United States Department of Labor
Employees' Compensation Appeals Board

B.N., Appellant	)	
and	)	**Docket No. 12-1394**
	)	**Issued: August 5, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Southeastern, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 4, 2012 appellant filed a timely appeal from the February 27, 2012 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than a four percent permanent impairment of his left arm or a two percent permanent impairment of his right leg, for which he received schedule awards.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

OWCP accepted that on June 21, 2003 appellant, then a 45-year-old mail handler, sustained a right knee sprain, left wrist sprain and lumbar strain due to a fall at work. He returned to limited duty in February 2004 and full duty in April 2004.[2]

In a July 15, 2004 report, Dr. Nicholas Diamond, an attending osteopath, detailed appellant's complaints and findings on examination, including the existence of 4/5 strength in his right quadriceps and extensor hallucis longus. He noted that appellant had diminished left grip strength and limited motion of his left second and third fingers. Dr. Diamond found that appellant had 25 percent permanent impairment of his left arm and 17 percent permanent impairment of his right leg under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). The file was referred to Dr. Arnold T. Berman, an OWCP medical adviser. On October 13, 2004 Dr. Berman opined that the medical evidence established that appellant had two percent permanent impairment of his left arm and two percent impairment of his right leg.[3] On November 17, 2004 appellant filed a claim for a schedule award.

In a January 31, 2005 decision, OWCP granted appellant a schedule award for a two percent permanent impairment of his left arm and a two percent permanent impairment of his right leg. It based its award on the October 13, 2004 report of Dr. Berman.

In an October 26, 2005 decision, an OWCP hearing representative determined that there was a conflict in the medical opinion between Dr. Diamond and Dr. Berman regarding the extent of appellant's permanent impairment. He set aside the January 31, 2005 decision and remanded the case for referral of appellant to an impartial medical specialist for evaluation of this issue.

On remand, OWCP referred appellant to Dr. Edward J. Resnick, a Board-certified orthopedic surgeon, for an impartial medical examination. On December 20, 2005 Dr. Resnick reported that, upon examination, appellant exhibited no synovial thickening or effusion in either knee and that range of motion was 0 to 120 degrees in both knees. He noted that appellant had full range of motion in both hands and that motor power was normal in his left arm. Neurological testing of the arms and legs was normal. Dr. Resnick found that appellant had no residual impairment of his arms or legs, noting the lack of any findings of restricted range of motion, decrease of strength, atrophy or sensory changes. Regarding appellant's complaints, he noted, "I have described the man's subjective complaint[s]. In my opinion, in the absence of objective findings, these cause no physical impairment."

[2] Appellant had a prior work injury on October 17, 2002 that was accepted under another claim for trigger finger of his left second and third fingers and sprains/strains of his left hand and his left third and fourth fingers. He had trigger finger release surgery on June 23, 2003 that OWCP authorized. Under this claim, appellant received a schedule award on April 15, 2005 for a two percent impairment of his left arm

[3] Dr. Berman indicated that there was no objective evidence of weakness in appellant's right leg, but noted that he had a right leg impairment of two percent due to right leg pain. He found full range of motion in appellant's left hand and fingers, but found that he had a left arm impairment of two percent due to left hand pain.

On April 7, 2006 Dr. Morley Slutsky, a Board-certified occupational medicine physician and an OWCP medical adviser, agreed with Dr. Resnick that appellant did not have any permanent impairment of his arms or legs.

In an April 12, 2006 decision, OWCP found that appellant was not entitled to receive any additional schedule award compensation for his left arm or right leg, basing its determination on the opinion of Dr. Resnick.

Appellant requested a hearing before an OWCP hearing representative. At the hearing held on August 16, 2006, counsel argued that Dr. Resnick was improperly selected under the computerized system for selecting impartial medical specialists.

In an October 30, 2006 decision, OWCP's hearing representative affirmed the August 16, 2006 decision, finding that the selection of Dr. Resnick was proper. In a July 2, 2008 decision, OWCP affirmed its October 30, 2006 decision.

In a February 17, 2009 decision, OWCP's hearing representative found that appellant was not entitled to additional schedule award compensation with respect to his right leg. She determined that there was a conflict in the medical evidence regarding his left arm impairment and that he should be referred back to Dr. Resnick for a new examination and additional evaluation.

