United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 21-0805**
	)	**Issued: July 19, 2023**
U.S. POSTAL SERVICE, PORTAGE POST OFFICE, Portage, IN, Employer	)	

Appearances:
Paul H. Felser, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On May 3, 2021 appellant, through counsel, filed a timely appeal from a January 20, 2021 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has met her burden of proof to expand the acceptance of her claim to include additional conditions as causally related to her accepted employment injury;

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

and (2) whether appellant has met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

FACTUAL HISTORY

On August 20, 1987 appellant, then a 45-year-old clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained a low back injury due to performing repetitive work tasks, including lifting sacks of mail, pushing all-purpose containers, and carrying trays of mail over the course of 23 years. She noted that she first became aware of her condition and realized its relation to her federal employment on May 12, 1987. Appellant stopped work on May 13, 1987 and returned to light-duty work on July 21, 1987. OWCP accepted her claim for acceleration/aggravation of both cervical herniated disc at C3-4 and lumbar degenerative disc disease. On November 25, 1988 appellant underwent OWCP-authorized surgery, including discectomy at C3-4. She had intermittent periods of total and partial disability after the surgery, and retired from the employing establishment effective October 1, 1992.

In a December 30, 2011 report, Dr. Swathi Mothkur, a Board-certified physiatrist, determined that appellant sustained several conditions related to the accepted employment injury other than those already accepted by OWCP, including work-related bilateral knee and hip arthritis, bilateral carpal tunnel syndrome, and bilateral chronic radiculopathy from spinal stenosis. She determined that appellant had 17 percent permanent impairment due to lumbar spinal stenosis with radiculopathy, 17 percent permanent impairment due to cervical stenosis, disc herniation and radiculopathy, and 16 percent permanent impairment due to bilateral hip arthritis, resulting in 42 percent permanent impairment of the whole person.

On May 14, 2012 appellant filed a claim for compensation (Form CA-7) for a schedule award. She also asserted that the acceptance of her claim should be expanded to include conditions causally related to her accepted injury other than those already accepted by OWCP.

On July 20, 2012 OWCP received a May 4, 2012 report wherein Dr. Mothkur opined that appellant had 17 percent permanent impairment of her whole person and 42 percent permanent impairment of her right lower extremity due to chronic radiculopathy.

On August 14, 2012 OWCP referred appellant and the case record, along with an August 14, 2012 statement of accepted facts (SOAF) and a series of questions, for a second opinion examination and evaluation with Dr. Alan Brecher, a Board-certified orthopedic surgeon. It requested that Dr. Brecher provide an opinion regarding appellant's permanent impairment under the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] OWCP also requested that he provide an opinion regarding appellant's assertion that it should expand the acceptance of her claim to include conditions causally related to her accepted injury other than those already accepted.

In a November 14, 2012 report, Dr. Brecher concluded that appellant had two percent permanent impairment of her whole person based on her responses to a pain disability questionnaire. He also found that the acceptance of her claim should not be expanded to include additional conditions as causally related to her accepted employment injury.

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

OWCP found that there was a conflict in the medical opinion evidence between the attending physician, Dr. Mothkur, and its referral physician, Dr. Brecher, regarding both the expansion and schedule award issues. It referred appellant and the case record, along with a SOAF and a series of questions, to Dr. Gregory Primus, a Board-certified orthopedic surgeon, for an impartial examination/evaluation of both the expansion and schedule award issues.

In a May 15, 2014 report, Dr. Primus, serving as the impartial medical examiner (IME) found that the acceptance of appellant's claim should not be expanded to include conditions causally related to her accepted injury other than those already accepted by OWCP. He also found that she was not entitled to a schedule award. By separate decisions, both dated August 14, 2014, OWCP denied appellant's expansion and schedule award claims, based on the opinion of Dr. Primus.

On September 12, 2014 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on March 23, 2015.

By decision dated June 4, 2015, OWCP's hearing representative set aside OWCP's August 14, 2014 decisions and remanded the case to OWCP for referral of appellant to a new IME. The hearing representative found that the opinion of Dr. Primus did not contain sufficient medical rationale to constitute the special weight of the medical evidence on the expansion and schedule award issues.

