United States Department of Labor
Employees' Compensation Appeals Board

E.B., Appellant	)	
and	)	**Docket No. 23-1021**
	)	**Issued: February 16, 2024**
U.S. POSTAL SERVICE, POST OFFICE, Kearny, NJ, Employer	)	

Appearances:
Russell T. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 27, 2023 appellant, through counsel, filed a timely appeal from a February 1, 2023 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.

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than four percent permanent impairment of her right upper extremity and eight percent permanent

[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.*

impairment of her left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On September 1, 2003 appellant, then a 48-year-old sack sorting machine operator, filed an occupational disease claim (Form CA-2) alleging that she developed bilateral carpal tunnel syndrome (CTS) as a result of factors of her federal employment, including repetitive movements of her upper extremities.[3] She noted that she first became aware of her condition and realized its relation to her federal employment on January 5, 2003. OWCP accepted the claim for bilateral CTS. Appellant stopped work on September 14, 2006. OWCP paid her wage-loss compensation on the supplemental rolls commencing September 14, 2006, and on the periodic rolls commencing October 29, 2006.

In a narrative report dated December 8, 2018,[4] Dr. Michael M. Cohen, an orthopedist, discussed appellant's history and medical and surgical treatment. He performed a physical examination which revealed slightly reduced strength in the shoulders, biceps, and triceps; decreased sensation of the left upper extremity in the C4, C5, and C6 distributions; reduced range of motion and moderately positive cross-over, Hawkin's, O'Brien's, and Speed's tests in the left shoulder; and positive Phalen's test in the right hand with tenderness over the thenar musculature. Dr. Cohen opined that appellant had reached maximum medical improvement (MMI) as of December 8, 2018.

Regarding the right upper extremity, Dr. Cohen utilized the diagnosis-based impairment (DBI) rating method, under Table 15-23, Entrapment/Compression Neuropathy Impairment, page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] for the right-sided CTS and assigned a grade modifier for physical examination (GMPE) of 1, a grade modifier for functional history (GMFH) of 3, and a grade modifier for clinical studies (GMCS) of 1, which resulted in an average grade modifier of 2, or a default value of five percent. He noted that she had a *Quick*DASH score of 63, which increased the impairment rating for right-sided CTS to six percent permanent impairment. Utilizing Table 15-2, Digit Regional Grid, page 392, for the right thumb, Dr. Cohen found six percent permanent impairment of the right hand. He noted a final combined right upper extremity permanent impairment of eight percent.

[3] OWCP assigned the current claim OWCP File No. xxxxxx447. Appellant had a subsequent October 21, 2003 traumatic injury claim (Form CA-1), which OWCP accepted for cervical and left shoulder strains under OWCP File No. xxxxxx443. She also had a November 27, 2009 traumatic injury claim, which OWCP accepted for a left hand contusion under OWCP File No. xxxxxx414. Appellant also has an accepted occupational disease claim for cervical/thoracic/lumbosacral sprains and a May 27, 2014 traumatic right bowler's thumb under OWCP File Nos. xxxxxx779 and xxxxxx051, respectively. On February 8, 2023 OWCP administratively combined OWCP File Nos. xxxxxx447, xxxxxx414, xxxxxx779, xxxxxx051, and xxxxxx443, with the latter serving as the master file.

[4] The report also reflected that it was updated on February 16, 2019.

