United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 16-0179**
	)	**Issued: March 14, 2017**
DEPARTMENT OF THE ARMY, CORPS OF ENGINEERS, Sallisaw, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 10, 2015 appellant filed a timely appeal from July 22 and October 28, 2015 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 10 percent permanent impairment of the left upper extremity, 25 percent of the left lower extremity, and 13 percent permanent impairment of the penis, for which he received schedule awards.

On appeal appellant asserts that he is entitled to a greater impairment because he has life-long limitations. He also asked that OWCP authorize an impairment evaluation by a Dr. John Ellis, transportation to the appointment, and reimbursement for records he provided to Dr. Ellis.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 7, 2012 appellant, then a 58-year-old river and harbor maintenance worker, was thrown from a boat during training and, as he fell, he hit a handrail and fractured his hip. OWCP adjudicated the claim under OWCP File No. xxxxxx775 and initially accepted closed pelvic fractures with disruption of pelvic floor, left. The claim was expanded to include impotence of organic origin and sprain of left shoulder and upper arm. Appellant stopped work on the date of injury and returned to full-time modified duty on June 3, 2013.

On October 31, 2013 appellant filed a second traumatic injury claim, alleging that on September 11, 2013 he injured his left thumb and suffered an abdominal hernia when he fell while dismounting a forklift. OWCP adjudicated the claim under OWCP File No. xxxxxx935.

Appellant filed a schedule award claim (Form CA-7). OWCP referred him to Dr. Timothy G. Pettingell, a Board-certified physiatrist, for an impairment rating of his left lower and left upper extremities due to the accepted pelvic fractures and upper extremity sprain. In an October 21, 2013 report, Dr. Pettingell noted the history of injury. He provided examination findings and diagnosed left shoulder impingement syndrome, bicipital tendinitis, symptomatic, subjective erectile dysfunction, left iliac wing fracture, comminuted, status post June 7, 2012 injury, and right inguinal hernia, symptomatic. Dr. Pettingell recommended a magnetic resonance imaging (MRI) scan of the left shoulder. He advised that, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (hereinafter A.M.A., *Guides*), for the accepted erectile dysfunction, under Table 7-6, appellant had a class 2 or eight percent whole person impairment. On November 17, 2013 Dr. Pettingell discussed November 24, 2013 left shoulder MRI scan findings. He advised that, under Table 15-5, Shoulder Regional Grid, and using the diagnosis-based impairment (DBI) rating method, for a diagnosis of impingement syndrome, appellant had a class 1 impairment with a default value of three percent. Dr. Pettingell found grade modifiers of 1 for both functional history and clinical studies, and a grade modifier of 2 for physical examination. After applying the net adjustment formula, he concluded that appellant had four percent left arm permanent impairment.

Dr. Ronald Blum, an OWCP medical adviser and Board-certified orthopedic surgeon, reviewed Dr. Pettingell's reports on December 3, 2013. He agreed with Dr. Pettingell's impairment analysis and conclusion that appellant had four percent left arm permanent impairment.

On January 8, 2014 under OWCP File No. xxxxxx935, OWCP accepted a sprain of hand, metacarpophalangeal, left.

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

On January 17, 2014 appellant filed an occupational disease claim (Form CA-2) , stating that following the June 7, 2012 accident he suffered depression, and that he also had hearing loss in his left ear. OWCP adjudicated the claim under OWCP File No. xxxxxx712.[3]

OWCP referred appellant to Dr. J. Steve Miller, a Board-certified urologist, for an impairment evaluation based on the accepted impotence. In a January 29, 2014 report, Dr. Miller reported the history of injury and appellant's complaint of erectile dysfunction. He described his physical examination, including a thorough genitourinary evaluation. Dr. Miller diagnosed erectile dysfunction and benign prostatic hyperplasia without obstruction and discussed treatment options. In an April 23, 2014 report, he advised that, in accordance with Table 7-6, penile disease, of the A.M.A., *Guides*, appellant had a class 1, five percent whole person impairment with regard to the genitourinary system.

In April 2014 OWCP referred appellant to Dr. Clint J. Basener, an osteopath and orthopedic surgeon. On April 25, 2014 Dr. Basener noted findings regarding the left shoulder. He diagnosed previous left pelvic fracture and left shoulder pain with significant loss of range of motion, adhesive capsulitis, and rotator cuff tendinosis.