In accordance with the February 17, 2009 decision, OWCP attempted to refer appellant to Dr. Resnick for further evaluation. Dr. Resnick advised, however, that he no longer performed permanent impairment evaluations. OWCP referred appellant to Dr. Howard Stein, a Board-certified orthopedic surgeon, for an impartial medical examination and evaluation of his impairment.

In a June 30, 2009 report, Dr. Stein determined that appellant had a six percent permanent impairment of his left arm under the standards of the fifth edition of the A.M.A., *Guides* due to range-of-motion deficits in the third and fourth fingers of his left hand. On October 9, 2009 Dr. Slutsky determined that appellant did not have any permanent impairment of his left arm because it had not been shown that the limited finger motion of his left hand was related to the accepted work injuries.

OWCP asked Dr. Stein to provide a supplemental assessment of appellant's left arm impairment under the standards of the sixth edition of the A.M.A., *Guides.* In a January 5, 2010 report, Dr. Stein determined that, under the sixth edition, appellant had a six percent permanent impairment of his left arm based on hand pain and limited finger motion. On January 22, 2010 Dr. Craig M. Uejo, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, stated that appellant had a two percent permanent impairment of his left arm under the standards of the sixth edition. He noted that appellant's impairment rating should depend on the sixth edition diagnosis-based impairment rather than loss of range of motion.

OWCP requested that Dr. Stein provide additional clarification of his January 5, 2010 report. On May 14, 2011 Dr. Stein stated that there was no evidence that appellant had residuals of his accepted left wrist sprain or trigger finger and noted, "If this is true, then the two percent disability of the hand based only on diagnosis may not be correct. The patient will still have a two

percent impairment rating if we eliminate the pain as being caused by the residuals of the injury since I found no objective cause of pain, then the loss of motion can be used as two percent impairment of the upper extremity." On May 25, 2011 Dr. Slutsky reiterated that appellant did not have permanent impairment of his left arm.

In a June 16, 2010 decision, OWCP determined that appellant did not have more than a four percent permanent impairment of his left arm or a two percent permanent impairment of his right leg, for which he received schedule awards.

In a September 8, 2010 decision,[4] the Board set aside OWCP's February 17, 2009 decision on the basis that the opinion of Dr. Resnick required clarification regarding appellant's right leg impairment. The Board noted that, if Dr. Resnick was unwilling or unable to clarify his opinion, the case should be referred to another appropriate impartial specialist. Because Dr. Resnick no longer performed permanent impairment evaluations, OWCP referred appellant to Dr. Andrew Collier, a Board-certified orthopedic surgeon, for examination and evaluation of his right leg impairment.

In an October 1, 2010 order,[5] the Board set aside its September 8, 2010 decision on its own motion to further consider whether OWCP properly followed its procedures in selecting Dr. Resnick, the impartial medical specialist.

In a November 9, 2010 report, Dr. Collier determined that, under the standards of the sixth edition of the A.M.A., *Guides*, appellant had a 10 percent permanent impairment of his right leg due to range-of-motion deficits of the right knee.

In a December 28, 2010 decision, OWCP set aside its June 16, 2010 decision finding that that Dr. Stein had not provided a rationalized opinion on appellant's impairment despite being provided an opportunity to clarify his opinion. It remanded the case for referral to a new impartial specialist in order to evaluate appellant's permanent impairment.

OWCP referred appellant to Dr. William H. Simon, a Board-certified orthopedic surgeon, for an impartial medical examination.[6]

In a July 26, 2011 report, Dr. Simon found that appellant did not have any permanent impairment of his left arm and right leg. He provided an extensive history of appellant's medical problems, including his accepted work injuries. Dr. Simon noted that range-of-motion testing of the knees was taken three times and all these movements were the same. Appellant could flex from 0 to 120 degrees on the right and left and there was no instability or effusion in either knee.

[4] Docket No. 09-1769 (issued September 8, 2010).

[5] Docket No. 09-1769 (issued October 1, 2010).

[6] The record contains a July 7, 2011 ME023 iFECS report, produced under the Medical Management Application system, stating that an impartial medical examination was scheduled with Dr. Simon. The record also contains bypass screen shots for other Board-certified orthopedic surgeons, including Dr. Mark Rekant, who was bypassed because he only specialized in hand injuries, Dr. Scott Rushton, who was bypassed because he was too busy to schedule any appointments at that time and Drs. Joseph Jelen, Herbert Stein and Stuart Trager, who were bypassed because they did not perform impairment evaluations.