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

Regarding the left upper extremity, utilizing the DBI method under Table 15-23, page 449, for the left-sided CTS, Dr. Cohen assigned a GMPE of 1, a GMFH of 2, and a GMCS of 1, which resulted in an average grade modifier of 2, or a default value of two percent. He noted that she had a *Quick*DASH score of 79, which increased the impairment rating for left-sided CTS to three percent permanent impairment. Utilizing Table 15-5, Shoulder Regional Grid, page 403, Dr. Cohen found a class of diagnosis (CDX) for left shoulder acromioclavicular joint arthropathy with distal clavicle, resulted in a Class 1 impairment with a default value of 10 percent of the left upper extremity. He assigned a GMPE of 2 under Table 15-8, page 408, a GMCS of 1 under Table 15-9, page 410, and GMFH not applicable, which resulted in a net adjustment of 1, for a total impairment of 11 percent. Utilizing Table 15-3, page 395, for left wrist strain and sprain, Dr. Cohen found one percent left upper extremity impairment. Utilizing Table 1 of *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) he found two percent left upper extremity impairment for moderate sensory deficit of the left C5 nerve root and a three percent left upper extremity impairment for moderate sensory deficit of the left C6 nerve root. Dr. Cohen reached a final combined permanent impairment of 20 percent of the left upper extremity.

On March 29, 2019 OWCP routed Dr. Cohen's report, along with a statement of accepted facts (SOAF) and the case record, to Dr. Herbert White, Jr., a Board-certified occupational medicine specialist, serving as OWCP's district medical adviser (DMA), for review and evaluation of appellant's permanent impairment pursuant to the sixth edition of A.M.A., *Guides*.[6]

In an April 9, 2019 report, Dr. White indicated that he had reviewed the SOAF and Dr. Cohen's report and that appellant had reached MMI on December 8, 2018. He noted that the A.M.A., *Guides* did not allow for an impairment rating under the range of motion (ROM) method for CTS. Dr. White utilized the DBI method under Table 15-23, page 449, and found a right upper extremity impairment rating of three percent for the right-sided CTS.[7] Relative to the right thumb, he used Table 15-2, page 392, and found a Class 1 impairment, with a default value of one percent impairment.[8] Dr. White found a combined impairment of five percent of the right upper extremity.

Regarding the left upper extremity, Dr. White concurred with Dr. Cohen's ratings of 3 percent permanent impairment of the left upper extremity for left-sided CTS, 11 percent permanent impairment of the left upper extremity for distal clavicle excision, and 1 percent permanent impairment of the left upper extremity for left wrist sprain. Regarding the cervical nerve roots, Dr. White found one percent impairment of the left upper extremity for each of the C5 and C6 nerve roots. Utilizing the Combined Values Chart, he found a combined left upper extremity impairment of two percent for spinal nerve extremity impairment. Dr. White opined that appellant's overall combined left upper extremity impairment rating was 17 percent.

[6] *Id*.

[7] Dr. White noted that he excluded Dr. Cohen's *Quick*DASH score of 63 for the right-sided CTS, because the functional history was determined to be unreliable or inconsistent with other documentation. A.M.A., *Guides* 406.

[8] Dr. White noted that he excluded Dr. Cohen's *Quick*DASH score of 79 for the right trigger thumb because the functional history was determined to be unreliable or inconsistent with other documentation. *Id*. at 406.

With respect to Dr. Cohen's differing impairment ratings, Dr. White observed that he provided a lower GMFH for right-sided CTS, as appellant did not have either a conduction block or axon loss present on electrodiagnostic testing. Regarding the differences in the spinal nerve extremity impairment ratings, he noted that he rated appellant's sensory findings as mild, not moderate. Dr. White found the date of MMI to be December 8, 2018, the date of Dr. Cohen's examination.

On May 2, 2019 OWCP forwarded Dr. White's April 9, 2019 report to Dr. Cohen for his review and comment.

On July 8, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

OWCP thereafter received June 24, 2019 and July 17, 2020 addendum reports by Dr. Cohen, who continued to maintain that appellant had a permanent impairment of her right upper extremity of 8 percent and of her left upper extremity of 20 percent.

On August 14, 2020 OWCP found a conflict of medical opinion evidence between Dr. White, for the government, and Dr. Cohen, for appellant, regarding the appropriate percentage of permanent impairment of the upper extremities. To resolve the conflict, OWCP referred appellant, the medical record, a statement of accepted facts (SOAF), and a series of questions to Dr. Ian Blair Fries, a Board-certified orthopedic surgeon, for an impartial medical evaluation of appellant's permanent impairment pursuant to the sixth edition of A.M.A., *Guides*.

