

**United States Department of Labor  
Employees' Compensation Appeals Board**

R.E., Appellant	)	
	)	
and	)	Docket No. 25-0223
	)	Issued: April 24, 2025
U.S. POSTAL SERVICE, HARTLY POST	)	
OFFICE, Hartly, DE, Employer	)	
	)	

*Appearances:* *Case Submitted on the Record*  
*Russell T. Uliase, Esq., for the appellant*<sup>1</sup>  
*Office of Solicitor, for the Director*

**DECISION AND ORDER**

Before:  
ALEC J. KOROMILAS, Chief Judge  
PATRICIA H. FITZGERALD, Deputy Chief Judge  
VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On January 7, 2025 appellant filed a timely appeal from a July 23, 2024 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

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<sup>1</sup> 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.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

## ISSUE

The issue is whether appellant has greater than one percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

## FACTUAL HISTORY

This case has previously been before the Board.<sup>3</sup> 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 August 16, 2004 appellant, then a 39-year-old postmaster, filed a traumatic injury claim (Form CA-1) alleging that on July 1, 2004 she developed right arm pain, swelling, and carpal tunnel syndrome. She stopped work on July 8, 2004, and worked intermittently thereafter. On April 27, 2005, OWCP assigned this claim OWCP File No. xxxxxx209 and accepted it for aggravation of right arm lymphedema. It subsequently expanded the acceptance of the claim to include right carpal tunnel syndrome, complex regional pain syndrome/myofascial pain syndrome, and thoracic outlet syndrome.<sup>4</sup>

By decision dated January 9, 2013, OWCP expanded the accepted conditions to include temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved. It based its decision on the opinion of Dr. Zohar Stark, a second opinion Board-certified orthopedic surgeon, who concluded the aggravation of her medical conditions had resolved.

On March 26, 2014 appellant filed a claim for compensation (Form CA-7) for a schedule award. She submitted an August 20, 2013 report from Dr. David Weiss, an osteopath Board-certified in clinical orthopedic surgery, who provided an impairment rating under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*<sup>5</sup> (A.M.A., *Guides*). Dr. Weiss advised that appellant had reached maximum medical improvement (MMI) on August 20, 2013. Appellant's history was significant for right breast cancer and a right lumpectomy with radiation. Dr. Weiss diagnosed cumulative and repetitive trauma disorder superimposed upon preexisting breast cancer diagnosed in 2002, occupational cervical spine

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<sup>3</sup> Docket No. 16-1618 (issued May 23, 2017).

<sup>4</sup> On March 28, 2006, appellant filed a notice of recurrence (Form CA-2a) alleging that, on March 10, 2006, she had pain and swelling of her right shoulder while performing her duties. She stopped work on March 12, 2006. On June 15, 2006, OWCP denied appellant's claim for a recurrence of disability. Appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review and, on August 16, 2006, an OWCP hearing representative set aside the June 15, 2006 decision and instructed OWCP to develop the recurrence claim as a claim for new occupational disease. OWCP developed this under OWCP File No. xxxxxx494. In decisions dated December 11, 2006, August 13, 2007, June 13, 2008, and December 7, 2009, OWCP denied appellant's claim under OWCP File No. xxxxxx494. OWCP has administratively combined OWCP File Nos. xxxxxx494 and xxxxxx209, with the latter serving as the master file.

<sup>5</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009).

syndrome, aggravation of preexisting brachial plexopathy secondary to radiation therapy, right carpal tunnel syndrome, complex regional pain syndrome to the right arm, cumulative and repetitive trauma disorder with aggravation of preexisting lymphedema of the right arm, and subsequent motor vehicle accident in 2008 with aggravation of cervical spine pathology and right arm pathology. He noted that the duties of her employment were the competent producing factor for her subjective and objective findings. Dr. Weiss noted a final combined impairment rating of 49 percent permanent impairment of the right upper extremity.<sup>6</sup>

OWCP subsequently referred the case record, along with a statement of accepted facts (SOAF) to Dr. Morley Slutsky, a Board-certified occupational medicine specialist, serving as an OWCP district medical adviser (DMA).

In a January 17, 2014 report, Dr. Slutsky reviewed Dr. Weiss' report and noted that he had found deficits with upper extremity motor weakness and sensory deficit, which were a significant variance from other physician's findings on physical examination. Dr. Slutsky recommended a second opinion referral.

