United States Department of Labor
Employees' Compensation Appeals Board

W.B., Appellant	)	
and	)	**Docket No. 17-1698**
	)	**Issued: May 16, 2018**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Plentywood, MT, Employer	)	

Appearances:
Appellant, pro se
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 August 2, 2017 appellant filed a timely appeal from a June 26, 2017 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 has established permanent impairment of his left upper extremity, warranting a schedule award.

FACTUAL HISTORY

On December 10, 2008 appellant, then a 36-year-old border patrol agent, filed a traumatic injury claim (Form CA-1) alleging that he was injured in a snowmobile accident while in the

[1] 5 U.S.C. § 8101 *et seq.*

performance of duty. He stopped work the next day, December 11, 2008. OWCP accepted the claim for fractures of the spinous processes at C5, C6, C7, and T1, a nondisplaced fracture of the right orbit, a closed head injury with loss of consciousness, subjective visual disturbances not otherwise specified that had resolved as of December 4, 2009, left brachial plexus lesions, and postconcussion syndrome. Appellant returned to part-time employment on April 15, 2009 and to his regular full-time work on December 9, 2009.

On November 4, 2013 appellant filed a claim (Form CA-7) for a schedule award. On November 13, 2013 OWCP requested that he submit a report from his attending physician addressing the extent of permanent impairment using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

In a report dated December 20, 2013, Dr. Michael S. McManus, Board-certified in occupational medicine, discussed appellant's history of injury and his current complaints of left paracervical pain and left upper extremity dysesthesia with some weakness. On examination, he found tenderness at the left paracervical region, mild left upper arm atrophy, 4/5 strength testing of the left wrist and elbow on extension, and decreased sensation to pinprick and light touch of the left upper extremity. Dr. McManus reviewed the results of objective studies and diagnosed a closed head injury with loss of consciousness, residual cognitive deficit and personality changes, a healed nondisplaced fracture of the posterolateral wall of the right orbit, status post fracture spinous process at C5 through T1, left brachial plexus, resolved left knee strain, and resolved thoracic and lumbar strains. Referencing Table 15-20 on page 435 of the A.M.A., *Guides*, he identified the diagnosis as class one left trunk brachial plexopathy, which yielded a default value of three percent for the sensory deficit and nine percent for the motor deficit. Dr. McManus applied grade modifiers and concluded that appellant had 16 percent permanent impairment of the left arm due to brachial plexus of the lower trunk.

Dr. Kenneth D. Sawyer, an orthopedic surgeon and OWCP medical adviser, reviewed the evidence on February 12, 2014. He asserted that appellant did not initially complain of left upper extremity symptoms after his injury. Dr. Sawyer opined that Dr. McManus' impairment evaluation was insufficient to support a schedule award as OWCP had not accepted brachial plexopathy as an accepted condition and as objective test results and findings did not support the diagnosis. He determined that appellant had no left arm impairment.

By decision dated February 14, 2014, OWCP denied appellant's schedule award claim. It found that the opinion of Dr. Sawyer constituted the weight of the evidence and established that he had no permanent impairment due to his accepted employment injury.

Appellant timely requested an oral hearing before an OWCP hearing representative. After an August 13, 2014 hearing, in an October 24, 2014 decision, OWCP's hearing representative vacated the February 14, 2014 decision. He noted that appellant had left arm symptoms within a month of his injury. The hearing representative found that a conflict in medical opinion existed between Dr. McManus and OWCP's medical adviser regarding whether appellant sustained left brachial plexopathy due to the December 10, 2008 work injury and whether he had permanent

[2] 6th ed. (2009).

impairment as a result of the condition. He remanded the case for OWCP to refer him to an impartial medical examiner (IME) to resolve the conflict.

On December 18, 2014 OWCP referred appellant to Dr. Joseph Carney, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated January 16, 2015, Dr. Carey found "some obvious decreased muscle mass in the left upper arm region" with 5/5 strength and intact sensation. He opined that appellant sustained left brachial plexopathy due to the employment injury based on the mechanism of injury. Dr. Carney found, however, that he had no permanent impairment due to his brachial plexus according to Table 15-20 on page 435 of the A.M.A., *Guides*.

On January 29, 2015 OWCP expanded acceptance of appellant's claim to include left brachial neuritis or radiculitis. On February 3, 2015 it expanded acceptance of the claim to include postconcussion syndrome.

Dr. Sawyer reviewed the evidence on February 3, 2015 and concurred with the findings of Dr. Carney that appellant had no permanent impairment of the left upper extremity.