On May 13, 2014 Dr. H. Mobley, an OWCP medical adviser, concurred with Dr. Miller's impairment analysis and conclusion that appellant had five percent whole person impairment due to erectile dysfunction. He indicated that, for OWCP purposes, under Table 7-5, Urethral Disease, the maximum whole person impairment for urethral disease was 28 percent and, under Table 7-6, 15 percent for penile disease. The medical adviser combined these values, for a maximum 39 percent whole person impairment. He then determined that 5 percent penile impairment, divided by 39 percent, multiplied by 100 percent, yielded 13 percent penis impairment.

Appellant retired on disability, effective May 21, 2014.

By decision dated May 22, 2014, appellant was granted a schedule award for four percent impairment of the left arm, for 12.48 weeks of compensation, to run from October 21, 2013 to January 16, 2014. He filed additional schedule award claims on June 9 and 10, 2014. By decision dated June 24, 2014, appellant was granted a schedule award for 13 percent penile impairment, for 26.65 weeks of compensation, to run from January 29 to August 3, 2014.

A June 26, 2014 functional capacity evaluation demonstrated that appellant had the ability to perform at the sedentary level with a modification of no crouching, climbing, bending, or overhead reaching with the left upper extremity. On a work capacity evaluation dated August 8, 2014, Dr. Basener provided physical restrictions.

[3] The employing establishment controverted appellant's emotional condition claim in an undated statement. It indicated that appellant had preexisting mental health treatment with a diagnosis of depression and sexual dysfunction before the June 7, 2012 accident, and had service-connected tinnitus, depression and anxiety.

On August 19, 2014 appellant requested that depression be accepted. In an undated note, Dr. John E. Raunikar, a Board-certified internist, diagnosed depression.[4]

OWCP referred appellant to Dr. Michael S. Brown, a Board-certified physiatrist. In an August 26, 2014 report, Dr. Brown noted the history of injury and his review of the record. He described examination findings and diagnosed left comminuted iliac wing fracture, left shoulder pain with reduced motion, and left acromioclavicular joint arthropathy. Dr. Brown reported that appellant had reached maximum medical improvement. He advised that, using DBI methodology in accordance with Table 15-5 for a diagnosis of acromioclavicular joint injury or disease, appellant had a class 1 impairment. Dr. Brown found grade modifiers of 4 for functional history, 1 for clinical studies, and 3 for physical examination. After applying the net adjustment formula, he concluded that appellant had five percent impairment of the left upper extremity.

With regarding to the pelvic fracture, Dr. Brown determined that, in accordance with Table 17-11, Diagnosis-Based Grid: Pelvis, appellant had a class 3 injury with modifiers of 3 for functional history and 2 for physical examination. He found a clinical studies modifier not applicable because it was used to determine class. After applying the net adjustment formula, Dr. Brown concluded that appellant had eight percent permanent impairment of the pelvis.

By decision dated October 7, 2014, OWCP denied appellant's claim for a schedule award under OWCP File No. xxxxxx935, accepted for sprain of hand, metacarpophalangeal, left. Appellant's then counsel timely requested a review of the written record.

On October 9, 2014 Dr. Michael M. Katz, an OWCP medical adviser Board-certified in orthopedic surgery, noted his review of the record, including Dr. Brown's report. He found Dr. Brown's report not probative for the purpose of recommending a schedule award under FECA and recommended another evaluation by a Board-certified physiatrist or orthopedic surgeon. The medical adviser noted that the pelvis was not a scheduled member and that FECA did not allow schedule awards for a whole person impairment. He further indicated that he disagreed with Dr. Brown's analysis regarding the left shoulder, and noted that acromioclavicular injury or disease was a diagnosis that could be evaluated under an alternative range of motion method.

Under OWCP File No. xxxxxx712, on October 20, 2014 OWCP accepted occupational injuries of unspecified pelvic fracture, closed, left, and sprain of hand, metacarpophalangeal, left.