On April 8, 2014 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions, to Dr. Stephen F. Penny, a Board-certified neurologist, for a second opinion regarding whether she had permanent impairment attributable to her accepted conditions. In a June 11, 2014 report, Dr. Penny noted that appellant's history was significant for brachial plexopathy, breast cancer, carpal tunnel syndrome, hypertension, and recurrent major depression. Appellant's surgical history included a breast biopsy and lymph node removal. Dr. Penny opined that appellant had developed a radiation-induced right brachial plexopathy related to her treatment for breast cancer and lymphedema. He indicated that musculoskeletal pain involving the shoulder and upper arm and regional pain syndrome contributed to her ongoing symptoms. Dr. Penny noted that appellant had evidence of mild carpal tunnel syndrome by electromyogram (EMG). He noted that appellant had reached MMI. Dr. Penny agreed that appellant had 49 percent permanent impairment of the right upper extremity.

In a September 19, 2014 report, Dr. Slutsky, OWCP's DMA, reviewed Dr. Penney's report. He indicated that Dr. Penny had provided nonspecific findings and agreed with the 49 percent right arm permanent impairment by Dr. Weiss. However, Dr. Slutsky noted that Dr. Penny had not performed a rating examination with calculations. He asked Dr. Penny to perform his own calculations, based upon his own clinical findings, but he failed to do so. Dr. Slutsky recommended that OWCP refer appellant to another second opinion physician with complete documentation of all clinical findings and calculations.

On October 7, 2014 OWCP advised appellant that the second opinion report from Dr. Penny failed to contain an independently-derived impairment rating consistent with the

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<sup>6</sup> Dr. Weiss evaluated carpal tunnel syndrome at the right medial nerve at the wrist under Table 15-23, page 449 of the A.M.A., *Guides* and opined that appellant had six percent permanent impairment of the right arm. For right brachial plexus of the upper trunk (C5 and C6), he calculated 19 percent permanent impairment of the right arm. For right brachial plexus of the middle trunk (C7), Dr. Weiss determined three percent permanent impairment of the right upper extremity. For motor strength deficit for the right biceps (C5 and C6), he found 25 percent permanent impairment of the right arm. For motor strength deficit for the right triceps (C7), Dr. Weiss calculated nine percent permanent impairment of the right arm.

A.M.A., *Guides*, as requested and the medical adviser recommended appellant be sent for another second opinion evaluation to determine impairment.

On April 8, 2014 OWCP referred appellant, along with the case record, a SOAF, and a series of questions for a new second opinion examination with Dr. Willie E. Thompson, a Board-certified physiatrist, for a determination of whether appellant had permanent impairment warranting a schedule award. In an October 21, 2014 report, Dr. Thompson noted that the underlying etiology of appellant's complaints related to the mastectomy performed in 2002 with residuals of chronic lymphedema. He noted that other accepted conditions included aggravation of right upper extremity lymphedema, right carpal tunnel syndrome, right complex regional pain syndrome with myofascial pain, and right thoracic outlet syndrome. Dr. Thompson further noted that, under the A.M.A., *Guides*, there was no diagnosis for persistent aggravation of the chronic lymphedema to the right arm and, therefore, the impairment rating for a chronic lymphedema was zero percent. He advised that there was no clinical evidence to support a diagnosis of complex regional pain syndrome and myofascial pain. With regard to complex regional pain syndrome, pursuant to Table 15-26, page 454, the Class was zero, which resulted in no impairment. Dr. Thompson indicated that the Allen's test was normal and there was no evidence of any residuals of thoracic outlet syndrome. With regard to brachial plexus impairment, pursuant to Table 15-20, page 434 of the A.M.A., *Guides*, appellant was a Class zero for no impairment. For entrapment neuropathy resulting in carpal tunnel syndrome, Dr. Thompson referenced Table 15-23, page 449 of the A.M.A., *Guides*, resulting in a grade modifier of 1 for an impairment rating of one percent for the right upper extremity.

OWCP requested that Dr. Thompson clarify his impairment rating and provide the clinical findings and test results considered in reaching his conclusion.

In a November 24, 2014 supplemental report, Dr. Thompson noted that appellant had abnormal EMG and nerve conduction velocity (NCV) studies documenting carpal tunnel syndrome. He advised that, pursuant to the A.M.A., *Guides*, entrapment neuropathy, Table 15-23, page 449, resulted in a grade modifier of 1 based on conduction delay in the EMG/NCV studies with mild intermittent symptoms and essentially normal examination as it relates to entrapment neuropathy. Dr. Thompson noted that this resulted in an impairment rating of one percent permanent impairment of the right upper extremity. He indicated that, under Table 15-18, carpal tunnel syndrome, pages 449 and 450 of the A.M.A., *Guides*, appellant was a grade modifier 1 as test findings on EMG/NCV studies were abnormal, her history revealed mild intermittent symptoms, but her examination was essentially within normal limits.