OWCP then engaged in a period of extensive development whereby it referred appellant to two additional IMEs. By decisions dated August 31, 2017 and May 1, 2019, it found deficiencies with the evaluations conducted by these IMEs and remanded appellant's case for further development.

On June 17, 2019 OWCP referred appellant and the case record, along with a SOAF and series of questions, for an impartial medical examination and evaluation with Dr. Julie Wehner, a Board-certified orthopedic surgeon. It requested that she address both the expansion and schedule award issues. The referral was made in accordance with the instructions of OWCP's May 1, 2019 decision.

In a July 9, 2019 report, Dr. Wehner discussed appellant's factual and medical history, noting the treatment for her accepted cervical and lumbar conditions. She reported physical examination findings, which included 4+/5 motor strength and intact sensation in the upper extremities. Appellant exhibited mildly decreased range of motion (ROM) of the shoulders and some limitations upon ROM of the hips. Dr. Wehner provided a discussion in which she concluded that appellant did not sustain any conditions causally related to her accepted employment injury other than those already accepted. She maintained that she did not find any evidence that appellant sustained bilateral traumatic arthritis of the shoulders related to the accepted employment injury. Dr. Wehner advised that this opinion was based on the fact that there was no documented work-related traumatic episode to appellant's shoulders, there was no diagnostic test result indicating decreased articular cartilage, the clinical examination showed only a mild decrease in shoulder ROM without much pain, and there was no mention prior to 1992 of any type of shoulder problem. She further opined that appellant's present clinical examination did not support a current diagnosis of bilateral traumatic arthritis of the shoulders. Dr. Wehner asserted that appellant might have some type of nonwork-related rotator cuff tendinitis, which was

not an unusual condition for an individual of her age. She noted that she did not elicit any specific pain with palpation of appellant's lateral epicondyles or pain with resisted dorsiflexion of her wrists. Dr. Wehner advised that the diagnostic testing of record did not document tendinitis of the extensor carpi radialis tendons. She maintained that there was nothing in the medical records that documented a diagnosis, an evaluation, or any type of treatment for lateral epicondylitis of the elbows prior to 1992. Appellant's present clinical examination did not indicate bilateral epicondylitis of the elbows and the medical records did not show that appellant had such a work-related condition.

Dr. Wehner further advised that appellant did not have any pain with palpation over the medial epicondyles or pain with resisted palmar flexion of the wrists. She indicated that diagnostic testing in the case record did not document any type of tendinitis and appellant did not receive a diagnosis of medial epicondyle of the elbows prior to 1992. There was nothing in the medical records to indicate a diagnosis, an evaluation, or any type of treatment for bilateral epicondylitis in connection with the accepted employment conditions. Dr. Wehner maintained that there was no finding of bilateral medial epicondylitis on the present examination or in the medical records. She concluded that appellant did not sustain such a work-related injury. Dr. Wehner further indicated that appellant did not presently have a positive Tinel's sign in her elbows. She did not have an electromyogram/nerve conduction velocity (EMG/NCV) study that was positive for cubital tunnel. Dr. Wehner noted that appellant did not receive a diagnosis of cubital tunnel prior to 1992. There was no finding that appellant had bilateral cubital tunnel with ulnar nerve impingement at the elbows based on the present clinical examination. Dr. Wehner maintained that there were no medical facts to support the diagnosis of cubital tunnel syndrome with ulnar nerve impingement at the elbows as a work-related injury. There was no finding on the present examination of any symptoms indicative of radial tunnel syndrome such as pain with resisted wrist extension or finger extension. Dr. Wehner noted that there was no mention prior to 1992 of any pain in appellant's forearms. There was no documentation of diagnosis or treatment of bilateral radial tunnel syndrome, and there was no x-ray study in the case record to confirm such a diagnosis.

