

ISSUE

The issue is whether appellant has met her burden of proof to establish more than five percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On January 24, 1987 appellant, then a 33-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on that day she slipped on ice and injured her left elbow and arm while in the performance of duty. OWCP assigned the claim OWCP File No. xxxxxx312. It initially accepted the claim for a left elbow contusion and injury to the left ulnar nerve.³

Effective September 12, 1992, appellant was reemployed as a modified clerk carrier.⁴ She continued in the modified position until she retired effective January 31, 2013.⁵

On September 3, 2013 appellant filed a claim for a schedule award (Form CA-7). In support of her schedule award claim, she submitted a May 23, 2013 report from Dr. Nicholas Diamond, an attending Board-certified physical medicine and rehabilitation physician. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),⁶ Dr. Diamond calculated 22 percent left upper extremity permanent impairment. The rating was based on the diagnoses of elbow fracture (3 percent); left ulnar nerve entrapment (6 percent), brachial plexopathy (13 percent), and left median nerve entrapment (3 percent). Dr. Diamond indicated that appellant had reached maximum medical improvement (MMI) on May 23, 2013.

OWCP routed Dr. Diamond's report, a statement of accepted facts (SOAF), and the case file to Dr. Arnold Berman, a Board-certified orthopedic surgeon serving as an OWCP District Medical Adviser (DMA), for review as to whether appellant sustained permanent impairment as a result of her accepted conditions.

In an October 21, 2013 report, Dr. Berman recommended a second opinion evaluation as appellant's medical records did not document a left radial head fracture and the left median nerve entrapment was not an accepted condition. He also found appellant's results from an electromyogram (EMG) questionable, with no clinical evidence of thoracic outlet syndrome, cervical strain, brachial neuritis, or traumatic arthropathy of the forearm and no evidence of thoracic root lesion or pain in the thoracic area. Based upon the accepted left ulnar nerve injury,

³ In a separate claim, OWCP File No. xxxxxx820, OWCP accepted a May 17, 1989 injury for an acute cervical/dorsal strain which occurred when appellant caught herself with her left arm as her right ankle twisted when descending stairs. It combined the two claims with OWCP File No. xxxxxx312 serving as the master file.

⁴ By decision dated January 20, 1993, OWCP found that the modified clerk carrier position fairly and reasonably represented appellant's wage-earning capacity. It denied modification of its loss of wage-earning capacity determination in decisions dated August 19, 2010 and April 12, 2011.

⁵ Appellant elected Office of Personnel Management (OPM) retirement benefits as of February 1, 2013.

⁶ A.M.A., *Guides* (6th ed. 2009).

Dr. Berman calculated five percent permanent impairment to the left upper extremity based on Table 15-23 of the A.M.A., *Guides*. He indicated that MMI had been reached as of May 23, 2013.

By decision dated October 30, 2013, OWCP granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The award ran for 15.6 weeks for the period May 23 to September 9, 2013. The decision was based on Dr. Berman's October 21, 2013 report.

On November 4, 2013 counsel requested a hearing before an OWCP hearing representative. A copy of a corrected version of Dr. Diamond's May 23, 2013 report, dated March 25, 2014, was submitted. A video hearing was held on April 14, 2014. By decision dated July 7, 2014, an OWCP hearing representative set aside OWCP's October 30, 2013 decision and remanded the case to OWCP for a second opinion evaluation regarding the extent of appellant's permanent impairment causally related to the accepted conditions in the claim.

OWCP issued an updated December 3, 2015 SOAF and referred appellant to Dr. Willie Thompson, a Board-certified orthopedic surgeon, for a second opinion evaluation. The December 3, 2015 SOAF indicated that appellant's January 24, 1987 claim was accepted for a left elbow contusion and left ulnar nerve injury, as well as left brachial neuritis/radiculitis, left forearm traumatic arthropathy, thoracic/lumbosacral neuritis/radiculitis, thoracic root lesion, and right thoracic spine pain. It also noted that appellant's claim under OWCP File No. xxxxxx820 was accepted for an acute cervical/dorsal strain with radiculopathy.

In a January 15, 2016 report, Dr. Thompson opined that, while multiple diagnoses had been listed in the SOAF, the only diagnosis which could be substantiated was an entrapment of the left ulnar nerve at the left elbow consistent with cubital tunnel syndrome. He opined that appellant had class 1, grade C or 5 percent permanent impairment to the left upper extremity. Dr. Thompson referenced Table 15-21, Peripheral Nerve Impairments, on page 443 of the A.M.A., *Guides*.