OWCP referred appellant to Dr. M. Shawn Smith, a Board-certified physiatrist, for a second opinion evaluation and impairment rating. In a November 12, 2014 report, Dr. Smith described the work injury, appellant's history, and his complaints of physical limitations. He reported physical examination findings including specific shoulder and hip range of motion

[4] Appellant also submitted evidence about other claims and a February 28, 2014 report in which Dr. Yameen Khalil diagnosed bilateral inguinal hernias and advised that these could be caused by trauma. A March 14, 2014 report with an illegible signature included diagnoses of insomnia and depression. Page one of a decision dated July 9, 2014, adjudicated under OWCP File No. xxxxxx939, indicated that compensation benefits were denied. In a letter dated July 22, 2014, regarding a claim adjudicated under OWCP File No. xxxxxx955, OWCP advised appellant to obtain an impairment evaluation from his attending physician. In an undated statement, Steven W. Fite, a coworker, described the work injury of September 11, 2014, adjudicated under OWCP File No. xxxxxx935.

measurements.[5] Dr. Smith diagnosed left shoulder acromioclavicular joint arthropathy with adhesive capsulitis and rotator cuff tendinosis with significant decrease in range of motion, left comminuted iliac fracture with subsequent hematoma and significant heterotopic ossification, and penile impotency following pelvic fracture. With regard to the left shoulder, he advised that since appellant had significant loss of shoulder motion, it was appropriate to use the range of motion method or Table 15-34, Shoulder Range of Motion. Dr. Smith found three percent impairment for abnormal flexion and six percent for abnormal abduction, for a total nine percent permanent impairment of the left shoulder. He then applied the shoulder range of motion modifiers found in Table 15-35 and Table 15-36 and concluded that appellant had 10 percent left arm shoulder impairment. Dr. Smith explained that using the range of motion method rather than the DBI method gave appellant a greater impairment rating.

With regard to the left leg, Dr. Smith maintained that using Table 16-24, hip motion impairments, better characterized appellant's hip problems. He found 10 percent impairment for abnormal hip flexion, and five percent impairments each for abnormal hip extension and internal rotation, for a total 20 percent impairment of the left hip. Dr. Smith concurred with Dr. Miller's analysis, that appellant had five percent whole person impairment under Table 7-6 for erectile dysfunction. He concluded that maximum medical improvement was reached on July 11, 2013.

On January 5, 2015 appellant submitted additional medical evidence. In a February 28, 2014 report, Dr. Khalil noted that appellant had been treated for bilateral inguinal hernias in November 2013. He advised that any type of trauma to the lower abdomen or groin area could cause an inguinal hernias such as with appellant. In a September 12, 2014 report, Dr. Raunikar advised that, based on appellant's stated history regarding the September 11, 2013 accident, it was more likely than not that the fall aggravated an underlying right inguinal hernia, increasing its size.

On January 15, 2015 Dr. Ronald Blum, an OWCP medical adviser Board-certified in orthopedic surgery, noted his review of the record including Dr. Smith's impairment evaluation. He advised that maximum medical improvement had been reached on November 12, 2014, the date of Dr. Smith's evaluation. The medical adviser agreed with Dr. Smith's finding that appellant had 10 percent left arm impairment. He noted that, as appellant had previously received a schedule award for four percent impairment, he was entitled to a schedule award for an additional six percent left arm impairment. The medical adviser also agreed with Dr. Smith's left leg impairment with regard to abnormal flexion, extension, and external rotation for 20 percent impairment, but found that appellant was also entitled to 5 percent impairment for abnormal internal rotation, for a total 25 percent left leg impairment. With regard to appellant's penile impairment, he noted that, while Dr. Smith recommended five percent whole person impairment, whole person impairment was not proper under FECA. The medical adviser concluded that 5 percent whole person impairment yielded 13 percent penile impairment, and

[5] Dr. Smith measured 100 degrees of left shoulder flexion, 50 degrees of extension, 80 degrees of abduction, 40 degrees of adduction, and 80 degrees of internal and external rotation. Left hip flexion was 70 degrees, hip extension 15 degrees, abduction 40 degrees, adduction 35 degrees, internal rotation 15 degrees, and external rotation 20 degrees.

since appellant had received a schedule award for 13 percent permanent impairment of the penis, he was not entitled to an additional schedule award.[6]

By decision dated February 25, 2015, appellant was granted a schedule award for an additional 6 percent left upper extremity permanent impairment, and 25 percent left lower extremity permanent impairment, for 90.72 weeks of compensation, to run from November 12, 2014 to August 8, 2016.

On April 23, 2015 an OWCP hearing representative found that appellant had no permanent impairment for the accepted condition under OWCP File No. xxxxxx935, and affirmed the October 7, 2014 decision.

On April 24, 2015 appellant requested reconsideration of the May 22 and June 24, 2014, and February 25, 2015 schedule award decisions.

Under OWCP File No. xxxxxx935, on May 13, 2015 OWCP additionally accepted bilateral inguinal hernia without obstruction or gangrene.