Dr. Wehner advised that there was no evidence of bilateral radial tunnel syndrome. She did not find any evidence in the medical records to indicate that appellant had incurred bilateral radial tunnel syndrome as a result of her occupational activities prior to 1992. There were no complaints of specific hand and wrist swelling, pain, or disuse prior to 1992 while she was working. Dr. Wehner advised that there was no documentation of any diagnosis of tendinitis of the hands and wrists, or any testing for this condition. In addition, there was no indication in the medical records that appellant had bilateral tendinitis of the hands and wrists which was causally related to an injury at work around May 12, 1987, or which was sustained as an occupational disease. Dr. Wehner further indicated that there was no indication that appellant was complaining of carpal tunnel symptoms, such as numbness in her thumbs, or index and middle fingers. Moreover, appellant did not have a positive Tinel's or Phalen's sign, or a positive EMG/NCV study prior to her retirement in 1992. Dr. Wehner advised that there was no medical indication that appellant received a diagnosis of carpal tunnel syndrome related to an injury at work around May 12, 1987, or that she sustained the condition as an occupational disease. She indicated that there was no indication of trauma to appellant's knees or that appellant was complaining of hip disease or limited hip ROM prior to 1992. In addition, there were no x-ray findings of hip arthritis prior to 1992. Dr. Wehner advised that appellant's hip arthritis was consistent with diffuse idiopathic skeletal hyperostosis (DISH), a disease of genetic origin, which was not causally related to activities at work, and that her knee arthritis was consistent with a normal, nonwork-related degenerative condition.

Dr. Wehner then conducted an evaluation of permanent impairment of appellant's extremities. She noted that, with regard to the right upper extremity and the accepted cervical herniated disc at C3-4, she was using Table 15-21 on page 436 of *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), which was a supplemental publication of the sixth edition of the A.M.A., *Guides*. Dr. Wehner advised that there was no motor or sensory loss in the upper extremities upon her physical examination. She noted that, based on Table 15-14 on page 425, this constituted severity of 0. There was no specific peripheral nerve related to the C3-4 level, but the C3 and C4 nerve roots did contribute to the trapezius and dorsal scapar nerve. Dr. Wehner indicated, however, that there was no specific weakness noted in these muscle groups. Therefore, the impairment rating from the peripheral nerve basis was zero. Dr. Wehner advised that, with regard to the left upper extremity and the accepted cervical herniated disc at C3-4, she used *The Guides Newsletter*, Table 15-21 on page 436. There was no motor or sensory loss in the upper extremities upon physical examination and, based on Table 15-14 on page 425, this constituted severity of 0. Dr. Wehner noted that there was no specific peripheral nerve related to the C3-4 level, but the C3 and C4 nerve roots did contribute to the trapezius and dorsal scapar nerve. However, there was no specific weakness noted in these muscle groups. Dr. Wehner advised that, therefore, the impairment rating from the peripheral nerve basis was zero.

With regard to the right lower extremity and the accepted permanent aggravation of lumbar degenerative disc disease, Dr. Wehner used the sixth edition of the A.M.A., *Guides*, Table 15-21 on page 436. She noted that there was sensory loss in the lower extremities upon physical examination. Based on Table l5-14 on page 425, this constituted severity of 0. Dr. Wehner indicated that appellant had some global weakness due to difficulty giving full effort due to the significant edema in her legs. She advised that there was no neurologic weakness and no specific weakness due to disc degeneration. Therefore, the impairment rating from the peripheral nerve basis was zero.

Dr. Wehner indicated that, with regard to the left lower extremity and the accepted permanent aggravation of lumbar degenerative disc disease, she used *The Guides Newsletter,* Table 15-21 on page 436. There was sensory loss in the lower extremities upon physical examination and, based on Table 15-14 on page 425, this constituted severity of 0. Dr. Wehner noted that appellant had some global weakness due to difficulty giving full effort due to the significant edema in her legs. This was no neurologic weakness and there was no specific weakness due to disc degeneration. Dr. Wehner found that, therefore, the impairment rating from the peripheral nerve basis was zero.

In a September 14, 2019 report, Dr. Jovito Estaris, a Board-certified occupational medicine specialist serving as an OWCP district medical adviser (DMA), expressed his agreement with Dr. Wehner's opinion on the expansion and schedule award issues.

By two separate decisions dated September 18, 2019, OWCP denied appellant's expansion and schedule award claims based on the opinion of Dr. Wehner. On October 2, 2019 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on February 14, 2020. By decision April 30, 2020, OWCP's hearing representative set aside the September 18, 2019 decisions and remanded the case to OWCP for further development, to be followed by issuance of a *de novo* decision on the expansion and schedule award issues. The hearing representative determined that Dr. Wehner needed to be provided additional medical documents.