In a February 15, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, found that Dr. Thompson's report lacked sufficient detail to be probative and that the preferred method for calculating upper extremity peripheral nerve entrapment syndromes (or cubital tunnel syndrome in this case) was under Table 15-23, not Table 15-21 as referenced by Dr. Thompson. He noted that appellant's prior positive electrodiagnostic test results for ulnar nerve dysfunction qualified her for a rating under Table 15-23.

OWCP referred appellant to Dr. David R. Pashman, a Board-certified orthopedic surgeon, for another second opinion impairment evaluation. In a March 21, 2016 report, Dr. Pashman noted appellant's history of injury and his review of her medical records including diagnostic testing. He provided examination findings, noting that her only ongoing clinical diagnosis was that of a possible ulnar neuropathy, as evidenced by a positive Tinel's sign at the elbow and positive Waddell's signs. Under Table 15-23, Dr. Pashman calculated five percent permanent impairment of the left upper extremity impairment, for four percent permanent impairment of the ulnar nerve and one percent permanent impairment of the brachial plexus.

In an April 25, 2016 report, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Pashman's report and agreed with the five percent permanent

impairment left upper extremity rating. He found that appellant had reached MMI on March 21, 2016. As appellant previously received a schedule award for five percent permanent impairment of the left upper extremity, the DMA concluded that she did not have an increased permanent impairment.

By decision dated April 26, 2016, OWCP denied an increased schedule award. It found that the medical evidence submitted did not support an increase in appellant's left upper extremity permanent impairment.

On May 2, 2016 counsel requested a hearing before an OWCP hearing representative. A video hearing was held on September 27, 2016. By decision dated November 16, 2016, an OWCP hearing representative vacated OWCP's decision and remanded the case for referral to an impartial medical specialist as a conflict existed between Dr. Diamond and Dr. Pashman with regards to appellant's permanent impairment rating.

A December 6, 2016 iFECS Report: MEO23 -- Appointment Schedule Notification noted that seven doctors within a 25-mile radius of appellant's home were bypassed before Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, was chosen as the impartial medical physician. The report indicated that he was 14.65 miles from appellant's zip code. The iFECS ME023 report further noted that the seven physicians were bypassed with bypass Code 0 -- other. The explanations provided included that the bypassed physicians did not perform impairment ratings, did not evaluate the spine, or only evaluated hands. No physicians were bypassed within a 50-mile range.

On January 9, 2017 OWCP received a December 30, 2016 EMG report from Dr. Bruce H. Grossinger, an osteopath and a Board-certified neurologist, which contained an impression of mild bilateral carpal tunnel syndrome with denervation. Dr. Grossinger noted that appellant also had vascular thoracic outlet syndrome and cervical facet syndrome. He concluded that these conditions were caused by appellant's January 24, 1987 employment injury.

In a January 12, 2017 impartial medical report, Dr. Askin discussed appellant's medical history, reviewed the December 3, 2015 SOAF, and her diagnostic testing, noting that the last nerve conduction studies of record were from June 11, 2014. He provided findings on physical examination and reported that the only diagnosis supported by clinical evidence was bilateral carpal tunnel syndrome, which was a coincidental degenerative process solely based on her demographic features that was not connected to her employment activities. Dr. Askin indicated that the lack of treatment for her carpal tunnel condition accounted for the right upper extremity symptomatology. He explained that it was a spontaneously occurring condition responsive to treatment that had been managed in a neglectful fashion by her chosen healthcare providers. Dr. Askin commented on each of the conditions accepted in appellant's claims and found that there was no clinical manifestation on examination, therefore he concluded that appellant had recovered

from those conditions.⁷ He found that MMI had been reached by January 12, 2017. Dr. Askin opined that appellant had zero percent work-related permanent impairment of her arms and wrists as no surgical procedures had been performed, range of motion of her arms and wrists were within normal limits, and she had no objective motor or sensory impairment. He also opined that there was no permanent impairment of the elbows as she had full range of motion of both elbows, no motor deficit at either elbow, and no clinical suggestion of ulnar neuropathy.

On February 16, 2017 OWCP indicated that appellant needed an updated EMG and nerve conduction velocity (NCV) studies. Appellant underwent an EMG/NCV on March 24, 2017.⁸

In an April 22, 2017 addendum report, Dr. Askin reviewed the March 24, 2017 EMG/NCV report and found no evidence of thoracic outlet syndrome, cervical radiculopathy, or focal neuropathies at the wrist or elbow. He noted that she had abnormal motor unit potential waveforms and abnormal interference pattern in the right abductor pollicis brevis (a median nerve innervated muscle) potentially supportive of carpal tunnel syndrome, which had been his clinical diagnosis. Dr. Askin concluded that the study was consistent with his conclusion that appellant had no evidence of continuing work-related conditions.

