United States Department of Labor
Employees' Compensation Appeals Board

V.K., Appellant	)	
and	)	**Docket No. 21-1006**
	)	**Issued: September 25, 2023**
U.S. POSTAL SERVICE, WEST CALDWELL POST OFFICE, West Caldwell, NJ, Employer	)	

Appearances:
Michael D. Overman, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 22, 2021 appellant, through counsel, filed a timely appeal from a January 6, 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.

[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*.

ISSUE

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

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On May 26, 2015 appellant, then a 62-year-old clerk, filed a traumatic injury claim (Form CA-1) alleging that on May 22, 2015 she injured her left wrist when she slipped and fell on a waxed floor while in the performance of duty. On July 10, 2015 OWCP accepted the claim for left distal radial fracture. On November 29, 2016 it expanded the acceptance of the claim to include left carpal tunnel syndrome (CTS).[4]

In a September 10, 2018 report, Dr. Albert Johnson, a Board-certified orthopedic surgeon, noted appellant's history of injury and medical treatment. He utilized the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] Dr. Johnson diagnosed acute displacement fracture to the distal left radius; primary closed reduction internal fixation of the distal left radius with specialized distal radius plate; post-traumatic CTS, left wrist. For the left wrist, he noted that range of motion (ROM) was tested three times. He related appellant's physical examination findings, but did not offer a rating based on ROM methodology. Dr. Johnson opined that appellant's class of diagnosis (CDX) of left wrist fracture, was a Class 1 impairment for a default of three percent permanent impairment. He applied grade modifiers based upon Table 15-3, page 396; Table 15-7, page 406; Table 15-8, page 408; and Table 15-9, page 410 of the A.M.A., *Guides*. Dr. Johnson found a grade modifier for functional history (GMFH) of 2 and a grade modifier for physical examination (GMPE) of 2. He noted that a grade modifier for clinical studies (GMCS) was not applicable. After applying the adjustment formula, Dr. Johnson calculated that appellant had five percent left upper extremity permanent impairment due to the left wrist distal fracture.

For appellant's left CTS, Dr. Johnson found entrapment neuropathy left median nerve at the wrist with a GMCS of 1, a GMFH of 3, and a GMPE of 3. He applied the adjustment formula and, utilizing Table 15-23, page 449, and Table 15-7, page 406, concluded that appellant had five

[3] Docket No. 18-1005 (issued February 1, 2019).

[4] By decision dated April 7, 2016, OWCP denied expansion of appellant's claim to include a left shoulder condition. It thereafter continued to deny modification of that decision. On April 18, 2018 appellant, through counsel, filed a timely appeal to the Board. By decision dated February 1, 2019, the Board affirmed a December 20, 2017 OWCP decision denying modification, finding that appellant had not met her burden of proof to establish that the acceptance of her claim should be expanded to include a left shoulder condition causally related to the accepted May 22, 2015 employment injury. Docket No. 18-1005 (issued February 1, 2019).

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

percent permanent impairment for the left CTS. Dr. Johnson also rated appellant's left shoulder partial rotator cuff thickness tear and opined that appellant had 10 percent permanent impairment for the left shoulder. He combined the 5 percent rating for the left distal radial fracture, the 5 percent rating for the left CTS, and the 10 percent rating for the left shoulder, and opined that appellant had a total of 19 percent permanent impairment of her left upper extremity. Dr. Johnson found that appellant reached maximum medical improvement (MMI) on September 10, 2018.

On October 30, 2018 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On November 6, 2018 OWCP referred Dr. Johnson's report to Dr. Morley Slutsky, Board-certified in occupational medicine and the district medical adviser (DMA), for review and calculation of appellant's permanent impairment.

In a December 11, 2018 report, Dr. Slutsky, the DMA, reviewed Dr. Johnson's report. Dr. Slutsky opined that appellant had 3 percent permanent impairment for the left wrist distal fracture and 2 percent permanent impairment for the left CTS. He noted that for the left wrist, the diagnosis-based impairment (DBI) methodology was used for the diagnosis of left wrist fracture. Dr. Slutsky explained that he also used a Class 1 for the CDX; however, he found net adjustment factors of 0; therefore, the impairment remained at the default value of 3 percent. He also noted that the ROM methodology resulted in 0 percent permanent impairment, therefore, the final impairment was based on the DBI methodology. Regarding the left CTS, the DMA noted that the *Quick*DASH score was not performed and advised that "this should have been done as it is a mandatory part of rating compression neuropathies." Dr. Slutsky explained that the GMFH was 1 as appellant had mild findings, GMPE was 1 as appellant had atrophy of the median nerve and some thenar weakness, and the GMCS was 1 based on electromyography (EMG) studies. He found that the average adjustment factor was 1, which resulted in 2 percent permanent impairment for the left CTS. The DMA also provided an impairment rating for the left shoulder of 11 percent. He utilized the Combined Values Chart on page 604 of the A.M.A., *Guides* and opined that his ratings of 3 percent for the left wrist, 2 percent for the left CTS, and 11 percent for the left shoulder resulted in a total of 16 percent left upper extremity permanent impairment.