On June 23, 2020 OWCP requested that Dr. Wehner clarify her July 9, 2019 report. Per OWCP's hearing representative's instructions, it provided her with a number of medical documents, which had not been previously available to her.

In a supplemental report dated June 25, 2020, Dr. Wehner advised that appellant had an underlying condition called ossification of the posterior spinal longitudinal ligament of the cervical spine, which was genetic and was not caused by work duties. She explained that individuals with this condition had a natural course of worsening over time regardless of their daily activities. Appellant also had an underlying condition called DISH, which had a natural course of worsening over time regardless of daily activities. Dr. Wehner addressed the timeline of appellant's symptoms and noted, "The development of symptoms in other body regions by [appellant] does not indicate causation merely because they came after she worked. She has been retired over 28 years, and the development of musculoskeletal complaints is no longer related to activities 25 years ago." Dr. Wehner provided a description of the calculation of appellant's permanent impairment which was similar to that contained in her July 9, 2019 report.

By decision dated July 23, 2020, OWCP found that appellant did not meet her burden of proof to expand the acceptance of her claim to include additional conditions causally related to her accepted employment injury. By separate decision dated July 23, 2020, it found that she did not meet her burden of proof to establish permanent impairment of a scheduled (listed) member or function of the body, warranting a schedule award.

On August 21, 2020 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on November 12, 2020.

By decision dated January 20, 2021, OWCP's hearing representative affirmed the July 23, 2020 decision. The hearing representative determined that Dr. Wehner served as an OWCP referral physician, rather than as an impartial medical specialist, and found that her second opinion evaluation represented the weight of the medical opinion evidence with respect to appellant's expansion and schedule award claims. The hearing representative found that a conflict in the medical opinion evidence was not created regarding the expansion and schedule award issues due to the fact that the opinion of Dr. Brecher, an OWCP referral physician, was of limited probative value because the SOAF provided to him did not adequately describe appellant's work history.

LEGAL PRECEDENT -- ISSUE 1

When an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[4] The medical evidence required to establish causal relationship between a specific condition, and the employment injury is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported

[4] *J.R.,* Docket No. 20-0292 (issued June 26, 2020); *W.L.*, Docket No. 17-1965 (issued September 12, 2018); *V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

The Board has held that when the medical evidence supports an aggravation or acceleration of an underlying condition precipitated by working conditions or injuries, such disability is compensable.[6] However, the normal progression of untreated disease cannot be stated to constitute "aggravation" of a condition merely because the performance of normal work duties reveals the underlying condition.[7]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to expand the acceptance of her claim to include additional conditions as causally related to her accepted May 12, 1987 employment injury.

In a July 9, 2019 report, Dr. Wehner discussed appellant's factual and medical history, reported physical examination findings, and provided a discussion in which she concluded that appellant did not sustain any conditions causally related to her accepted employment injury other than those already accepted. She maintained that she did not find any evidence that appellant sustained bilateral traumatic arthritis of the shoulders related to the accepted employment injury. Dr. Wehner advised that this opinion was based on the fact that there was no documented work-related traumatic episode to appellant's shoulders, there was no diagnostic test result indicating decreased articular cartilage, the clinical examination showed only a mild decrease in shoulder ROM without much pain, and there was no mention prior to 1992 of any type of shoulder problem. She further opined that appellant's present clinical examination did not support a current diagnosis of bilateral traumatic arthritis of the shoulders. Dr. Wehner asserted that appellant might have some type of nonwork-related rotator cuff tendinitis, which was not an unusual condition for an individual of her age. She noted that she did not elicit any specific pain with palpation of appellant's lateral epicondyles or pain with resisted dorsiflexion of her wrists. Dr. Wehner advised that the diagnostic testing of record did not document tendinitis of the extensor carpi radialis tendons. She maintained that there was nothing in the medical records that documented a diagnosis, an evaluation, or any type of treatment for lateral epicondylitis of the elbows prior to 1992. Appellant's present clinical examination did not indicate bilateral epicondylitis of the elbows and the medical records did not show that appellant had such a work-related condition.