In a February 17, 2015 decision, OWCP denied appellant's claim for a schedule award. It found that Dr. Carney and OWCP's medical adviser represented the weight of the medical evidence and established that he had no permanent impairment due to his work injury.

Dr. L.J. Weaver, an OWCP medical adviser, reviewed the evidence on February 17, 2015. The medical adviser indicated that Dr. Carney's finding of no sensory deficit was unclear given appellant's symptoms of pain and paresthesia. Dr. Weaver asserted that muscle atrophy was an objective measure of motor dysfunction. The medical adviser recommended that OWCP refer appellant to a neurologist to determine the extent of any permanent impairment.

An April 8, 2015 electromyogram (EMG) and nerve conduction velocity (NCV) study revealed findings "consistent with [a] history of brachial plexus injury involving [the] lower trunk and "with at least mild axonal loss and reinnervation since [the] injury of 2008."

Appellant, on March 1, 2015, requested a telephone hearing with an OWCP hearing representative. Following a preliminary review on September 9, 2015 OWCP's hearing representative vacated the February 17, 2015 decision. She discussed Dr. Weaver's finding that it was unclear why Dr. Carney had found no sensory deficit or loss of strength given appellant's sensory complaints and the objective findings of atrophy. The hearing representative remanded the case for OWCP to obtain clarification from Dr. Carney regarding his impairment evaluation and to provide him with the results of the April 8, 2015 electrodiagnostic testing.

In an addendum dated September 28, 2015, provided by Dr. Carney related that he had reviewed the February 17, 2015 EMG/NCV and Dr. Weaver's February 17, 2015 report. He agreed with Dr. Weaver that appellant should be evaluated by a neurologist given the findings on electrodiagnostic testing.

On October 16, 2015 OWCP referred appellant to Dr. John S. Wendt, a Board-certified neurologist, for a second opinion examination. In a report dated October 21, 2015, Dr. Wendt described his complaints of pain and tingling with some weakness in his arm with periodic

discoloration. On examination he found no sensory loss or reduced muscle strength. Dr. Wendt opined that appellant had no impairment of the upper extremity due to brachial plexus based on the lack of objective findings.

Dr. Sawyer reviewed the evidence on November 2, 2015 and concurred with Dr. Wendt's finding that appellant had no permanent impairment of his left upper extremity.

By decision dated November 9, 2015, OWCP denied appellant's schedule award claim, finding that the weight of the medical evidence did not establish that he had a work-related permanent impairment. On November 13, 2015 appellant requested an oral hearing.

An April 4, 2016 magnetic resonance imaging (MRI) scan of appellant's cervical spine showed no evidence of nerve root impingement and old fractures of the T1 and T2 spinous processes.

Following a preliminary review, in a decision dated April 12, 2016, OWCP's hearing representative set aside the November 9, 2015 decision. He found that OWCP had erred in referring appellant for a second opinion examination rather than for an impartial medical examination. The hearing representative remanded the case for OWCP to obtain a report from an IME sufficient to resolve the conflict in medical opinion.

A May 3, 2016 Form ME023, appointment schedule notification, indicates that OWCP scheduled an appointment with Dr. Linda M. Wray, a Board-certified neurologist. The record contains a series of bypass screens providing the reasons that OWCP bypassed other physicians prior to the selection of Dr. Wray, including that the physicians did not perform impartial medical examinations, had retired, had relocated, or had no valid telephone number.

OWCP, on May 5, 2016, referred appellant to Dr. Linda M. Wray, a Board-certified neurologist, for an impartial medical examination. In a letter dated May 23, 2016, appellant advised OWCP that he had previously requested to participate in the selection of the IME. He maintained that research established that Dr. Wray was biased and also asserted that she worked with Dr. Wendt. Appellant noted that she acted for the employing establishment in 31 cases before the Board of Industrial Insurance Appeals in Washington State. He cited the case of *J.S.*[3] In support of his request to participate in selecting an IME. Appellant submitted a decision and order from the Board of Industrial Insurance Appeals for the State of Washington finding that Dr. Wray's examination was less focused than that of another physician and that her finding that a claimant could return to her regular work was "not credible, and undermines her opinion on impairment."

In a May 23, 2016 response, OWCP requested that appellant submit evidence documenting that Dr. Wray worked with Dr. Wendt or evidence supporting that she acted for the employing establishment in 30 other cases.[4] It further noted that it had not received a prior request to be involved in the selection process for the IME.

[3] Docket No. 10-2198 (issued July 26, 2011).