In a September 14, 2021 report, Dr. Fries, serving as the impartial medical examiner (IME), outlined the results of his August 28, 2021 evaluation, including his review of appellant's history and medical records. He noted that her current symptoms included a burning sensation over the top of the left shoulder and down the arm with numbness in the left hand, which occurred approximately two times per week and resolved within one to two minutes. Dr. Fries further noted that appellant also related burning and numbness from the right thenar eminence to the right wrist, which occurred during sleep and while working. He performed a physical examination, where he observed right thenar eminence pain, mild tenderness over the left anterior rotator cuff and infraclavicular area, slight left deltoid and right thenar eminence atrophy, and reduced sensation over the right thumb, middle, and ring fingers. Dr. Fries also found strong flexor hallucis longus function with no triggering, no flexor sheath tenderness of the right thumb, and negative provocative tests with no sensory or motor findings relative to left-sided CTS.

Utilizing Table 15-23, page 449, for right-sided carpal tunnel syndrome, Dr. Fries assigned a GMPE of 2 due to mild median sensory findings and mild thenar atrophy, a GMFH of 2 due to burning and numbness from the right thenar eminence to the wrist, and a GMCS of 1 for conduction delay during testing. He found an average grade modifier of 2, which placed appellant in the upper extremity impairment range of 4, 5, or 6. Utilizing the functional scale, Dr. Fries rated her as mild with a grade modifier of 1, and therefore assigned the lower value in the upper extremity impairment range of the right upper extremity due to CTS, which yielded four percent permanent impairment. Relative to the right thumb, utilizing Table 15-2, page 392, he indicated that for a CDX of trigger digit without residual symptoms, appellant was a Class 0 impairment,

with a default value of zero percent permanent impairment. Dr. Fries opined that the combined right upper extremity impairment rating was four percent.

Regarding the left upper extremity, Dr. Fries indicated that the operative report for the October 27, 2010 distal left clavicular resection was not available nor were any medical records for treatment appellant received during the six months prior to the procedure. He indicated that the absence of those records limited his ability to apportion left upper extremity due to the shoulder condition. Utilizing Table 15-5, page 403, Dr. Fries found that the CDX of distal left clavicular resection represented a Class 1 impairment with a default value of grade C, resulting in 10 percent permanent impairment. He assigned a GMFH of 0 due to minimal symptoms in the left upper extremity which resolved after a minute or two; a GMPE of 1 due to minimal palpatory findings and no loss of motion; and a GMCS of 0 due to lack of imaging studies. Dr. Fries applied the net adjustment formula, which yielded a net adjustment of -2 and moved the default value of grade C two places to the left to grade A, which resulted in an eight percent permanent impairment of the left upper extremity for the left shoulder distal clavicular resection. Regarding left-sided CTS, utilizing Table 15-3, page 449, he assigned a GMPE of 0, a GMFH of 0, and a GMCS of 1 for conduction delay during testing and found an average grade modifier of 0 and a resulting permanent impairment of zero. Dr. Fries further found no evidence to support a diagnosis of left cervical radiculopathy, noting that appellant had no motor, reflex, or measurable sensory deficits on examination. He concluded that appellant had a total left upper extremity impairment of eight percent and found that she reached MMI as of the date of his examination, August 28, 2021.

By decision dated September 29, 2021, OWCP granted appellant a schedule award for four percent permanent impairment of the right upper extremity and eight percent permanent impairment of the left upper extremity. The date of MMI was found to be August 28, 2021. The award covered a period of 37.44 weeks and ran from August 28, 2021 through May 17, 2022. OWCP noted that the special weight of the medical evidence rested with the IME, Dr. Fries.