Deep tendon reflexes about the knees and ankles were hypo-reactive but symmetrical and sensation was intact to pinprick in both lower extremities. Dr. Simon stated that wrist range of motion was performed three times and was equal on each time with palm flexion being 60 degrees and dorsiflexion being 90 degrees on the right and left. Power was normal on flexion and extension. Ulnar deviation on both sides (done three times) was 45 degrees and radial deviation on both sides (done three times) was 25 degrees. Dr. Simon indicated that range-of-motion testing of the digits of the hands was performed. The metacarpophalangeal (MP) joints were measured at 0 degrees extension to flexion of 90 degrees three times in both hands and the interphalangeal (IP) joints were measured at 0 degrees extension and 90 degrees of flexion three times in both hands. Testing of the distal interphalangeal (DIP) joints of the fingers and the IP joint of the thumbs in both hands was performed three times and measured 0 to 45 degrees of flexion. Dr. Simon noted that appellant could make a tight fist in both hands and that grip strength was good on the right and left. Examination of the spine to palpation showed no areas of tenderness in the mid line or to the right or left of the mid line. Dr. Simon found that all of appellant's work-related conditions had resolved, noting that he did not have any objective findings confirming the existence of these conditions. He opined that appellant did not have any permanent impairment of his left arm or right leg under the sixth edition of the A.M.A., *Guides*. Regarding the A.M.A., *Guides*, Dr. Simon stated:

> "Using the Digit Regional Grid, Table 15-2, for sprain/strain of the 3rd and 4th fingers of the left hand came up with class 0. Class 0 is not ratable for impairment, there were no adjustment modifiers since they are not required with class 0, therefore the residual impairment of the 3rd and 4th fingers is 0.
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> "Using the Wrist Grid, Table 15-3 on page 395, indicates that a wrist sprain is a class 0 which is non-ratable and again adjustments are not required for class 0. This is equivalent to 0 permanent impairment for wrist sprain.
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> "Utilizing the Knee Regional Grid, Table 16-3, page 509, for strain of the knee gives a class 0. Adjustments are not required for class 0. The impairment of the lower extremity or a strain/sprain is 0 percent permanent impairment.
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> "Using the Lumbar Spine Regional Grid on page 570, [Table] 17-4, for sprain/strain gives a class 0, again with class 0 adjustment is not required.
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> "There were no peripheral nerve injuries and therefore no impairment of the lower extremities is given for the lumbar spine sprain and strain. Since there were no peripheral nerve injuries I did not have to use the findings in [*The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009)] to determine any permanent impairment due to any injury of the lumbar spine."

On August 7, 2011 Dr. Slutsky agreed with Dr. Simon that appellant did not have any permanent impairment of his left arm or right leg.

In an August 22, 2011 decision, OWCP denied appellant's claim for additional schedule award compensation. It found that the opinion of Dr. Simon, the impartial specialist, was well

rationalized and established that appellant did not have permanent impairment related to his accepted conditions.

In a September 27, 2011 decision, the Board set aside OWCP's February 17, 2009 decision and found that Dr. Resnick had been improperly selected as an impartial medical specialist. The Board determined that OWCP had not complied with its selection procedures.[7]

In an October 6, 2011 decision, OWCP affirmed its August 22, 2011 schedule award decision.

Appellant requested a review of the written record. He submitted an updated November 28, 2011 report from Dr. Diamond who took his examination findings from July 15, 2004 and applied the standards of the sixth edition of the A.M.A., *Guides.* Dr. Diamond found that appellant had a nine percent permanent impairment of his right leg.

In a February 27, 2012 decision, OWCP affirmed its October 6, 2011 decision denying appellant's claim for additional schedule award compensation. It found that the opinion of Dr. Simon established that appellant was not entitled to additional compensation.

LEGAL PRECEDENT

Under FECA, Congress has provided that when there is disagreement between the physician on the part of the United States and that of the employee, the Secretary shall appoint a third physician who shall make an examination.[8] The Board has noted that the appointment of a referee physician under this section is mandatory in cases where there is such disagreement and that failure of OWCP to properly appoint a medical referee may constitute reversible error.[9]

In cases arising under section 8123(a), the Board has long recognized the discretion of the Director to appoint physicians to examine claimants under FECA in the adjudication of claims.[10] FECA does not specify how the appointment of a medical referee is to be accomplished. Moreover, it is silent as to the qualifications of the physicians to be considered.[11] The implementing federal regulations, citing to the Board's decision in *James P. Roberts*, provide that development of the claim is appropriate when a conflict arises between medical opinions of virtually equal weight.[12]

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

[7] Docket No. 09-1769.