Dr. Wehner further advised that appellant did not have any pain with palpation over the medial epicondyles or pain with resisted palmar flexion of the wrists. She indicated that diagnostic testing in the case record did not document any type of tendinitis and appellant did not receive a diagnosis of medial epicondyle of the elbows prior to 1992. There was nothing in the medical records to indicate a diagnosis, an evaluation, or any type of treatment for bilateral epicondylitis in connection with the accepted employment conditions. Dr. Wehner maintained that there was no finding of bilateral medial epicondylitis on the present examination or in the medical records. She concluded that appellant did not sustain such a work-related injury. Dr. Wehner further

[5] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

[6] *C.H.,* Docket No. 17-0488 (issued September 12, 2017).

[7] *Id.*

indicated that appellant did not presently have a positive Tinel's sign in her elbows. She did not have an EMG/NCV study that was positive for cubital tunnel. Dr. Wehner noted that appellant did not receive a diagnosis of cubital tunnel prior to 1992. There was no finding that appellant had bilateral cubital tunnel with ulnar nerve impingement at the elbows based on the present clinical examination. Dr. Wehner maintained that there were no medical facts to support the diagnosis of cubital tunnel syndrome with ulnar nerve impingement at the elbows as a work-related injury. There was no finding on the present examination of any symptoms indicative of radial tunnel syndrome such as pain with resisted wrist extension or finger extension. Dr. Wehner noted that there was no mention prior to 1992 of any pain in appellant's forearms. There was no documentation of diagnosis or treatment of bilateral radial tunnel syndrome, and there was no x-ray study in the case record to confirm such a diagnosis.

Dr. Wehner advised that there was no evidence of bilateral radial tunnel syndrome. She did not find any evidence in the medical records to indicate that appellant had incurred bilateral radial tunnel syndrome as a result of her occupational activities prior to 1992. There were no complaints of specific hand and wrist swelling, pain, or disuse prior to 1992 while she was working. Dr. Wehner advised that there was no documentation of any diagnosis of tendinitis of the hands and wrists, or any testing for this condition. In addition, there was no indication in the medical records that appellant had bilateral tendinitis of the hands and wrists, which was causally related to an injury at work around May 12, 1987, or which was sustained as an occupational disease. Dr. Wehner further indicated that there was no indication that appellant was complaining of carpal tunnel symptoms, such as numbness in her thumbs, or index and middle fingers. Moreover, appellant did not have a positive Tinel's or Phalen's sign, or a positive EMG/NCV study prior to her retirement in 1992. Dr. Wehner advised that there was no medical indication that appellant received a diagnosis of carpal tunnel syndrome related to an injury at work around May 12, 1987, or that she sustained the condition as an occupational disease. She indicated that there was no indication of trauma to appellant's knees or that appellant was complaining of hip disease or limited hip ROM prior to 1992. In addition, there were no x-ray findings of hip arthritis prior to 1992. Dr. Wehner advised that appellant's hip arthritis was consistent with DISH, a disease of genetic origin, which was not causally related to activities at work, and that her knee arthritis was consistent with a normal, nonwork-related degenerative condition.

In a supplemental report dated June 25, 2020, Dr. Wehner further found that appellant did not sustain a cervical condition causally related to the accepted employment conditions. She provided medical rationale for this determination by explaining that appellant had an underlying condition called ossification of the posterior spinal longitudinal ligament of the cervical spine, which was genetic and was not caused by work duties. Dr. Wehner explained that individuals with this condition had a natural course of worsening over time regardless of their daily activities. Appellant also had an underlying condition called DISH, which had a natural course of worsening over time regardless of daily activities. Dr. Wehner addressed the timeline of appellant's symptoms and noted, "The development of symptoms in other body regions by [appellant] does not indicate causation merely because they came after she worked. [Appellant] has been retired over 28 years, and the development of musculoskeletal complaints is no longer related to activities 25 years ago."