By letter dated January 4, 2019, OWCP requested that Dr. Johnson review and comment on the DMA's report.

In a February 20, 2019 report, Dr. Johnson noted that he and Dr. Slutsky rated appellant for a left wrist fracture, entrapment neuropathy of the left median nerve, and ROM deficit for the left shoulder. He amended his rating for the left shoulder impairment to 11 percent and noted that he was in agreement with the DMA regarding the left shoulder rating.

Regarding the left wrist fracture, Dr. Johnson concurred with the DMA regarding a CDX of Class1; however, he disagreed with the applicable grade modifiers. He explained that the GMFH and GMCS were not applicable. Dr. Johnson concurred that the GMPE in Table 15-8, page 408 of the A.M.A., *Guides*, based on minimal findings without observed abnormalities, was equal to 1. However, he explained that appellant had undergone surgery to the left wrist and had a six-centimeter scar over the distal radius, which was in addition to the ROM deficit in palmar flexion and marked grip deficit, and that appellant's GMPE would therefore be consistent with a

grade modifier of 2. Dr. Johnson concluded that after net adjustment, due to a Class 1 left wrist fracture, the permanent impairment would equal four percent, rather than the three percent found by the DMA.

Regarding the left CTS, Dr. Johnson concurred with the Dr. Slutsky regarding the CDX of Class 1; however, he disagreed with the GMFH and GMPE. He explained appellant's complaints regarding the left wrist and hand which included pain and stiffness on a constant basis, swelling, numbness, and tingling in the left wrist, pins and needles sensation, awakening with the hand feeling asleep, and difficulty with self-care, such as bathing, dressing, styling her hair, household chores, lifting, grasping, gripping. Dr. Johnson referred to Table 15-23, page 449, and explained that her constant and daily symptoms would correlate to a GMFH of 3. In terms of the GMPE, he noted that appellant had a decreased pinch strength, which would also qualify for a GMPE of 3 according to Table 15-23, page 449, rather than a GMPE of 1, as noted by the DMA, which would correlate to normal physical examination findings. Dr. Johnson calculated appellant's permanent impairment due to left CTS to be 5 percent and determined that the final combined left upper extremity permanent impairment rating was 18 percent, including his rating for appellant's left shoulder.

On March 18, 2019 OWCP referred Dr. Johnson's February 20, 2019 report to Dr. Slutsky, the DMA, for further review and calculation of appellant's permanent impairment.

In April 8 and 21, 2019 reports, Dr. Slutsky, the DMA, disagreed with Dr. Johnson's opinion. Regarding the left CTS, he noted that, according to page 433 of the A.M.A., *Guides*, a GMFH of 3 for constant symptoms meant that the pain or numbness was consistently present and at least a conduction block, if not axon loss, would be present on electrodiagnostic testing to substantiate the symptom severity. The DMA explained that there was no documentation that appellant was unable to perform at least one of the activities of daily living, or that someone else consistently performed the activity for the individual. He noted that appellant did not have axonal loss of conduction block and therefore opined that there was no basis for a GMFH of 3 for appellant's symptoms. Regarding the GMPE, the DMA noted that appellant was assigned a GMPE of 3 by Dr. Johnson; however, pinch strength was controlled by more than one nerve and was non-specific, therefore, it was not used to rate CTS. He referred to page 446, of the A.M.A., *Guides* and noted that appellant had normal two-point discrimination and monofilament testing and atrophy was not found on the median nerve, which was equal to a GMPE of 0. The DMA explained that to qualify for GMPE of 3 by physical findings, there should be constant numbness and no protective sensation, two-point discrimination of 16 millimeters or greater for the median or ulnar nerve, and grade 3 or less motor function or a history of a surgical tendon transfer to restore function. He opined, "This is almost never seen in peripheral nerve entrapment. [Appellant] obviously does not meet this criteria and does not qualify for a GMPE of 3 for physical findings." The DMA assigned a GMPE of 1 and explained that pinch strength deficits may be partially caused by the median nerve, which is 90 percent sensory, and without sensory findings, appellant did not have a higher score.