[8] 5 U.S.C. § 8123(a).

[9] *Tony F. Chilefone*, 3 ECAB 67 (1949).

[10] *See William C. Gregory*, 4 ECAB 6 (1950).

[11] *See Melvina Jackson*, 38 ECAB 443 (1987).

[12] 20 C.F.R. § 10.321(a); *James P. Roberts*, 31 ECAB 1010 (1980).

program created under FECA.[13] It is an established principle, however, that FECA is a remedial statute and should be broadly construed in favor of the employee to effectuate its purpose and not in derogation of an employee's rights.[14] The primary rule of statutory construction is to give effect to legislative intent and, in arriving at intent; it is well settled that the words in a statute should be construed according to their common usage.[15]

Under the Federal (FECA) Procedure Manual, the Director has exercised discretion to implement practices pertaining to the selection of the impartial medical referee. Unlike second opinion physicians, the selection of referee physicians is made from a strict rotational system.[16] OWCP will select a physician who is qualified in the appropriate medical specialty and who has no prior connection with the case.[17] Physicians who may not serve as impartial specialists include those employed by, under contract to or regularly associated with federal agencies;[18] physicians previously connected with the claim or claimant or physicians in partnership with those already so connected[19] and physicians who have acted as a medical consultant to OWCP.[20] The fact that a physician has conducted second opinion examinations in connection with FECA claims does not eliminate that individual from serving as an impartial referee in a case in which he or she has no prior involvement.[21]

In turn, the Director has delegated authority to each district OWCP for selection of the referee physician by use of the Medical Management Application within the Integrated Federal Employees' Compensation Systems (iFECS).[22] This application contains the names of physicians who are Board-certified in over 30 medical specialties for use as referees within appropriate geographical areas.[23] The Medical Management Application in iFECS replaces the prior Physician Directory System (PDS) method of appointment.[24] It provides for a rotation among physicians from the American Board of Medical Specialties, including the medical

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[13] *See, e.g., Harry D. Butler*, 43 ECAB 859, 866 (1992) (The Director delegated discretion in determining the manner by which permanent impairment is evaluated for schedule award purposes).

[14] *Stephen R. Lubin*, 43 ECAB 564, 569 (1992), citing *Erin J. Belue*, 13 ECAB 88 (1961) and *Samuel Berlin*, 4 ECAB 39 (1950).

[15] *Erin J. Belue, id. See also* Sutherland Stat. Const. § 65.03, 239-40 (4th ed. 1986).

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (July 2011).

[17] *Id.* at Chapter 3.500.4(b)(1).

[18] *Id.* at Chapter 3.500.4(b)(3)(a).

[19] *Id.* at Chapter 3.500.4(b)(3)(b).

[20] *Id.* at Chapter 3.500.4(b)(3)(c).

[21] *See* note to *id.*

[22] *Id.* at Chapter 3.500.4(b)(6).

[23] *Id.* at Chapter 3.500.4(b)(6)(a).

[24] *Id.* at Chapter 3.500.5.

boards of the American Medical Association, and those physicians Board-certified with the American Osteopathic Association.[25]

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.[26] The medical scheduler imputes the claim number into the application, from which the claimant's home zip code is loaded.[27] The scheduler chooses the type of examination to be performed (second opinion or impartial referee) and the applicable medical specialty.[28] 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.[29] Once an appointment with a medical referee is scheduled the claimant and any authorized representative is to be notified.[30]

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. The procedures contemplate that the impartial medical specialists will be selected on a strict rotating basis in order to negate any appearance that preferential treatment exists between OWCP and a particular physician.[31] OWCP has an obligation to verify that it selected an impartial medical specialist in a fair and unbiased manner. It maintains records for this very purpose.[32]

The schedule award provision of FECA[33] and its implementing regulations[34] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

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[25] *Id.* at Chapter 3.500.5(a).

[26] *Id.* at Chapter 3.500.5(b).