By decision dated June 1, 2017, OWCP denied an additional schedule award. It based its decision on Dr. Askin's medical findings.

On June 8, 2017 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. A video conference was held on August 29, 2017. Counsel presented procedural arguments relating to the selection of the IME, Dr. Askin, along with substantive arguments relating to OWCP's reliance on Dr. Askin's reports.

In a July 13, 2017 report, Dana Steiner, a certified physician assistant, noted diagnoses of left and right median neuropathy; left ulnar neuropathy, bilateral brachial plexopathy/cervical radiculopathy with radicular symptoms on left; and bilateral sympathetically mediated pain syndrome.

By decision dated October 10, 2017, a hearing representative affirmed OWCP's June 1, 2017 decision that appellant was not entitled to an additional schedule award. The hearing representative found that OWCP followed proper procedure in the selection of Dr. Askin as the impartial medical specialist as he was properly selected from the Medical Management Application (MMA) and was within appellant's initial zip code cluster. The hearing representative further found that Dr. Askin's reports were properly accorded the special weight of an impartial medical specialist.

⁷ Dr. Askin found that the thoracic outlet was not implicated by appellant's work injuries, but to the extent it was accepted, there was no objectively determinable thoracic outlet syndrome condition on examination. He found that she had fully recovered from the double-crush phenomenon as two areas of compression were not identified on examination. For the brachial plexopathy and cubital tunnel syndrome, Dr. Askin opined that she had fully recovered as there was no clinical manifestation on examination.

⁸ A copy of the March 24, 2017 EMG/NCV study was received on September 18, 2017.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of scheduled members or functions of the body.⁹ However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.¹⁰ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.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, the evaluator identifies the impairment for the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS). The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹³ Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.¹⁴

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.¹⁵ The A.M.A., *Guides* further indicate that Table 15-23 is to be used for rating focal nerve compromise,¹⁶ and Appendix 15-B provides further guidance regarding electrodiagnostic evaluation of entrapment syndromes.¹⁷

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

¹⁰ *K.H.*, Docket No. 09-0341 (issued December 30, 2011). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

¹¹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (March 2017); Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

¹² A.M.A., *Guides* (6th ed. 2009) at 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

¹³ *Id.* at 411.

¹⁴ *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

¹⁵ *Id.* at 448.

¹⁶ *Id.*

¹⁷ *Id.* at 487-90.

Section 8123(a) 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.¹⁸ The implementing regulations state 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.¹⁹ When there exist opposing medical reports of virtually equal weight 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.²⁰

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish more than five percent permanent impairment of the left upper extremity, for which she has previously received a schedule award.

OWCP properly determined that a conflict in the medical opinion evidence existed between Dr. Diamond, a treating physician, and Dr. Pashman, an OWCP referral physician, regarding the extent of appellant's permanent impairment of the left upper extremity due to her accepted work-related conditions.

Dr. Askin was selected as the impartial medical specialist, to resolve the conflict in medical opinion, pursuant to 5 U.S.C. § 8123(a). On appeal and before OWCP counsel argued that Dr. Askin was not properly selected as the impartial medical specialist. The Board has placed great importance on the appearance, as well as the fact of impartiality in selecting a referee physician, and only if the selection procedures designed to achieve impartiality are scrupulously followed may the selected physician carry the special weight accorded to an impartial specialist.²¹

¹⁸ 5 U.S.C. § 8123(a).

¹⁹ 20 C.F.R. § 10.321.

²⁰ *V.G.*, 59 ECAB 635 (2008); *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Gary R. Sieber*, 46 ECAB 215 (1994).

²¹ *See T.D.*, Docket No. 16-0028 (issued November 28, 2016); *L.W.*, 59 ECAB 471, 478 (2008).

The Board finds that the selection of Dr. Askin was made in accordance with OWCP's procedures.²² A December 6, 2016 ME023 report of file contains screen shots with Code 0 and explanations why several physicians were bypassed during the referee selection process. Specifically, seven doctors within a 25-mile radius of appellant's zip code were bypassed as they either did not perform impairment evaluations or specialized in areas different from that needed to assess appellant's conditions. The ME023 report further indicates that Dr. Askin was 14.65 miles from appellant's home and was thus within the initial zip code cluster, as were the seven doctors who were bypassed. The ME023 report constitutes substantive evidence that the appointment with Dr. Askin was scheduled through the use of the rotational system in the MMA and within appellant's initial zip code cluster.²³ Accordingly, counsel's argument that Dr. Askin was chosen outside of the MMA and outside of appellant's initial zip code cluster lacks merit.