In a July 22, 2015 decision, OWCP denied modification of the May 22, June 24, 2014, and February 25, 2015 schedule award decisions. It noted that appellant had not provided medical evidence of a higher percentage of permanent impairment than previously assessed.

Appellant requested reconsideration on July 30, 2015. He stated that he was seeking approval to be seen by Dr. John Ellis for an impairment evaluation and would like to be reimbursed for $1,200.00 which Dr. Ellis charged to have appellant's records organized and to have transportation provided to and from the requested appointment with Dr. Ellis.

In a merit decision dated October 28, 2015, OWCP denied modification of the prior schedule award decisions. It noted that the record did not include evidence to support a higher percentage of permanent impairment than previously assessed and that appellant should ask her treating physician for a referral to Dr. Ellis and, thereafter, he could request to change physicians.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function as a result of any employment injury.[7]

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA program with the Director of OWCP.[8] Section 8107

[6] Dr. Blum, OWCP's medical adviser, calculated appellant's penis impairment exactly as Dr. Mobley had in his May 13, 2014 report.

[7] *See Tammy L. Meehan*, 53 ECAB 229 (2001).

[8] *See* 20 C.F.R. §§ 1.1-1.4.

of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[9] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within months of the initial printing, the A.M.A. issued a 52-page document entitled "Clarifications and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as an erratum/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[11] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12]

ANALYSIS

No schedule award is payable for a member, function, or organ of the body that is not specified in FECA or in the implementing regulations.[13] The list of scheduled members includes the eye, arm, hand, fingers, leg, foot, and toes.[14] Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[15] By authority granted under FECA, the Secretary of Labor expanded the list of scheduled members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina, and skin.[16]

Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based

[9] For a complete loss of use of an arm, an employee shall receive 312 weeks' compensation. 5 U.S.C. § 8107(c)(1).

[10] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[12] *Isidoro Rivera*, 12 ECAB 348 (1961).

[13] *See Anna V. Burke*, 57 ECAB 521 (2006).

[14] 5 U.S.C. § 8107(c).

[15] *Id*.

[16] *Id*.; 20 C.F.R. § 10.404(b).

on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[17] The net adjustment formula is (GMFH – CDX) + (GMPE – CDX) + (GMCS – CDX).[18] 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.[19] Section 16.2a of the A.M.A., *Guides*, provides that if the class selected is defined by physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[20]

OWCP procedures provide a formula to measure the percentage of impairment of an organ when the whole person impairment is provided. The whole person impairment of the claimant, identified as A, is divided by B, the maximum impairment of the organ, which equals X, the impairment rating, divided by 100. For organs such as the penis, which have more than one physiologic function, the A.M.A., *Guides* provide whole person impairment levels for each function. When calculating the impairment of these organs, OWCP's medical adviser must consider all functions as instructed in the A.M.A., *Guides*. The maximum whole person impairment ascribed to the particular organ (B) is obtained by combining the maximum levels for all functions using the Combined Values Chart in the current edition of the A.M.A., *Guides*. The actual whole person impairment (A) is obtained by combing all functional impairments found using the Combined Values Chart in the A.M.A., *Guides*.[21]

OWCP procedures further provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[22]

The issue on appeal is whether appellant has met his burden of proof to establish more than 10 percent permanent impairment of the left upper extremity, 25 percent permanent impairment of the left lower extremity, and 13 percent permanent impairment of the penis, for which he received schedule awards.

The Board finds that this case is not in posture for decision as to the extent of permanent impairment of the left upper extremity and finds that appellant has not met his burden of proof to establish increased schedule awards for the left lower extremity or the penis.

On the issue of extent of left upper extremity impairment, the Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when

[17] A.M.A., *Guides* 494-531.

[18] *Id*. at 521.

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

[20] *Id*. at 500.

[21] *Supra* note 11 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(d)(2)(b) (January 2010).