[27] *Id.* at Chapter 3.500.5(c).

[28] *Id.* The roster of physicians is not made visible to the medical scheduler under the application. The medical scheduler may update information pertaining to whether the selected physician can schedule an appointment in a timely manner and, if not, will enter an appropriate bypass code. *Id.* at Chapter 3.500.5(e-f). Upon entry of a bypass code, the Medical Management Application will present the next physician based on specialty and zip code.

[29] *Id.* at Chapter 3.500.5(g). The ME023 serves as documentary evidence that the referee appointment was scheduled through the Medical Management Application rotational system. Should an issue arise concerning the selection of the referee specialist, a copy of the ME023 may be reproduced and copied for the case record.

[30] *Id.* at Chapter 3.500.4(d). Notice should include the existence of a conflict in the medical evidence under section 8123; the name and address of the referee physician with date and time of appointment; a warning of suspension of benefits under section 8123(d) and information on how to claim travel expenses.

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

[32] *M.A.*, Docket No. 07-1344 (issued February 19, 2008).

[33] 5 U.S.C. § 8107.

[34] 20 C.F.R. § 10.404 (1999).

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 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.[35] For OWCP decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[36]

In determining impairment for the upper and lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper and lower extremities to be rated. Reference is made to tables relating to the parts of the body involved, including in the present case, Table 15-2 (Digit Regional Grid), Table 15-3 (Wrist Regional Grid) and Table 16-3 (Knee Regional Grid).[37] After the Class of Diagnosis (CDX) is determined from the relevant grid, the Net Adjustment Formula is applied using the grade modifier for Functional History (GMFH), grade modifier for Physical Examination (GMPE) and grade modifier for Clinical Studies (GMCS). The Net Adjustment Formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[38] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[39]

It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[40] However, when a claimant does not demonstrate any permanent impairment caused by the accepted exposure, the claim is not ripe for consideration of any preexisting impairment.[41] The Board has held that an impairment rating that is not based on reasonably current examination findings is of reduced probative value.[42]

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[35] *Id*.

[36] *See* FECA Bulletin No. 9-03 (issued March 15, 2009). For OWCP decisions issued before May 1, 2009, the fifth edition of the A.M.A., *Guides* (5th ed. 2001) is used.

[37] *See* A.M.A., *Guides* (6th ed. 2009) 391, 395, 509, Table 15-2, Table 15-3 and Table 16-3.

[38] *Id.* at 515-22.

[39] *Id.* at 23-28.

[40] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3(a)(3) (January 2010). This portion of OWCP procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

[41] *Thomas P. Lavin*, 57 ECAB 353 (2006).

[42] *See W.M.*, Docket No. 12-773 (issued March 29, 2013) (where the Board found that a physician's 2010 impairment opinion, seeking to update a prior report based on 2004 findings, constituted stale medical evidence); *P.S.*, Docket No. 12-649 (issued February 14, 2013) (the Board found a physician's impairment opinion of reduced probative value where the physician relied on three year old findings to update his impairment rating).

ANALYSIS

OWCP accepted that on October 17, 2002 appellant sustained trigger finger of his left second and third fingers and sprains/strains of his left hand and his left third and fourth fingers. It also accepted that on June 21, 2003 he sustained a right knee sprain, left wrist sprain and lumbar strain. Appellant received schedule awards for a total left arm impairment of four percent and a schedule award for a total right leg impairment of two percent, but he later claimed entitlement to additional schedule award compensation.

OWCP properly determined that there was a conflict in the medical evidence regarding the extent of appellant's left arm and right leg impairment and referred appellant to Dr. Simon, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the extent of his permanent impairment.[43] In a July 26, 2011 report, Dr. Simon determined that appellant had no permanent impairment of his left arm and right leg.

Before OWCP and on appeal, counsel contends that Dr. Simon was not properly selected as the impartial medical specialist and, therefore, OWCP improperly relied on his report in making its schedule award determination. It has an obligation to verify that it selected Dr. Simon in a fair and unbiased manner and it maintains records for this very purpose.[44] The record contains a July 7, 2011 ME023 iFECS report, produced under the Medical Management Application system, stating that an impartial medical examination was scheduled with Dr. Simon. The record also contains bypass screen shots for other physicians, including Dr. Rekant, who was bypassed because he only specialized in hand injuries, Dr. Rushton, who was bypassed because he was too busy to schedule any appointments at that time and Drs. Jelen, Stein and Trager, who were bypassed because they did not perform impairment evaluations.

