United States Department of Labor
Employees' Compensation Appeals Board

J.A., Appellant	)	
and	)	**Docket No. 24-0416**
	)	**Issued: July 24, 2025**
DEPARTMENT OF JUSTICE, U.S. MARSHALS SERVICE, Montgomery, AL, Employer	)	

Appearances:
Alan J. Shapiro, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On March 11, 2024, appellant, through counsel, filed a timely appeal from a January 26, 2024 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 to consider the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 7 percent permanent impairment of his right upper extremity and/or 19 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 his left upper extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On May 4, 2000, appellant, then a 40-year-old criminal investigator/deputy, filed a traumatic injury claim (Form CA-1) alleging that on April 7, 2000 he injured his left shoulder, neck, and right forearm and bicep, and experienced weakness in his right hand and shooting pain in his right arm as he performed curls on a bench with heavy weights while in the performance of duty.[3] OWCP accepted the claim for enthesopathy; right and left neck sprain; and brachial neuritis or radiculitis.

On June 9, 2015, appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated June 22, 2015, OWCP requested that appellant submit a report from his treating physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and provide the date appellant reached maximum medical improvement (MMI). It afforded him 30 days to submit the necessary evidence.

In a July 8, 2015 report, Dr. Lawrence T. Williams, an osteopath specializing in internal medicine, diagnosed right and left neck sprain and brachial neuritis or radiculitis. He also diagnosed cervical degenerative disc disease. Dr. Williams determined that appellant had reached MMI and opined that he had 30 percent permanent impairment.

On September 10, 2015, OWCP referred appellant's claim to Dr. Michael M. Katz, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA), to review the medical evidence of record, including Dr. Williams' July 8, 2015 report, and requested that he provide an opinion regarding appellant's bilateral upper extremities permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.

In a September 11, 2015 report, Dr. Katz advised that appellant reached MMI on October 2, 2000. He referenced *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) and determined that appellant had zero percent permanent impairment for the C5 nerve root. Dr. Katz contended

[3] Appellant has prior claims with OWCP. Under OWCP File No. xxxxxx275, OWCP accepted appellant's December 22, 2003 traumatic injury for sprain of fifth finger, right. Under OWCP File No. xxxxxx566, by decision dated June 28, 2004, OWCP denied appellant's occupational disease claim (Form CA-2) alleging that on April 7, 2000 he sustained an injury while in the performance of duty. Under OWCP File No. xxxxxx825, OWCP accepted appellant's July 31, 2007 traumatic injury for olecranon bursitis, left. By decision dated July 6, 2018, OWCP granted appellant a schedule award for two percent permanent impairment of the left arm. By decision dated April 2, 2020, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the left arm, for a total of 12 percent left arm permanent impairment.

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

that Dr. Williams' 30 percent permanent impairment rating was entirely arbitrary, explaining that the most recent medical records were from the year 2000.

By decision dated October 28, 2015, OWCP denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish permanent impairment of a scheduled member or function of the body due to the accepted April 7, 2000 employment injury. It accorded the weight of the medical evidence to Dr. Katz, the DMA.

On November 3, 2015, appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on March 8, 2016.

Appellant subsequently submitted additional medical evidence, including an undated report, wherein Dr. Williams reiterated his 30 percent permanent impairment rating and finding that appellant had reached MMI. He explained that the rating was based on appellant's complaints of recurring pain and sensory complaints and weakness in his hands and upper extremities.

By decision dated April 22, 2016, OWCP's hearing representative affirmed the October 28, 2015 decision, finding that Dr. Williams failed to properly utilize the A.M.A., *Guides* in assessing appellant's permanent impairment.

On June 6 and August 27, 2019, appellant filed additional Form CA-7 schedule award claims.