[4] By decision dated July 25, 2016, OWCP denied appellant's request to expand the acceptance of his claim to

On May 26, 2016 appellant again requested to participate in the selection of the IME.[5] He asserted that his case was similar to *J.S.* and *Geraldine Foster*,[6] in which the Board found that the claimants submitted sufficient evidence of bias to warrant participating in selecting the IME. Appellant provided the address of a website that he maintained showed the other 30 times Dr. Wray participated in cases for the state. He noted that OWCP had bypassed eight physicians before selecting Dr. Wray. On June 13, 2016 appellant requested that OWCP issue a decision regarding whether Dr. Wray was biased or lacked credibility.

In a report dated June 14, 2016, Dr. Wray noted that she initially allowed appellant to videotape the examination until she received "notification that videotaping was not permitted in the setting of this exam[ination]." She discussed his complaints of left arm pain that increased with activity, some weakness, and periodic redness and tingling. On examination, Dr. Wray measured circumference of the biceps as 30 centimeters on the right and 29.6 centimeters on the left, and forearm circumference of 27 centimeters on the right and 26.4 centimeters on the left. She found intact sensation in the fingers and indicated that appellant complained of severe pain left elbow pain and left median nerve pain at the wrist with percussion. Dr. Wray found "no neurologic permanent impairment of the left upper extremity." She noted that OWCP had accepted fractures of multiple spinous processes and an injury to the left brachial plexus. Dr. Wray related, "However, at present, there is no clinical objective evidence of cervical radiculopathy or brachial plexopathy. [Appellant] has normal strength, normal sensation to sharp and two-point discrimination, normal reflexes and no evidence of muscle atrophy in the left upper extremity." She opined that appellant had reached maximum medical improvement (MMI) within six to nine months of his injury.

In a report dated June 15, 2016, Dr. Arthur Watanabe, a Board-certified radiologist, discussed appellant's symptoms of pain in his cervical spine, left subscapular region, left shoulder, and left upper arm. On examination he found no motor or sensory loss of the upper extremity, but reduced range of motion of the left upper extremity with "palpable tenderness over the left greater tuberosity." Dr. Watanbe diagnosed neck and shoulder pain and recommended a shoulder MRI scan study and further studies regarding the cervical spine. On August 10, 2016 he performed a steroid injection on appellant's left shoulder.

In an August 16, 2016 letter, OWCP asked that Dr. Watanabe provide a copy of the MRI scan study and address whether appellant had reached MMI.

An MRI scan study arthrogram of the left shoulder dated June 22, 2016, received by OWCP on September 6, 2016, revealed no internal derangement and no atrophy of the rotator cuff muscles.

On September 7, 2016 OWCP informed Dr. Wray that appellant continued to receive treatment for his left shoulder and that one of his physicians had recommended surgery. It

include a right elbow fracture.

[5] Appellant sent a similar letter on June 6, 2016 requesting participation in selecting the IME.

[6] 54 ECAB 435 (2003).

requested that she review the current treatment notes relevant to his left shoulder and explain whether her opinion regarding his left upper extremity condition had altered.

Dr. Wray, in a supplemental report dated September 13, 2016, discussed the progress reports submitted subsequent to her June 14, 2016 examination. She noted that diagnostic studies did not reveal an abnormality and that repeated injections to the neck and shoulder area had "no reported benefit." Dr. Wray did not find a recommendation for surgery from a physician from the medical evidence contained in the record and noted that Dr. Watanabe's examination yielded normal objective findings. She opined that her opinion was unchanged from her June 14, 2016 report.

Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as OWCP medical adviser, reviewed the evidence on October 20, 2016 and opined that appellant had no left upper extremity impairment based on the findings by Dr. Wray.

In a decision dated November 15, 2016, OWCP denied appellant's schedule award claim. It found that the report from Dr. Wray and OWCP's medical adviser established that he had no permanent impairment of his left upper extremity.

Appellant, on November 23, 2016, requested an oral hearing. At the telephone hearing, held on May 23, 2017, appellant related that a state workers' compensation board found that Dr. Wray was not credible. He asserted that he had demonstrated bias under Board case law. Appellant maintained that OWCP's procedures did not require that he establish bias or unprofessional conduct to participate in the selection of the IME, but instead submit evidence documenting such bias or conduct. He contended that a judge's finding that Dr. Wray was not credible was sufficient to allow him to participate in the selection of the IME. Appellant also questioned why OWCP did not allow the examination to be recorded.

By decision dated June 26, 2017, OWCP's hearing representative affirmed the November 15, 2016 decision. He found that appellant had not provided evidence of bias by Dr. Wray as the state board did not find that she was either unprofessional or biased. The hearing representative further found no evidence that Dr. Wray worked with Dr. Wendt and that OWCP adequately documented reasons for bypassing other physicians. He determined that her opinion constituted the weight of the evidence and established that appellant had no permanent employment of his left upper extremity.