[22] *Supra* note 11 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6f (February 2013).

granting schedule awards for upper extremity claims. No consistent interpretation has been followed regarding the proper use of the DBI or the range of motion methodology when assessing the extent of permanent impairment for schedule award purposes.[23] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[24] In *T.H.*, the Board concluded that OWCP physicians are at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and range of motion methodologies interchangeably without any consistent basis. Furthermore, the Board has observed that physicians interchangeably cite to language in the first printing or the second printing when justifying use of either range of motion or DBI methodology. Because OWCP's own physicians are inconsistent in the application of the A.M.A., *Guides*, the Board finds that OWCP can no longer ensure consistent results and equal justice under the law for all claimants.[25]

In light of the conflicting interpretation by OWCP of the sixth edition with respect to upper extremity impairment ratings, it is incumbent upon OWCP, through its implementing regulations and/or internal procedures, to establish a consistent method for rating upper extremity impairment. In order to ensure consistent results and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the upper extremity disability award in the decisions of July 22 and October 28, 2015 decision as it relates to appellant's left upper extremity. Following OWCP's development of a consistent method for calculating permanent impairment for upper extremities to be applied uniformly, and such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.

Under OWCP File No. xxxxxx775, OWCP also accepted that appellant sustained closed pelvic fractures with disruption of pelvic floor, left, and impotence of organic origin. Under OWCP File No. xxxxxx935, it accepted sprain of hand, metacarpophalangeal, left, and bilateral inguinal hernia without obstruction or gangrene. Under OWCP File No. xxxxxx712, OWCP accepted occupational injuries of unspecified pelvis fracture, closed, left, and sprain of hand, metacarpophalangeal, left.

The record supports that appellant has 25 percent permanent impairment of the left leg. In assessing appellant's lower extremity impairment, Dr. Smith again maintained that using Table 16-24, hip motion impairments, better characterized appellant's hip problems. He found 10 percent impairment for abnormal hip flexion, and five percent impairments each for abnormal hip extension and internal rotation, for a total 20 percent impairment of the left hip.

Dr. Blum, OWCP's medical adviser, agreed with Dr. Smith's findings and conclusions with regard to the left arm. He further found that appellant was entitled to an additional five percent impairment for lower extremity internal rotation, for a total of 25 percent left lower

[23] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[24] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[25] *Supra* note 23.

extremity impairment. There is no other probative medical evidence which indicates that appellant is entitled to a greater impairment.[26] Appellant has, therefore, not established entitlement to a schedule award for the left upper and left lower extremities greater than those previously awarded.

There also is no evidence of record to establish that appellant is entitled to a schedule award for penis impairment greater than the 13 percent previously awarded. Dr. Miller, an OWCP referral urologist, advised that appellant had five percent whole person penis impairment. The sixth edition of the A.M.A., *Guides*, provides that the penis has both sexual and urinary functions and states that, when evaluating penile impairments, an examiner must consider both sexual and urinary function.[27] Both Dr. Mobley and Dr. Blum, OWCP medical advisers, advised that under Table 7-5, the maximum whole person impairment for urethral disease was 28 percent and that, under Table 7-6, 15 percent for penile disease. The medical advisers combined these values, finding 39 percent whole person impairment and then determined that five percent penile impairment divided by 39 percent times 100 percent yielded 13 percent penis impairment. Their evaluation conforms to the A.M.A., *Guides*[28] and establishes that appellant has no more than 13 percent impairment of the penis.[29]

On appeal appellant asserts that authorization should be provided for an impairment evaluation by Dr. John Ellis and reimbursement for a record evaluation and transportation. OWCP has broad discretion in determining the need for an examination, the type of examination, the choice of locale, and the choice of medical examiners.[30] The Board has long held that OWCP has broad discretion in approving services provided under FECA.[31] The only limitation on OWCP's authority is that of reasonableness.[32] There is no evidence of record to show that OWCP abused its discretion in denying an evaluation by Dr. Ellis.

As to his claims of permanent impairment of the left lower extremity and the penis, 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.

[26] *See D.N.*, 59 ECAB 576 (2008).

[27] *Supra* note 2 at 143-44.

[28] *See M.H.*, Docket No. 09-1184 (issued April 6, 2010).

[29] Regarding the sprain of the left hand, appellant has not appealed the April 23, 2015 OWCP decision and thus is not before the Board.

[30] *See J.T.*, 59 ECAB 293 (2008).

[31] *W.M.*, 59 ECAB 132 (2007).

[32] *See R.L.*, Docket No. 08-855 (issued October 6, 2008).

CONCLUSION

The Board finds this case not in posture for decision as to the extent of appellant's left upper extremity impairment. The Board further finds that appellant has not met his burden of proof to establish increased schedule awards for the left lower extremity or the penis.

ORDER

IT IS HEREBY ORDERED THAT the October 28 and July 22, 2015 decisions of the Office of Workers' Compensation Programs are affirmed in part and set aside in part, and the case is remanded for further action consistent with this decision.

Issued: March 14, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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