Regarding the left wrist fracture, the DMA explained that their opinions differed due to the GMPE. He explained that a 6-centimeter scar was consistent with a CDX of Class 1 and was assigned a GMPE of 1. The DMA noted that weakness was not used to assign a GMPE, per Table 15-8, page 408. He noted no other objective deficits were documented and that appellant's GMPE

was 1, therefore the final permanent impairment was 3 percent, as opposed to the 4 percent assigned by Dr. Johnson. The DMA combined the left wrist, left CTS, and left shoulder values pursuant to the Combined Values Chart, page 604 of the A.M.A., *Guides*, and concluded that appellant had a total of 16 percent left upper extremity permanent impairment (11 percent for the shoulder, combined with 3 percent for the wrist, and 2 percent for the CTS).

On May 9, 2019 OWCP determined that a conflict existed in the medical opinion evidence between the treating physician, Dr. Johnson, and the DMA, Dr. Slutsky, regarding the extent of appellant's permanent impairment. It referred appellant for an impartial medical examination with Dr. Howard Pecker, a Board-certified orthopedic surgeon, to resolve the conflict.

In a June 24, 2019 report, Dr. Pecker, the impartial medical examiner (IME), opined that appellant had 3 percent permanent impairment for the left wrist fracture, 2 percent permanent impairment for the left CTS, and 1 percent permanent impairment for the left shoulder. Regarding the left wrist fracture, he noted that appellant had radial deviation of 20 degrees bilaterally, ulnar deviation of 30 degrees bilaterally, dorsiflexion of 80 degrees bilaterally, palmar flexion of 90 degrees bilaterally, supination of 80 degrees bilaterally, pronation of 75 degrees bilaterally, and a well-healed longitudinal scar on the volar radial aspect of the left distal forearm and wrist. Dr. Pecker found discrete tenderness with palpation of the thumb and trapeziometacarpal joint, negative Tinel's; negative Phalen's, normal interosseous strength with intermittent effort, and 5/5 endpoint with distraction. He noted variable effort with grip testing with 5/5 endpoint and right left confusion during distraction and coaching, full strength in the thumb to small finger opposition, no wasting of the thenar eminence, no crepitance, full fist, and no locking or triggering. Dr. Pecker also noted that appellant's complaints of pain did not match the diagnosis, and her history could not be relied upon and should not be used as a determining factor. He indicated that measured ROM was equal to the opposite side and reports of pain in the thumb were not consistent with the sequela of open reduction internal fixation surgery, which invalidated the ROM method and favored the DMA's DBI evaluation.

Regarding the left CTS, Dr. Pecker agreed with the DMA that the DBI method should be used as he found that appellant was unreliable and gave a variable history that did not coincide with her physical findings. He also noted that the findings on an EMG scan were "just barely in favor of [CTS] and are within the measurement error for a normal median nerve." Dr. Pecker found no evidence of loss of grip strength as appellant had right/left confusion during testing, 5/5 endpoint with distractions, and intermittent effort with interosseous motion, not related to the median nerve.

Regarding the left shoulder, Dr. Pecker indicated that during his physical examination, appellant's left shoulder movement measurement was variable in four separate attempts. He noted that appellant would only allow her shoulder to be brought to 45 degrees forward elevation, but on distraction and examination of other parts of the body, she would elevate her shoulder to 125 degrees. Dr. Pecker utilized the DBI methodology and found that GMFH was unreliable, GMPE was 0, and GMCS was 1 for mild pathology. He applied the net adjustment formula and concluded that appellant had one percent permanent impairment of the left shoulder.

In a letter dated November 14, 2019, OWCP requested that Dr. Pecker clarify his permanent impairment rating for the left upper extremity and the date of MMI.

OWCP received a copy of Dr. Pecker's June 24, 2019 report, which was amended to include June 24, 2019 as appellant's date of MMI.

By decision dated December 3, 2019, OWCP granted appellant a schedule award for six percent impairment of the left upper extremity and explained that the opinion of the IME was given special weight. The period of the award ran from June 24 to November 2, 2019.

On December 9, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on April 6, 2020.

