report. He calculated that appellant had two percent impairment for median nerve entrapment and five percent impairment for ulnar nerve entrapment. Dr. Magliato noted that Dr. Abate used the "lowest value" for four percent impairment, but it was not clear why. He explained that when he combined five percent impairment with one percent impairment, appellant had a total of six percent left upper extremity permanent impairment. Dr. Magliato recommended that OWCP either accept a six percent left upper extremity impairment rating or ask Dr. Abate why he reduced the five percent for the ulnar nerve to the lower value of four percent.

In an October 2, 2015 report, Dr. Abate noted that he erroneously changed appellant's left ulnar nerve impairment rating from five percent to four percent. He reported that the correct value for ulnar nerve impairment should be five percent plus the median nerve value at one percent for a total of six percent left upper extremity permanent impairment.

OWCP noted in a February 4, 2016 memorandum that Dr. Abate should be treated as a second opinion examiner because it incorrectly declared a conflict in medical opinion between Dr. Graf and Dr. Krohn.

In a decision dated February 10, 2016, OWCP granted appellant a schedule award for six percent permanent impairment of the left upper extremity. It noted a MMI date of February 11, 2014. The award ran from February 11 to June 22, 2014. OWCP noted that appellant's permanent impairment rating was based on Dr. Abate's October 2, 2015 report and Dr. Magliato's July 24, 2015 report.

On February 22, 2016 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. On June 30, 2016 OWCP advised appellant that it received his petition to withdraw his hearing request and that it was returning his claim back to the district OWCP.

On September 2, 2016 appellant, through counsel, requested reconsideration. He reviewed the timeline of appellant's schedule award claim. Counsel alleged that OWCP erred in instructing Dr. Abate to evaluate appellant's impairment in accordance with Table 15-23 rather than Table 15-21 as used by Drs. Graf, Krohn, Levine, and Abate. He noted that the A.M.A., *Guides* indicated that Section 15-23 "may" be used when rating more than one impairment. Counsel asserted that the language was permissive, not mandatory. He related that Table 2.1 mandated that, if the A.M.A., *Guides* provided for more than one method to rate a particular impairment or condition, the method producing the higher rating "must be used." Counsel further alleged that OWCP should not have obtained a second opinion from Dr. Abate when it had already obtained a second opinion from Dr. Graf. He asserted that OWCP should have adopted Dr. Graf's impairment rating.

By decision dated November 8, 2016, OWCP denied modification of the February 10, 2016 schedule award decision. It found that Dr. Magliato and Dr. Abate properly based appellant's impairment rating on Table 15-23 of the A.M.A., *Guides* because appellant's impairment rating was based on diagnoses of carpal and cubital tunnel syndrome.

## LEGAL PRECEDENT

The schedule award provisions of FECA and its implementing regulations 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.<sup>4</sup> FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as a standard for evaluation of scheduled losses and the Board has concurred in such adoption.<sup>5</sup> For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.<sup>6</sup>

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).<sup>7</sup> Under the sixth edition, the evaluator identifies the impairment for the Class of Diagnoses (CDX) condition, which is then adjusted by grade modifiers based on functional history, physical examination, and clinical studies. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>8</sup> Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.<sup>9</sup>

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 in section 15.4f of the A.M.A., *Guides*.<sup>10</sup> In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of 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 based on functional scale, an assessment of impact on daily living activities.<sup>11</sup> The A.M.A., *Guides* specifically indicate that, if multiple simultaneous neuropathies occur in the same limb, both impairments may be related and the nerve qualifying for the larger impairment is given the full impairment while the nerve qualifying for the smaller

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<sup>4</sup> 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

<sup>5</sup> 20 C.F.R. § 10.404 (1999); *see also* Jacqueline S. Harris, 54 ECAB 139 (2002).

<sup>6</sup> Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (January 2010).

<sup>7</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009) 3, section 1.3.

<sup>8</sup> *Id.* at 385-419.

<sup>9</sup> *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

<sup>10</sup> *Supra* note 5 at 449.

<sup>11</sup> *Id.* at 448-49.

impairment is rated at 50 percent.<sup>12</sup> The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise,<sup>13</sup> and Appendix 15-B provides further guidance regarding electrodiagnostic evaluation of entrapment syndromes.<sup>14</sup>

### ANALYSIS

OWCP accepted appellant's claim for left cubital tunnel syndrome as a result of an August 20, 2009 employment injury. On November 20, 2009 appellant underwent authorized left ulnar nerve and carpal tunnel release surgery. On January 31, 2013 he filed a claim for a schedule award. By decision dated February 10, 2016, OWCP granted appellant a schedule award of six percent permanent impairment of the left upper extremity. On November 8, 2016 it denied modification of its February 10, 2016 schedule award decision and found that appellant did not have more than six percent left upper extremity permanent impairment.

The Board finds that appellant has not met his burden of proof to establish more than six percent permanent impairment of the left upper extremity.