On March 31, 2015 OWCP referred the case record, along with SOAF, to an OWCP DMA. The referral letter indicated that the accepted conditions were temporary aggravation of the right arm lymphedema resolved, temporary aggravation of right carpal tunnel syndrome resolved, temporary aggravation of complex regional pain syndrome resolved, and temporary aggravation of thoracic outlet syndrome, resolved.

In a March 31, 2015 report, the DMA reviewed the medical evidence, including Dr. Thompson's October 21 and November 24, 2014 reports, and concurred in his findings. He noted that the date of MMI was October 21, 2014.

By decision dated November 18, 2015, OWCP granted appellant a schedule award for one percent permanent impairment of the right hand. The period of the award ran for 2.44 weeks from October 21 through November 7, 2014.

On December 3, 2015 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on March 4, 2016.

By decision dated April 29, 2016, OWCP's hearing representative affirmed, as modified, the November 18, 2015 decision, finding that appellant's one percent permanent impairment was to the right upper extremity rather than the right hand.

Appellant, through counsel, appealed to the Board. By decision dated May 23, 2017, the Board set aside the April 29, 2016 decision and remanded the case for further medical development.<sup>7</sup> On January 3, 2018 OWCP referred appellant to Dr. Matthew L. Drake, a Board-certified orthopedic surgeon, for a second opinion regarding whether she had permanent impairment attributable to her accepted conditions.<sup>8</sup> In a January 24, 2018 report, Dr. Drake noted that appellant's history was significant for brachial plexopathy, breast cancer, carpal tunnel syndrome, hypertension, and recurrent major depression. He diagnosed temporary aggravated but resolved right arm lymphedema, carpal tunnel syndrome, complex regional pain syndrome, and thoracic outlet syndrome. Dr. Drake reported that he saw no evidence of any work-related conditions. He noted slightly increased circumference of the right brachial region compared to the left which was consistent with a history of lymphedema after breast cancer surgery. Dr. Drake advised that this condition was not caused or worsened by the work activities described. He opined that there was no objective evidence on examination of complex regional pain syndrome and thoracic outlet syndrome. With regard to the right carpal tunnel syndrome, Dr. Drake noted mild EMG studies from 10 years ago. He noted that her sensory examination was invalid and that the condition does not continue to exist. Dr. Drake indicated that appellant was engaging in symptom magnification and had secondary gain issues. He disagreed with Dr. Weiss' impairment rating of 49 percent permanent impairment of the right upper extremity and opined that, pursuant to the A.M.A., *Guides*, appellant had zero percent permanent impairment of the right upper extremity related to her work duties.

On February 20, 2018 OWCP referred the case record, along with a SOAF to a DMA. In a report dated March 11, 2018, Dr. David Slutsky, a Board-certified orthopedist, serving as DMA, noted that an impairment rating could not be performed for the diagnosis of temporary aggravation of lymphedema of the right arm or temporary exacerbation of thoracic outlet syndrome under the A.M.A., *Guides*. Additionally, he noted that an impairment rating for temporary aggravation of carpal tunnel syndrome and temporary aggravation of complex regional pain syndrome could not be performed due to a lack of information in Dr. Drake's report. Specifically, Dr. Slutsky noted that an impairment rating using range of motion (ROM) rating method could not be performed due to a lack of validated upper extremity motion measurements. He noted that Dr. Drake did not

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<sup>7</sup> Docket No. 16-1618 (issued May 23, 2017).

<sup>8</sup> The record reflects that Dr. Penny had retired.

provide any calculation, nor rationale for the zero percent permanent impairment rating and asserted that Dr. Drake had considerable bias.

On March 22, 2018 OWCP requested that Dr. Drake clarify his impairment rating and provide clinical findings and test results considered in reaching his conclusion.

On April 8, 2018 Dr. Drake explained the basis for his opinion and indicated that there was no objective evidence to support complex regional pain syndrome. He noted that appellant's physical examination was not suggestive of thoracic outlet syndrome as provocative maneuvers from the physical examination were negative. Dr. Drake further noted that physical examination could not corroborate the continued existence of right carpal tunnel syndrome. He opined that appellant was engaging in symptom magnification and malingering. Dr. Drake disagreed with Dr. Slutsky and opined that pursuant to the A.M.A., *Guides* appellant had zero percent impairment.