In a May 8, 2020 report, Dr. Johnson noted that he had reviewed the reports from the DMA and the IME. He advised that his opinion had not changed, and that appellant sustained a left upper extremity permanent impairment of 18 percent. Dr. Johnson also noted that the IME's rating of 2 percent for the left CTS did not document how the impairment was rated pursuant to Table 15-23.

By decision dated June 16, 2020, OWCP's hearing representative vacated the December 3, 2019 decision. She specifically noted that Dr. Pecker did not indicate that ROM was measured more than once and that his ROM rating did not meet the criteria set forth in the A.M.A., *Guides* for an ROM rating. The hearing representative noted that OWCP should seek further medical review by the DMA, any needed clarification from the IME regarding his impairment evaluation, and a reexamination, if necessary.

In a June 26, 2020, report, Dr. Slutsky, the DMA, noted that the IME, Dr. Pecker, reviewed and documented the pertinent history and diagnostic reports and performed a focused physical examination addressing the accepted conditions of the claim. The DMA related that as the IME, Dr. Pecker was entitled to his opinion that the shoulder examination for ROM was unreliable as well as appellant's functional history, and that he had provided adequate justification for his opinion. He noted that Dr. Pecker did not provide a detailed calculation of his impairments for the wrist fracture, using Table 15-3, or his calculation of impairment for the left CTS using Table 15-23. The DMA advised that the Dr. Pecker should be contacted and offered the opportunity to submit a corrective supplemental report to justify his determination of three percent for the left wrist fracture and two percent for the left CTS.

In a letter dated July 2, 2020, OWCP requested that Dr. Pecker clarify his report.

In a July 7, 2020 supplemental report, Dr. Pecker reiterated his opinion that appellant had three percent permanent impairment due to the left wrist fracture diagnosis, and two percent permanent impairment due to the left CTS diagnosis. He referred to Table 15-3, page 396 for the CDX of left wrist fracture and provided a Class 1. The IME explained that a GMFH could not be used because appellant was an unreliable historian, the GMPE was 0 as there were no consistent findings, and a GMCS of 2 was based on a confirmed diagnosis with moderate pathology. He used the net adjustment formula and found 3 percent left wrist permanent impairment due to left wrist fracture. For the left CTS, Dr. Pecker referred to Table 15-23, page 449, for entrapment neuropathy impairment, noted a GMCS of 1 for conduction delay sensory/motor delay and a GMPE of 0 for physical findings. He noted that a GMFH could not be rated due to unreliable

history. Dr. Pecker used the net adjustment formula and found two percent permanent impairment due to appellant's left CTS.

On July 9, 2020 OWCP referred Dr. Pecker's report to Dr. Slutsky, the DMA, for review.

In a July 22, 2020 report, Dr. Slutsky advised that he concurred with the IME that the total permanent impairment of appellant's left upper extremity was six percent, including the impairment rating for the left shoulder. He indicated that the date of MMI was June 24, 2019, the date of Dr. Pecker's examination.

By *de novo* decision dated August 3, 2020, OWCP determined that appellant did not sustain greater than the six percent permanent impairment of the left upper extremity previously awarded.

On August 11, 2020 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on November 12, 2020.

By decision dated January 6, 2021, OWCP's hearing representative affirmed the August 3, 2020 decision, according the special weight of the medical evidence to the opinion of Dr. Pecker, the IME.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[8] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[9] 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.[10]

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*.; *see V.O.,* Docket No. 20-0287 (issued June 1, 2021); *see also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[10] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health *Organization's International Classification of Functioning Disability and Health (ICF): A Contemporary Model of Disablement*.[11] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a GMFH, GMPE, and/or GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[14]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[15] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (via the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[16]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or IME) who shall make an examination.[17] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[18] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME

[11] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

[12] *Id*. at 383-492.

[13] *Id*. at 411.

[14] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[15] FECA Bulletin No. 17-06 (issued May 8, 2017).

[16] *Id*.

[17] 5 U.S.C. § 8123(a); *see C.S.*, Docket No. 20-1149 (issued September 8, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[18] 20 C.F.R. § 10.321.

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.[19]

OWCP's procedures provide that, if a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for OWCP's medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*. The procedures further note that the Board has held that, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. OWCP's medical adviser cannot resolve a conflict in medical opinion. If necessary, clarification by the referee examiner may be needed.[20]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than six percent permanent impairment of her left upper extremity, for which she has received schedule award compensation.