The Board finds that OWCP presented documentation which provided valid reasons for bypassing physicians and that it properly utilized its Medical Management Application system in selecting Dr. Simon as the impartial medical examiner. The Board has placed great importance on the appearance as well as the fact of impartiality and only if the selection procedures which were designed to achieve this result are scrupulously followed may the selected physician carry the special weight accorded to an impartial specialist.[45] As OWCP has met its affirmative obligation to establish that it properly followed its selection procedures, the Board finds that counsel's argument is not substantiated.[46]

[43] The conflict was created between Dr. Diamond, an attending osteopath, and an OWCP medical adviser.

[44] *See supra* note 32.

[45] *See N.C.*, Docket No. 12-1718 (issued April 11, 2013); *T.T.*, Docket No. 12-1358 (issued April 11, 2013); *P.B.*, Docket No. 12-1393 (issued December 18, 2012).

[46] It should be noted that, in a September 27, 2011 decision, the Board found that Dr. Resnick, a Board-certified orthopedic surgeon who previously served as an impartial medical specialist, was not properly selected through the rotational system to serve in that capacity.

The Board finds that the July 26, 2011 report of Dr. Simon establishes that appellant did not sustain permanent impairment under the sixth edition of the A.M.A., *Guides.* OWCP properly denied appellant's claim for additional compensation.

In a July 26, 2011 report, Dr. Simon found that appellant did not have any permanent impairment of his left arm or right leg under the standards of the sixth edition of the A.M.A., *Guides*. He provided an extensive history of appellant's medical problems, including appellant's accepted injuries and noted ranges of motion for his extremities, including his digits, wrists and knees. Dr. Simon found that appellant's work-related conditions had resolved by explaining that he did not have any objective findings that confirmed these conditions. He noted that, using the Digit Regional Grid of Table 15-2 on page 391, appellant's sprain/strain of the 3rd and 4th fingers of the left hand fell under class 0. This class 0 finding was not ratable for impairment and there were no applicable adjustment modifiers under class 0. Dr. Simon thus concluded that the residual impairment of the 3rd and 4th fingers was zero percent. Using the Wrist Grid of Table 15-3 on page 395, he indicated that appellant's wrist sprain fell under class 0 which was not ratable and did not require adjustments modifiers. Therefore, there was a zero permanent impairment for wrist sprain. Utilizing the Knee Regional Grid of Table 16-3 on page 509, appellant's right knee strain fell under class 0. Dr. Simon noted that adjustments were not required for class 0 and that the impairment of the right leg due to strain/sprain was zero percent. He further properly noted that there were no accepted peripheral nerve injuries and therefore no impairment of the lower extremities for peripheral nerve injuries.[47]

Before OWCP and on appeal, counsel argued that a November 28, 2011 report of Dr. Diamond showed that appellant had nine percent permanent impairment of his right leg. However, the Board finds that this report constitutes stale medical evidence because Dr. Diamond took his examination findings from July 2004 and applied the standards of the sixth edition of the A.M.A., *Guides* more than seven years later.[48] On appeal, counsel also argued that appellant had a preexisting right S1 radiculopathy (evidenced by diagnostic testing from September 2003) which should have been taken into account by Dr. Simon. However, when a claimant does not demonstrate any permanent impairment caused by the accepted exposure, the claim is not ripe for consideration of any preexisting impairment.[49]

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.

[47] Moreover, on August 7, 2011, Dr. Slutsky, a Board-certified occupational medicine physician serving as an OWCP medical adviser, stated that he agreed with Dr. Simon that appellant did not have any permanent impairment of his left arm and right leg.

[48] *See supra* note 42.

[49] *See supra* note 41. On appeal, counsel argued that OWCP should have accepted the impairment rating of Dr. Collier, a Board-certified orthopedic surgeon. However, the opinion of Dr. Simon constituted the most recent, well-rationalized impairment rating of record by an impartial specialist. Dr. Collier did not provide a rationalized medical opinion explaining how the observed right leg deficits were related to a continuing accepted work injury.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than a four percent permanent impairment of his left arm and a two percent permanent impairment of his right leg, for which he received schedule awards.

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 27, 2012 is affirmed.

Issued: August 5, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board