By *de novo* decision dated April 24, 2018, OWCP denied appellant's claim for an increased schedule award.

On April 30, 2018, appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated August 1, 2018, an OWCP hearing representative set aside the April 24, 2018 decision and remanded the case for further development. The hearing representative instructed OWCP to comply with the Board's instructions and provide a new SOAF to Dr. Penny, the second opinion physician, and obtain a supplemental report.

On August 6, 2018, QTC Medical Services (QTC), OWCP's scheduling service, indicated that Dr. Penny was no longer available.

By *de novo* decision dated November 15, 2018, OWCP denied appellant's claim for an increased schedule award.

On November 26, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on March 11, 2019. Appellant submitted a report dated March 6, 2019, wherein Dr. Weiss opined that pursuant to the A.M.A., *Guides* appellant had a final combined impairment rating of 49 percent permanent impairment of the right upper extremity.

By decision dated April 22, 2019, an OWCP hearing representative vacated the November 15, 2018 decision and remanded the case for an impartial medical examination due to a conflict in medical opinion between Dr. Weiss, for appellant and Dr. Drake, for OWCP.

On July 17, 2019, OWCP referred appellant, along with the case record, a SOAF, and a series of questions, to Dr. Andrew Gelman, an osteopath and Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict in the case.

In a September 12, 2019 report, Dr. Gelman, serving as the impartial medical examiner (IME), noted full active range of motion of the cervical spine, negative Spurling sign, no pain upon

palpation over the paravertebral musculature of the cervical spine, tenderness of the right upper trapezius and anterior right pectoralis, tenderness over the acromioclavicular joint and proximal biceps on the right, intact range of motion of the elbows, equal right and left wrist range of motion, negative Tinel's sign, negative Phalen's sign, and no thenar or hypothenar atrophy. He noted that appellant displayed guarding and fear behavior. Dr. Gelman noted the examination was suggestive of radiation-induced right shoulder adhesive capsulitis, right upper extremity lymphedema, and brachial neuritis. He disagreed with the diagnosis of median nerve neuropathy through the carpal tunnel or complex regional pain syndrome. Dr. Gelman supported Dr. Drake's conclusion of zero percent permanent impairment related to appellant's accepted work-related conditions.

By *de novo* decision dated March 26, 2020, OWCP denied appellant's claim for an increased schedule award.

On April 1, 2020 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated May 29, 2020, an OWCP hearing representative vacated the March 26, 2020, decision and remanded the case for further development. The hearing representative instructed OWCP to provide Dr. Gelman the complete case file, a complete SOAF including all conditions accepted, and provide an addendum report addressing whether appellant has remaining residual of her accepted conditions that cause impairment.

On November 13, 2020 and March 4, 2021, OWCP requested that Dr. Gelman clarify his impairment rating and provide the clinical findings and test results considered in reaching his conclusion.

On March 18, 2021 Dr. Gelman indicated that his prior examination on September 12, 2019, revealed no clinical findings with regard to median nerve entrapment through the carpal tunnel. He noted that the right wrist motion was equal when compared to the left, negative entrapment signs through the carpal tunnel, negative Tinel and Phalen's signs, and no visible thenar and hypothenar atrophy. Dr. Gelman opined that the clinical assessment does not support a diagnosis of median nerve entrapment. He indicated that the clinical findings from an objective and subjective perspective, supported a diagnosis of adhesive capsulitis, subacromial impingement, brachial plexopathy, and lymphedema, all diagnoses secondary to appellant's breast care.

By *de novo* decision dated October 21, 2021, OWCP denied appellant's claim for an increased schedule award.

On October 28, 2021 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated January 4, 2022, an OWCP hearing representative vacated the October 21, 2021, decision and remanded the case for further development. The hearing representative noted that there was no indication that Dr. Gelman reviewed a corrected SOAF and acknowledged all of the accepted conditions. The hearing

representative instructed OWCP to request that Dr. Gelman provide a rationalized explanation of whether appellant has permanent impairment due to carpal tunnel syndrome.

On February 9, 2022 OWCP requested that Dr. Gelman clarify his impairment rating and provide clinical findings and test results considered in reaching his conclusion.