In his January 12, 2017 report, Dr. Askin reviewed appellant's medical records, including diagnostic studies, and the SOAF. He provided examination findings and indicated that her arm, wrist, and elbow range of motion was within normal limits, she had no objective motor or sensory impairments, and she had not undergone any surgical procedures with respect to her arms and wrists. Dr. Askin provided a discussion for each accepted condition, finding that since there was no clinical manifestation on examination with respect to thoracic outlet syndrome, double-crush phenomenon, brachial plexopathy and cubital tunnel syndrome, she had fully recovered from the accepted conditions with no work-related impairment. He noted that while appellant had clinical evidence of bilateral carpal tunnel syndrome, this was a coincidental degenerative process solely based on her age-related demographic feature, which was not work related and for which she had not been treated. Dr. Askin further opined that appellant reached MMI by January 12, 2017. In an April 22, 2017 addendum report, Dr. Askin reviewed a March 24, 2017 EMG/NCV report. He reported that there was no evidence of thoracic outlet syndrome, cervical radiculopathy or focal neuropathies at the wrist or elbow, which was consistent with his conclusion that appellant's employment related conditions had resolved. Dr. Askin indicated that the study confirmed his clinical diagnosis of carpal tunnel syndrome, a nonwork-related condition.

Counsel also argued on appeal and before OWCP that Dr. Askin ignored the December 30, 2016 EMG/NCV testing results, which Dr. Grossinger indicated showed bilateral carpal tunnel syndrome, vascular thoracic syndrome and cervical facet syndrome causally related to appellant's

²² See Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.5 (May 2013). Congress did not address the manner by which an impartial medical referee is to be selected. Rather, this was left to the expertise of the Director in administering the compensation program created under FECA. Unlike second opinion physicians, the selection of referee physicians is made from a strict rotational system. In turn, the Director has delegated authority to each OWCP district for selection of the referee physician by use of the Medical Management Application (MMA) within iFECS. Selection of the referee physician is made through use of the application by a medical scheduler. The claims examiner may not dictate the physician to serve as the referee examiner. The 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 a Form 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 is to be notified.

²³ *Id.*

employment injuries. While Dr. Grossinger opined that the diagnosed conditions were causally related to the work injuries, his opinion is of limited probative value. He merely offered a conclusion relative to causal relationship and failed to offer any rationalized medical explanation on the issue of causal relationship.²⁴ While the December 30, 2015 EMG/NCV test was not of record at the time Dr. Askin's appointment was scheduled, Dr. Askin reviewed a subsequent more recent EMG/NCV test of March 24, 2017. He provided examination findings and found that there was no clinical manifestation of appellant's accepted conditions on which permanent impairment could be based. Dr. Askin concluded that, based on the lack of objective findings, the accepted employment injuries resolved with zero percent permanent impairment. The Board finds his impartial medical opinion is sufficiently well rationalized and based upon a proper factual and medical background such that it is entitled to special weight.²⁵

The remaining evidence of record, a July 13, 2017 report from a certified physician assistant, has no probative value. The Board has consistently held that physician assistants are not competent to render a medical opinion.²⁶ This report lacks probative value because a physician assistant is not considered a "physician" as defined by section 8101(2) of FECA.²⁷

There is no other evidence of record, conforming to the sixth edition of the A.M.A., *Guides*, showing a greater permanent impairment. As Dr. Askin found that appellant had zero percent permanent impairment due to her accepted employment conditions, she has not established greater than five percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

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 met her burden of proof to establish greater than five percent permanent impairment of the left upper extremity, for which she has previously received a schedule award.

²⁴ *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

²⁵ *See A.H.*, Docket No. 18-0050 (issued March 26, 2018); *J.J.*, Docket No. 10-1758 (issued May 16, 2011).

²⁶ *See K.C.*, Docket No. 16-1181 (issued July 26, 2017); *Janet L. Terry*, 53 ECAB 570 (2002).

²⁷ *See K.C.*, *id.*; *Allen C. Hundley*, 53 ECAB 551 (2002).

ORDER

IT IS HEREBY ORDERED THAT the October 10, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 10, 2019
Washington, DC

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

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

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