On appeal appellant contends that OWCP purposefully selected Dr. Wray after bypassing other physicians. He asserts that she is not ethical and consistently testified for companies rather than injured workers. Appellant maintains that she had been reprimanded for judicial authorities for lying and questions why OWCP bypassed multiple physicians.

LEGAL PRECEDENT

The schedule award provisions of FECA,[7] and its implementing federal regulations,[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

The sixth edition requires identifying the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[11] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

Section 8123(a) of FECA 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.[12] When there exists 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.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.[14] The Board has held that, to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides*. OWCP's medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[15]

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id.* at § 10.404(a).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

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

[12] 5 U.S.C. § 8123(a).

[13] *See Darlene R. Kennedy*, 57 ECAB 414 (2006).

[14] *Supra* note 10 at Chapter 2.808.6(f) (March 2017).

[15] *Id.* at Chapter 2.808.g (March 2017).

OWCP's procedures further provide that a claimant who asks to participate in selecting the referee physician or who objects to the selected physician should be requested to provide his or her reason for doing so. OWCP is responsible for evaluating the explanation offered. Examples of circumstances under which the claimant may participate in the selection include documented bias by the selected physician and documented unprofessional conduct by the selected physician. If the reason is considered acceptable, OWCP will prepare a list of three specialists, including a candidate from a minority group if indicated and ask the claimant to choose one. This is the extent of the intervention allowed by the claimant in the process of selection or examination. If the reason offered is not considered valid, a formal denial of the claimant's request, including appeal rights, may be issued if requested.[16]

Unlike the selection of second opinion examining physicians, the selection of a referee physician is made on a strict rotational basis. The selection of a physician to perform a referee medical examination is done by using Medical Management Application (MMA).[17] The MMA contains the names of physicians who are Board-certified in certain specialties. The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality. This is accomplished by selecting physicians (in the designated specialty in the appropriate geographic area) in alphabetical order as listed in the roster and repeating the process until the list is exhausted.[18]

The MMA contains an automatic and strict rotational scheduling feature. This application provides for consistent rotation among physicians and records the information needed to document the selection of the physician.[19] Selection of a referee physician should be made only through the MMA (absent exceptional circumstances) and OWCP may not dictate which physician will serve as a referee examiner.[20] 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 by the selected physician carries the special weight accorded to an impartial medical specialist.[21]

ANALYSIS

OWCP accepted that appellant sustained fractures of the spinous processes at C5, C6, C7, and T1, a nondisplaced fracture of the right orbit, closed head injury with loss of consciousness, subjective visual disturbances resolved as of December 4, 2009, left brachial plexus lesions, and postconcussion syndrome due to a December 10, 2008 employment injury. On November 4, 2013 appellant filed a claim for a schedule award.

[16] *Supra* note 10 at Chapter 3.500.4(f) (July 2011).

[17] *Id*. at 3.500.4b (July 2011).

[18] *Id*. at 3.500.4(b)(6) (July 2011)

[19] *Id*. at 3.500.5 (May 2013).

[20] *Id*. at 3.500.5(b) (May 2013).

[21] *See N.R.*, Docket No. 16-1613 (issued February 7, 2017); *J.O.*, Docket No. 14-0039 (issued April 2, 2014).

OWCP determined that a conflict in medical opinion evidence arose between Dr. McManus, an attending physician who found 16 percent permanent impairment of the left arm due to brachial plexus of the lower trunk, and Dr. Sawyer, an OWCP medical adviser who found that he had no left arm permanent impairment. It initially referred appellant to Dr. Carney, a Board-certified orthopedic surgeon, for an impartial medical examination. However, on February 17, 2015 an OWCP medical adviser recommended appellant referral to a neurologist to determine the extent of any left arm impairment. On September 28, 2015 Dr. Carney concurred with the OWCP medical adviser's recommendation that a neurologist evaluate appellant given the findings on electrodiagnostic testing.

OWCP, on May 5, 2016, referred appellant to Dr. Wray, a Board-certified neurologist, for an impartial medical examination. On May 23, 2016 appellant requested that OWCP allow him to participate in the selection of the IME, asserting that Dr. Wray was biased, consistently testified for employers, and worked with Dr. Wendt, an OWCP referral physician. On May 26, 2016 he also noted that OWCP had bypassed eight physicians prior to selecting Dr. Wray. As noted, OWCP's procedures provide that a claimant may be allowed to participate in selecting the referee physician when he or she provides a valid reason for the request, for example, documented bias by the selected physician or documented unprofessional conduct by the selected physician.[22] In support of his request, appellant submitted a decision from the State of Washington's Board of Industrial Insurance Appeals finding that Dr. Wray's opinion that a claimant could resume her usual employment was "not credible and undermines her opinion on impairment." He asserts that under the Board's findings in *Geraldine Foster* and *J.S.*, he has met the requirement to submit evidence of documented bias and thus should be allowed to participate in the selection of the IME.