On February 22, 2022 Dr. Gelman indicated that his prior examination on September 12, 2019 revealed no clinical findings of median nerve entrapment through the carpal tunnel to support a diagnoses of median nerve entrapment. He opined that thoracic outlet syndrome and complex regional pain syndrome resolved and would equate to a zero percent permanent impairment. Dr. Gelman opined that he could not conclude any quantified impairment rating with regard to the right upper extremity and the diagnoses lymphedema, thoracic outlet syndrome and complex regional pain syndrome causally related to appellant's employment activities.

By *de novo* decision dated June 27, 2022, OWCP denied appellant's claim for an increased schedule award.

On July 6, 2022 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on November 10, 2022.

Appellant submitted a report from Dr. Weiss dated November 29, 2022. He opined that the thoracic outlet syndrome was not resolved, rather he noted that his examination on August 20, 2013 found positive supraclavicular and infraclavicular Tinel producing radicular symptomology. Dr. Weiss noted that in terms of the lymphedema he noted swelling over the right hand and sensory deficits at C6 and C7 and motor deficits at C5 and C7 consistent with thoracic outlet syndrome.

By decision dated January 25, 2023, an OWCP hearing representative vacated the June 27, 2022 decision and remanded the case for further medical development. The hearing representative instructed OWCP to obtain a supplemental report from Dr. Gelman addressing total impairment of a scheduled member and whether the diagnosed lymphedema, thoracic outlet syndrome, and complex regional pain syndrome conditions resolved.<sup>9</sup>

On November 21, 2023 OWCP referred appellant, along with the case record, a SOAF, and a series of questions to Dr. Stanley Askin, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict in medical opinion.

In a January 25, 2024 report, Dr. Askin discussed appellant's medical history, reviewed the SOAF, and her diagnostic testing, and provided findings on physical examination. He noted that appellant's conditions were still evolving such that she had not achieved a fixed and stable status. Dr. Askin noted findings on examination of essentially no flexion or extension of her neck. Appellant declined to move her shoulders due to pain. A Phalen's test was not performed because

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<sup>9</sup> The record reveals that after multiple attempts OWCP was not able to obtain a supplemental report from Dr. Gelman. On October 16, 2023, OWCP referred appellant for a second opinion examination. In a memorandum dated October 16, 2023, it noted that she should not be scheduled for a second opinion evaluation rather it should be an IME.

she noted that her fingers were already tingling at rest. Appellant had difficulty standing due to her stroke, and Dr. Askin noted diminished sensation in the entire forefoot from the metatarsal heads to the tips of both feet. He further noted that appellant experienced complications of the treatment for her right breast cancer including radiation-induced brachial neuritis and lymphedema. Dr. Askin advised that appellant's condition was not fixed and stable with worsening of her physical status associated with the 2023 stroke and peripheral neuropathies consequential to the chemotherapy for her cancer. He indicated that she has not achieved MMI.

By *de novo* decision dated February 15, 2024, OWCP denied appellant's claim for an increased schedule award.

On February 22, 2024 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on May 9, 2024.

An EMG/NCV study dated May 1, 2024 revealed bilateral carpal tunnel syndrome, moderate, right greater than left, and peripheral neuropathy, possibly due to chemotherapy.

By decision dated July 23, 2024, an OWCP hearing representative affirmed the February 15, 2024 decision.

### **LEGAL PRECEDENT**

The schedule award provisions of FECA<sup>10</sup> and its implementing regulations<sup>11</sup> 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. 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 and the Board has concurred in such adoption.<sup>12</sup> As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.<sup>13</sup>

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.<sup>14</sup> In Table 15-23, grade modifiers 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

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<sup>10</sup> 5 U.S.C. § 8107.

<sup>11</sup> 20 C.F.R. § 10.404.

<sup>12</sup> *Id.* at § 10.404(a); *see also T.T.*, Docket No. 18-1622 (issued May 14, 2019); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

<sup>13</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

<sup>14</sup> A.M.A., *Guides* (6<sup>th</sup> ed. 2009) at 449.

rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities.<sup>15</sup>

In addressing upper extremity impairments, the sixth edition requires identification of the class of diagnosis (CDX), which is then adjusted by a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and/or a grade modifier for clinical studies (GMCS).<sup>16</sup> The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).<sup>17</sup>

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

“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.)<sup>18</sup>

The Bulletin further advises:

“If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allows for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE [claims examiner]. If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.”<sup>19</sup>

OWCP’s procedures provide that, after obtaining all necessary medical evidence, the file should be routed to its 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.<sup>20</sup>

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<sup>15</sup> *Id.* at 448-49.

<sup>16</sup> *Id.* at 383-492.

<sup>17</sup> *Id.* at 411.