OWCP found a conflict in the medical opinion evidence between Dr. Johnson, appellant's treating physician, and Dr. Slutsky, the DMA, regarding the extent of her permanent impairment. It properly referred the case to an IME, Dr. Pecker, for resolution of the conflict between the ratings of the treating physician and the DMA, pursuant to 5 U.S.C. § 8123(a).

In a June 24, 2019 report, Dr. Pecker concluded that appellant had three percent permanent impairment for the left wrist fracture, two percent permanent impairment for the left CTS, and one percent permanent impairment for the left shoulder. Regarding the left wrist fracture, he noted appellant's physical examination findings, including her ROM of left wrist. Dr. Pecker noted variable effort with grip testing with 5/5 endpoint and right left confusion during distraction and coaching. He also noted that appellant's complaints of pain did not match the diagnosis, and her history could not be relied upon and should not be used as a determining factor. Dr. Pecker indicated that measured ROM was equal to the opposite side and reports of pain in the thumb were not consistent with the sequela of open reduction internal fixation surgery, which invalidated the ROM method and favored the DMA's evaluation under the DBI methodology. Regarding the left CTS, he agreed with the DMA that the DBI method should be used as he found that appellant was unreliable and gave a variable history that did not coincide with her physical findings. Dr. Pecker found no evidence of loss of grip strength as appellant had right/left confusion during testing, 5/5 endpoint with distractions, and intermittent effort with interosseous motion, not related to the median nerve. Likewise, regarding the left shoulder, he indicated that during his physical examination, appellant's left shoulder movement measurement was variable in four separate attempts. Dr. Pecker noted that appellant would only allow her shoulder to be brought to 45

[19] *D.C.*, Docket No. 23-0455 (issued August 28, 2023); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

[20] *See supra* note 9 at Chapter 2.810.8g (September 2010); *see S.P.*, Docket No. 20-0418 (issued February 19, 2021); *Richard R. LeMay*, 56 ECAB 341 (2005); *K.D.*, Docket No. 19-0281 (issued June 30, 2020).

degrees forward elevation, but on distraction and examination of other parts of the body, she would elevate her shoulder to 125 degrees.

In a June 26, 2020, report, Dr. Slutsky, the DMA, advised that Dr. Pecker should be asked to provide a supplemental report to justify his rating under the DBI methodology of three percent for the left wrist fracture and two percent for the left CTS. He advised that Dr. Pecker should provide his rating under Table 15-3 for the left wrist fracture and Table 15-23 for appellant's left CTS. The DMA also related that Dr. Pecker had provided adequate justification for his opinion regarding appellant's left shoulder permanent impairment.

In a July 7, 2020 supplemental report, Dr. Pecker reiterated his opinion that appellant had three percent permanent impairment due to the left wrist fracture diagnosis, and two percent permanent impairment due to the left CTS diagnosis. He properly referred to Table 15-3, page 396 for the CDX of left wrist fracture and provided a Class 1. Dr. Pecker explained that a GMFH could not be used because appellant was an unreliable historian, the GMPE was 0 as there were no consistent findings, and a GMCS of 2 was based on a confirmed diagnosis with moderate pathology. He used the net adjustment formula and found three percent left wrist permanent impairment due to left wrist fracture. For the left CTS, Dr. Pecker properly referred to Table 15-23, page 449, for entrapment neuropathy impairment, noted a GMCS of 1 for conduction delay sensory/ motor delay and a GMPE of 0 for physical findings. He noted that a GMFH could not be rated due to unreliable history. Dr. Pecker used the net adjustment formula and found 2 percent permanent impairment due to appellant's left CTS.

The Board finds that the special weight of the evidence is represented by the well-rationalized opinion of Dr. Pecker, the IME selected to resolve the conflict in medical opinion.[21] In his reports he provided rationale for his opinion that appellant's permanent impairment of the left upper extremity could not be rated using the ROM methodology due to appellant's inconsistent examination measurements. The Board finds that Dr. Pecker properly utilized the A.M.A., *Guides* to rate appellant's permanent impairment based on the DBI methodology. His opinion thus represents the special weight of the evidence and establishes that appellant had no greater than six percent permanent impairment of the left upper extremity.[22]

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.

CONCLUSION

The Board finds that appellant has not established that she has greater than six percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

[21] *R.P.*, Docket No. 19-0057 (issued May 16, 2019).

[22] *A.M.*, Docket No. 18-1243 (issued October 7, 2019).

ORDER

IT IS HEREBY ORDERED THAT the January 6, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 25, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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