OWCP granted appellant's schedule award based on the opinion of Dr. Magliato, the second OWCP medical adviser. In a July 24, 2015 report, Dr. Magliato related that he reviewed Dr. Abate's May 30, 2015 report, which determined that appellant had five percent permanent impairment of the left upper extremity according to the A.M.A., *Guides*. In calculating appellant's impairment for left cubital tunnel syndrome, he properly utilized Table 15-23, Entrapment/Compression Neuropathy, Impairment, page 449 of the A.M.A., *Guides* and properly applied Dr. Abate's clinical findings. Dr. Magliato noted that for appellant's median nerve entrapment, appellant had a grade modifier of one for test findings for conduction delay. Clinical studies included a July 7, 2012 EMG/NCV study, which showed evidence of significant residual left ulnar neuropathy and mild residual left medial neuropathy at the wrist. Dr. Magliato further determined that appellant had grade modifier of one for functional history due to mild intermittent symptoms and grade modifier of two for physical examination for decreased sensation. He properly calculated the average of the modifiers to equal one and determined that appellant had two percent left upper extremity impairment under Table 15-23 of the A.M.A., *Guides* based on Dr. Abate's clinical findings.

Regarding appellant's ulnar nerve entrapment, Dr. Magliato reported that appellant had grade modifier of one for clinical studies. He also noted a grade modifier of two for functional history due to significant intermittent symptoms and two for physical examination due to decreased sensation. Dr. Magliato properly calculated the average of the modifiers to equal two, which resulted in five percent left upper extremity impairment. He indicated that he disagreed with Dr. Abate's decision to use the lower value of four percent to rate appellant's ulnar nerve entrapment and noted that Dr. Abate did not explain why he chose the lower value. Dr. Magliato further noted that for patients with multiple neuropathies, the second or smaller nerve

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<sup>12</sup> *Id.* at 448.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at 487-90



impairment was rated at 50 percent of the impairment listed in Table 15-23. He accurately combined these impairment ratings and concluded that appellant had six percent permanent impairment of the left upper extremity. In an October 2, 2015 report, Dr. Abate agreed with Dr. Magliato's impairment rating that the correct value for ulnar nerve impairment should be five percent. He noted that he erroneously changed appellant's left ulnar nerve impairment rating from five percent to four percent.

The Board finds that OWCP's medical adviser's opinion represents the weight of the evidence and establishes that appellant has no more than the six percent permanent impairment previously awarded. In his July 24, 2015 report, Dr. Magliato properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record to determine appellant's impairment rating for his accepted left cubital tunnel syndrome.<sup>15</sup> There is no current medical evidence of record, in conformance with the sixth edition of the A.M.A., *Guides*, showing greater impairment.

The Board finds that the additional medical reports on the record fail to establish that appellant has more than six percent permanent impairment of the left upper extremity.

In support of his schedule award claim, appellant submitted a report from his treating physician, Dr. Levine, who opined in an October 29, 2013 report that appellant had 17 percent left upper extremity permanent impairment according to Table 15-21, page 443, of the A.M.A., *Guides* and 10 percent whole body impairment according to Table 15-11, page 420 of the of the A.M.A., *Guides*. As noted above, however, when rating impairment due to cubital tunnel syndrome an evaluator should follow the scheme outlined in Table 15-23 for Entrapment/Compression Neuropathy Impairment of the A.M.A., *Guides* and accompanying relevant text.<sup>16</sup> The Board has held that an attending physician's report is of diminished probative value where the A.M.A., *Guides* are not properly followed.<sup>17</sup> Because Dr. Levine did not properly follow the A.M.A., *Guides* in providing an impairment rating for appellant's left cubital tunnel syndrome, his report is insufficient to support an additional schedule.

Likewise, the reports of OWCP's referral physicians, including Dr. Graf's February 11, 2014 report, Dr. Krohn's May 4, 2014 report, and Dr. Abate's December 8, 2014 report also fail to demonstrate that appellant is entitled to an additional schedule award as their impairment ratings were also improperly based on Table 15-21 of the A.M.A., *Guides*. The Board has found that when the examining physician does not provide an estimate of impairment conforming to the proper edition of the A.M.A., *Guides*, OWCP may rely on the impairment rating provided by the medical adviser.<sup>18</sup>

The Board finds that Dr. Magliato, the second OWCP medical adviser, was the only physician of record who properly applied the specific methodology for rating appellant's left

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<sup>15</sup> See *M.T.*, Docket No. 16-0296 (issued May 20, 2016).

<sup>16</sup> *Supra* note 8.

<sup>17</sup> *J.G.*, Docket No. 09-1128 (issued December 7, 2009).

<sup>18</sup> See *J.Q.*, 59 ECAB 366 (2008).

upper extremity permanent impairment due to his accepted left cubital tunnel syndrome in accordance with the A.M.A., *Guides*. Accordingly, there is no medical basis to support appellant's claim for an additional schedule award.

On appeal counsel alleges that OWCP erroneously failed to use Table 15-21 of the A.M.A., *Guides* in determining appellant's schedule award benefits. As explained above, however, the proper method for rating permanent impairment due to cubital tunnel syndrome is found in Table 15-23 of the A.M.A., *Guides*. The Board finds that, as the second OWCP medical adviser properly applied the A.M.A., *Guides* to determine appellant's left upper extremity permanent impairment, his opinion represents the weight of the medical evidence.

Appellant may request a schedule award or increased schedule award at any time 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 has not established more than six percent permanent impairment of the left upper extremity, for which he previously received a schedule award.

**ORDER**

**IT IS HEREBY ORDERED THAT** the November 8, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 8, 2017  
Washington, DC

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

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

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