On October 6, 2021 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on December 15, 2021. After the hearing, appellant submitted a further addendum report dated December 27, 2021 by Dr. Cohen, who reviewed the September 14, 2021 report of Dr. Fries and amended his right upper extremity impairment rating for right-sided CTS to five percent and his final combined right upper extremity impairment rating to seven percent. He further amended his final combined left upper extremity impairment rating to 18 percent.

By decision dated March 3, 2022, an OWCP hearing representative remanded the case to OWCP to provide additional medical records to Dr. Fries, including the October 27, 2010 distal clavicle resection operative report, appellant's medical records from six months prior to the October 27, 2010 surgery, and Dr. Cohen's December 27, 2021 addendum report.

On March 30, 2022 OWCP sent additional medical records and a list of questions to Dr. Fries for his review and comments.

In an April 21, 2022 addendum report, Dr. Fries noted that he reviewed the SOAF, medical records pertaining to six months of medical treatment up to and including the October 27, 2010 left distal clavicular resection surgery, Dr. Cohen's December 27, 2021 addendum report, and his

August 28, 2021 physical examination findings. He noted inconsistent clinical findings throughout an April 26, 2010 functional capacity evaluation (FCE) and a normal electromyography and nerve conduction velocity (EMG/NCV) study dated June 17, 2010 of the upper extremities. Dr. Fries opined that there was insufficient evidence to modify the permanent impairment rating calculations that he previously provided.

By *de novo* decision dated June 21, 2022, OWCP denied appellant's claim for an increased schedule award.

On June 28, 2022 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which took place on November 17, 2022. Following the hearing, counsel submitted a further addendum report by Dr. Cohen dated November 18, 2022, who maintained his permanent impairment ratings for the right upper extremity of 7 percent and of the left upper extremity of 18 percent.

By decision dated February 1, 2023, OWCP's hearing representative affirmed the June 21, 2022 decision, findings that the special weight of the medical evidence rested with the IME, Dr. Fries.

LEGAL PRECEDENT

The schedule award provisions of FECA[9] and its implementing regulations[10] 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[11] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[12]

It is the claimant's burden of proof to establish permanent impairment of the scheduled member or function of the body as a result of an employment injury.[13] OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this

[9] *Supra* note 1.

[10] 20 C.F.R. § 10.404.

[11] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[13] *E.D.*, Docket No. 19-1562 (issued March 3, 2020); *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[14]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[15] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "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)."[18]

The FECA Bulletin further advises:

> "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."[19]

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[20] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities (*Quick*DASH).[21]

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[14] *Supra* note 12 at Chapter 2.808.5 (March 2017).

[15] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[16] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[17] *Id.* at 411.

[18] FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[19] *Id.*

[20] A.M.A., *Guides* 449.

[21] *Id.* at 448-49.

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

Section 8123(a) of FECA which 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 known as an IME who shall make an examination.[23] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[24] The Board has long held that an OWCP DMA may create a conflict in medical opinion with an examining physician.[25] When there exists opposing reports of virtually equal weight and rationale and the case is referred to an IME 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.[26]

ANALYSIS

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

OWCP properly found a conflict in medical opinion between Dr. Cohen and Dr. White regarding the extent of permanent impairment in appellant's upper extremities under the sixth edition of the A.M.A., *Guides*.[27] In order to resolve the conflict, it referred her to Dr. Fries, as an IME, for an impartial medical examination to resolve the conflict in medical opinion pursuant to 5 U.S.C. § 8123(a).

In his September 14, 2021 report, Dr. Fries opined that appellant had reached MMI as of his evaluation on August 28, 2021. Based upon his review of medical records and examination findings, he opined that she had four percent permanent impairment of her right upper extremity based on her CTS diagnosis and an eight percent permanent impairment to her left upper extremity due to left shoulder distal clavicle excision. Dr. Fries explained that, according to Table 15-23 of

[22] *See supra* note 12 at Chapter 2.808.6f) (February 2013). *See also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[23] 5 U.S.C. § 8123(a); *J.K.*, Docket No. 20-0907 (issued February 12, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[24] 20 C.F.R. § 10.321; *R.C.*, 58 ECAB 238 (2006).