<sup>18</sup> FECA Bulletin No. 17-06 (issued May 8, 2017).

<sup>19</sup> *Id.*

<sup>20</sup> *Supra* note 13 at Chapter 2.808.5a (March 2017).

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.<sup>21</sup> OWCP's 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 that the date on which this 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*.<sup>22</sup> Its procedures further provide that, if a claimant has not submitted a permanent impairment evaluation, it should request a detailed report that includes a discussion of how the impairment rating was calculated.<sup>23</sup> If the claimant does not provide an impairment evaluation and there is no indication of permanent impairment in the medical evidence of file, the claims examiner may proceed with a formal denial of the award.<sup>24</sup>

Section 8123(a) of FECA provides, in pertinent part: "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 a referee physician or an IME) who shall make an examination."<sup>25</sup> 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.<sup>26</sup> When there exist opposing medical 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.<sup>27</sup>

### ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than one percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

Initially, the Board notes that it is unnecessary to consider the evidence appellant submitted prior to the issuance of OWCP's April 29, 2016 decision, which was considered by the Board in

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<sup>21</sup> *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

<sup>22</sup> *Supra* note 20.

<sup>23</sup> *Id.* at Chapter 2.808.6a (March 2017).

<sup>24</sup> *Id.* at Chapter 2.808.6c.

<sup>25</sup> 5 U.S.C. § 8123(a).

<sup>26</sup> 20 C.F.R. § 10.321; *P.B.*, Docket No. 20-0984 (issued November 25, 2020); *R.C.*, 58 ECAB 238 (2006).

<sup>27</sup> *See W.N.*, Docket No. 21-0123 (issued December 29, 2021); *A.G.*, Docket No. 21-0315 (issued December 29, 2021); *R.R.*, Docket No. 19-0086 (issued February 10, 2021); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001) *James P. Roberts*, 31 ECAB 1010 (1980).

its May 23, 2017 decision. Findings made in prior Board decisions are *res judicata* absent further merit review by OWCP under section 8128 of FECA.<sup>28</sup>

OWCP found a conflict in the medical opinion evidence between Dr. Weiss, an attending physician, who found 49 percent impairment of the right upper extremity, and Dr. Drake, the second opinion physician, who found that appellant had zero percent permanent impairment to the right upper extremity. In order to resolve the conflict, OWCP properly referred appellant to Dr. Askin, pursuant to 5 U.S.C. § 8123(a), for an impartial medical examination.

In a January 25, 2024 report, Dr. Askin reviewed the medical record and SOAF and performed a physical examination. He provided a detailed discussion of the examination findings noting appellant had essentially no flexion or extension of her neck and declined to move her shoulders due to pain. Dr. Askin noted that a Phalen's test was not performed because she reported that her fingers were already tingling at rest. He further noted that she had difficulty standing due to her stroke, and experienced diminished sensation in the entire forefoot from the metatarsal heads to the tips of both feet. Dr. Askin related that appellant experienced complications of the treatment for her right breast cancer including radiation induced brachial neuritis and lymphedema. He advised that appellant's condition was not fixed and stable with worsening of her physical status associated with the 2023 stroke and peripheral neuropathies consequential to the chemotherapy for her cancer. Dr. Askin indicated that appellant has not reached MMI.

OWCP procedures provide that, to support a schedule award, the file must contain medical evidence which shows that the impairment has reached a permanent and fixed state, indicates the date on which this occurred, describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of permanent impairment in accordance with the A.M.A., *Guides*.<sup>29</sup> As noted above, Dr. Askin, provided examination findings and found that appellant had not achieved MMI. He concluded that, based on the lack of MMI, appellant has not shown increased permanent impairment. The Board thus finds that the special weight of the medical opinion evidence is represented by the thorough, well-rationalized opinion of Dr. Askin.<sup>30</sup> Consequently, appellant has not met her burden of proof.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

### **CONCLUSION**

The Board finds that appellant has not met her burden of proof to establish greater than one percent permanent impairment of the right upper extremity, for which she previously received a schedule award.

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<sup>28</sup> *C.M.*, Docket No. 19-1211 (issued August 5, 2020); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

<sup>29</sup> *Supra* note 20.

<sup>30</sup> *See L.M.*, Docket No. 24-0620 (issued September 9, 2024); *K.M.*, Docket No. 23-1103 (issued February 6, 2024).

**ORDER**

**IT IS HEREBY ORDERED THAT** July 23, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 24, 2025  
Washington, DC

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

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

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