In *Geraldine Foster*,[23] the claimant timely objected to the selection of the IME and requested to participate in the IME's selection. She submitted court decisions from the State of Pennsylvania denigrating the credibility and integrity of the physician selected by OWCP as the IME. In *J.S.*,[24] the Board reviewed a state workers' compensation judge's finding that the physician selected as IME was "as a whole preposterous throughout, offensive at times, ill willed and entirely not credible." The Board found that the judge's determination was sufficient to show documented bias such that appellant should be allowed to participate in selecting the IME.

The circumstances of the present case can be distinguished from the Board's finding of documented bias in *Geraldine Foster* and *J.S.* In this case the judge for the State of Washington's Board of Industrial Insurance Appeals found that Dr. Wray's opinion was not credible and that her examination was less focused than that of another physician. The judge, while discrediting the weight accorded Dr. Wray's opinion, did not find that she either lacked integrity or provided preposterous testimony. In *J.D.*,[25] the claimant submitted two insurance decisions finding that a physician opinion negating disability was not credible. The Board found that, while the court may have discredited the weight to be afforded to the opinion, that fact without more was not sufficient

[22] *See supra* note 16.

[23] *Supra* note 6.

[24] *Supra* note 3.

[25] Docket No. 12-0920 (issued February 15, 2013).

to demonstrate bias. Similarly, the finding that Dr. Wray's opinion was not credible, without more, is insufficient to constitute documented evidence of bias in this case.[26]

The Board also finds that Dr. Wray was properly selected to perform the impartial medical examination as the record supports that OWCP followed its established procedure in her selection. The record contains a Form ME023 documenting the selection of Dr. Wray and a log of bypassed physicians, including bypass codes and explanations of why each physician was bypassed, and a certification that the MMA had been used to select the referee physician. The logs indicated that OWCP bypassed eight physicians prior to selecting Dr. Wray either because the physician did not perform impartial medical examinations, had retired or relocated, or as the telephone number was no longer valid. The Board finds that OWCP provided adequate documentation to establish that it properly utilized its MMA system in selecting Dr. Wray.[27]

When a case is referred to an impartial medical examiner for the purpose of resolving a conflict, the opinion of such specialist, is sufficiently well rationalized and based on a prior factual and medical background, must be given special weight.[28] The Board finds that Dr. Wray's report is entitled to special weight and establishes that appellant has no ratable permanent impairment of the left upper extremity.

On June 14, 2016 Dr. Wray reviewed appellant's complaints of left arm pain worse with activity, weakness, and intermittent redness and tingling. On examination, she reported measurements of biceps and forearm circumference, found normal strength, sensation, reflexes, and no left upper extremity atrophy. Dr. Wray concluded that appellant had no neurological impairment of the left arm or objective evidence demonstrating cervical radiculopathy or brachial plexopathy. She asserted that he had no permanent impairment of the left upper extremity from a neurological standpoint. In a supplemental report dated September 13, 2016, Dr. Wray reviewed the recent progress reports and diagnostic studies and related that her opinion regarding the question of permanent impairment was unchanged. Her opinion is well rationalized and based on a proper factual and medical history. Dr. Wray accurately summarized the relevant medical evidence, provided detailed findings on examination and reached conclusions about appellant's condition which comported with her findings.[29] As her report is detailed, well rationalized and based on a proper factual background, her opinion is entitled to the special weight accorded an IME.[30]

On appeal appellant contends that OWCP purposefully selected Dr. Wray after bypassing other physicians, that she testified for companies instead of injured workers, and that she had been reprimanded for lying. He also notes that OWCP bypassed multiple physicians prior to selecting

[26] *Id*.

[27] *See S.L.*, Docket No. 14-1250 (issued December 2, 2015); *B.H.*, Docket No. 14-0423 (issued June 26, 2014).

[28] *See M.S.*, Docket No. 15-1064 (issued June 15, 2016); *V.G.*, 59 ECAB 635 (2008).

[29] *Manuel Gill*, 52 ECAB 282 (2001).

[30] *Supra* note 21.

Dr. Wray. As discussed, however, appellant has not submitted sufficient evidence to document bias by Dr. Wray, and OWCP properly used its MMA system in selecting her as IME.

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 permanent impairment of his left upper extremity, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the June 26, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 16, 2018
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