The Board finds that the hearing representative properly determined in the January 20, 2021 decision that Dr. Wehner served as an OWCP referral physician with respect to the expansion issue, rather than as an IME, and properly found that her second opinion evaluation represented the weight of the medical opinion evidence with respect to the expansion issue. As the medical

evidence of record is insufficient to any additional conditions as causally related to her accepted employment injury, the Board finds that she has not met her burden of proof.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provisions of FECA,[8] and its implementing federal regulation,[9] 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.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11] A claimant has the burden of proof under FECA to establish permanent impairment of a scheduled member or function as a result of his or her employment injury entitling him or her to a schedule award.[12]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[13] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[14] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*, which is a supplemental publication of the sixth edition of the A.M.A., *Guides*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[15]

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[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id. See also T.T.,* Docket No. 18-1622 (issued May 14, 2019).

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

[12] *M.G.*, Docket No. 19-0823 (issued September 17, 2019); *I.T.*, Docket No. 18-1049 (issued December 31, 2018).

[13] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.,* Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[14] *Supra* note 11 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[15] *Supra* note 11 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met her burden of proof to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

The Board finds that the hearing representative properly determined in the January 20, 2021 decision that Dr. Wehner served as an OWCP referral physician with respect to the schedule award issue, rather than as an impartial medical specialist, and properly found that her second opinion evaluation represented the weight of the medical opinion evidence with respect to the schedule award issue.

In her July 9, 2019 report, Dr. Wehner noted that, with regard to the right upper extremity and the accepted cervical herniated disc at C3-4, she was using *The Guides Newsletter*, Table 15-21 on page 436. She advised that there was no motor or sensory loss in the upper extremities on her examination. Dr. Wehner indicated that, based on Table 15-14 on page 425, this constituted severity of 0. There was no specific peripheral nerve related to the C3-4 level, but the C3 and C4 nerve roots did contribute to the trapezius and dorsal scapar nerve. Dr. Wehner indicated, however, that there was no specific weakness noted in these muscle groups. Therefore, the impairment rating from the peripheral nerve basis was zero. Dr. Wehner advised that, with regard to the left upper extremity and the accepted cervical herniated disc at C3-4, she used *The Guides Newsletter*, Table 15-21 on page 436. There was no motor or sensory loss in the upper extremities upon physical examination and, based on Table 15-14 on page 425, this constituted severity of 0. Dr. Wehner noted that there was no specific peripheral nerve related to the C3-4 level, but the C3 and C4 nerve roots did contribute to the trapezius and dorsal scapar nerve. However, there was no specific weakness noted in these muscle groups. Dr. Wehner advised that, therefore, the impairment rating from the peripheral nerve basis was zero.

With regard to the right lower extremity and the accepted permanent aggravation of lumbar degenerative disc disease, Dr. Wehner used the sixth edition of the A.M.A. *Guides*, Table 15-21 on page 436. She noted that there was sensory loss in the lower extremities upon physical examination. Based on Table 15-14 on page 425, this constituted severity of 0. Dr. Wehner indicated that appellant had some global weakness due to difficulty giving full effort due to the significant edema in her legs. She advised that there was no neurologic weakness and no specific weakness due to disc degeneration. Therefore, the impairment rating from the peripheral nerve basis was zero. Dr. Wehner indicated that, with regard to the left lower extremity and the accepted permanent aggravation of lumbar degenerative disc disease, she used *The Guides Newsletter,* and the A.M.A., *Guides*, Table 15-21 on page 436. There was sensory loss in the lower extremities upon physical examination and, based on Table 15-14 on page 425, this constituted severity of 0. She noted that appellant had some global weakness due to difficulty giving full effort due to the significant edema in her legs. This was not a neurologic weakness and there was no specific weakness due to disc degeneration. Dr. Wehner found that, therefore, the impairment rating from the peripheral nerve basis was zero. In a supplemental June 25, 2020 report, she provided a description of the calculation of appellant's permanent impairment, which was similar to that contained in her July 9, 2019 report.

As the medical evidence of record is insufficient to establish permanent impairment of a scheduled member or function of the body, the Board finds that appellant has not met her burden of proof to establish her schedule award claim.

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 permanent impairment.

CONCLUSION

The Board finds that appellant has not met her burden of proof to expand the acceptance of her claim to include additional conditions as causally related to her accepted employment injury. The Board further finds that appellant has not met her burden of proof to establish permanent impairment of a scheduled member, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 20, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 19, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board