[25] *See G.W.*, Docket No. 16-0525 (issued August 2, 2017); *Harold Travis*, 30 ECAB 1071 (1979); *see* 20 C.F.R. § 10.321(b).

[26] *See J.K.*, *supra* note 23; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

[27] *Supra* note 5.

the A.M.A., *Guides*, appellant had a GMCS of 1, a GMFH of 2, and a GMPE of 2, which yielded an upper extremity impairment rating of four percent of the right upper extremity due to CTS. Relative to the right thumb, he explained that, according to Table 15-2, the diagnosis of trigger digit without residual symptoms was a Class 0 impairment, with a default value of zero percent. Therefore, the combined right upper extremity impairment rating was four percent.

Regarding the left upper extremity, Dr. Fries explained that according to Table 15-5 appellant's CDX of distal left clavicular resection represented a Class 1 impairment with a default value of grade C, resulting in 10 percent impairment. He assigned a GMFH of 0, a GMPE of 1, and a GMCS of 0 due to lack of imaging studies. Dr. Fries applied the net adjustment formula, which adjusted to the default value of grade C to grade A and resulted in an eight percent permanent impairment of the left upper extremity for the left shoulder distal clavicular resection. For the diagnosis of left-sided CTS, he explained that according to Table 15-23 appellant had a GMPE of 0, a GMFH of 0, and a GMCS of 1 which yielded an average grade modifier of 0 and a resulting permanent impairment of zero. Dr. Fries further found no evidence to support a diagnosis of left cervical radiculopathy, noting that appellant had no motor, reflex, or measurable sensory deficits on examination. He concluded that appellant had a total left upper extremity impairment of eight percent. Following remand of its September 29, 2021 decision, OWCP forwarded the appropriate records to Dr. Fries for his review and comment, and, by addendum report dated April 21, 2022 he opined that there was insufficient evidence to modify the permanent impairment rating calculations reflected in his September 14, 2021 report.

The Board finds that the special weight of the medical opinion evidence regarding the above-noted issues is represented by the thorough, well-rationalized opinion of Dr. Fries. Dr. Fries' reports established that he properly applied the A.M.A., *Guides* to his examination findings, and explained that appellant's current impairment was four percent right upper extremity impairment based on right-sided CTS and eight percent left upper extremity permanent impairment based on left distal clavicular resection. The Board finds that Dr. Fries' opinion has reliability, probative value, and convincing quality with respect to its conclusions regarding the relevant issues of the present case. Dr. Fries provided a thorough factual and medical history, and he accurately summarized the relevant medical evidence. He properly utilized the DBI method to rate appellant's accepted upper extremity conditions. As Dr. Fries' report is detailed, well rationalized, and based on a proper factual background, his opinion represents the special weight of the medical evidence. Consequently, appellant has not met her burden of proof to establish greater than four percent permanent impairment of her right upper extremity or eight percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

The Board notes that in response to Dr. Fries' September 14, 2021 report and supplemental April 21, 2022 report, Dr. Cohen submitted supplemental reports dated December 27, 2021 and November 18, 2022, which amended his impairment ratings for each upper extremity. The Board notes that Dr. Cohen was on one side of the conflict created and resolved pursuant to 5 U.S.C. § 8123(a) and his additional reports do not create a new conflict. Additional reports from a

physician on one side of the conflict that is properly resolved by an IME are generally insufficient to overcome the special weight accorded the IME's report or to create a new conflict.[28]

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 establish more than four percent permanent impairment of her right upper extremity or eight percent permanent impaiment of her left upper extremity, for which she previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the February 1, 2023 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 16, 2024
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[28] *See T.B.*, Docket No. 12-0866 (issued September 25, 2012); *Harrison Combs, Jr.*, 45 ECAB 716 (1994); *Dorothy Sidwell*, 41 ECAB 857 (1990).