Subsequently, appellant, through counsel, submitted a February 14, 2020 report by Dr. Ralph D'Auria, a Board-certified physiatrist. Dr. D'Auria noted the accepted conditions of enthesopathy, right and left, neck sprain, and brachial neuritis. He also diagnosed tendinitis of the left shoulder and right elbow, cervical sprain/strain, and cervical radiculopathy. Dr. D'Auria utilized *The Guides Newsletter* and determined that appellant had 11 percent permanent impairment of the right upper extremity and 32 percent permanent impairment of the left upper extremity due to cervical spine nerve deficits. Regarding permanent impairment of the right upper extremity, he found 2 percent permanent impairment for right C5 moderate sensory deficit, 6 percent permanent impairment for right C8 mild motor deficit, and 3 percent permanent impairment for right T1 mild motor deficit for a total of 11 percent permanent impairment of the right upper extremity. Regarding permanent impairment to the left upper extremity, Dr. D'Auria found 4 percent permanent impairment for left C5 mild motor deficit, 5 percent permanent impairment for left C6 mild motor deficit, 3 percent permanent impairment for left C6 moderate sensory deficit, 5 percent permanent impairment for left C7 mild motor deficit, 2 percent permanent impairment for left C7 moderate sensory deficit, 6 percent permanent impairment for left C8 mild motor deficit, 2 percent permanent impairment for left C8 moderate sensory deficit, 3 percent permanent impairment for left T1 mild motor deficit, and 2 percent permanent impairment for left T1 moderate sensory deficit for a total of 32 percent permanent impairment of the left upper extremity. He noted that the sixth edition of the A.M.A., *Guides* did not allow the use of the range of motion (ROM) method to rate permanent impairment to the cervical spine. Dr. D'Auria opined that appellant reached MMI on the date of his impairment evaluation.

On May 12, 2020, OWCP referred appellant's claim to its DMA, Dr. Katz, to review the medical evidence of record, including Dr. D'Auria's February 14, 2020 report, for a determination

regarding appellant's bilateral upper extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and date of MMI. It noted that, under OWCP File No. xxxxxx825, appellant had previously received schedule award compensation for 10 percent permanent impairment of the left arm on April 2, 2020, and 2 percent permanent impairment of the same arm on July 6, 2018, totaling 12 percent left arm permanent impairment.

In a May 15, 2020 report, Dr. Katz noted that the medical evidence of record lacked detailed physical examination findings to support or refute Dr. D'Auria's February 14, 2020 findings, particularly with respect to his finding of marked motor and sensory deficits diffusely in the right upper extremity involving each ratable spinal nerve. The DMA reviewed a September 14, 2015 report, bearing an illegible signature, who utilized *The Guides Newsletter* and determined that appellant had zero percent permanent impairment with no motor or sensory impairment at C5. In light of this opinion, along with Dr. D'Auria's findings of multiple impaired spinal nerves in the right upper extremity, which is uncommon under the accepted diagnosis, he recommended a second opinion impairment evaluation.

On May 11, 2021, OWCP referred appellant's claim, along with a SOAF, the case record, and a series of questions, to Dr. Tai Q. Chung, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine permanent impairment of his bilateral upper extremities in accordance with the sixth edition of the A.M.A., *Guides*.

In a June 3, 2021 report, Dr. Chung related appellant's physical examination findings and noted the accepted conditions of right and left brachial neuritis or radiculitis, and neck sprain. He explained that appellant's neck sprain had resolved, but appellant had residuals of his right and left brachial neuritis or radiculitis. Dr. Chung explained that appellant continued to have pain radiating down both arms, and numbness and weakness in the arms on physical examination. He related that sensation was decreased bilaterally to pinwheel at the deltoids, along the radial and ulnar borders of the forearms, in the hands, especially at the middle fingers. Dr. Chung also related appellant's grip strength testing. He found that appellant reached MMI on the date of his impairment evaluation. Dr. Chung referenced *The Guides Newsletter* and rated appellant's bilateral upper extremity permanent impairment. He reported that appellant's physical examination showed numbness in the C5 and C6 distributions in the arms, and bilateral weakness of grip in the hands, which implicated C5, C6, and C7 nerve roots bilaterally. Dr. Chung found that the class of diagnosis (CDX) for mild sensory deficit at C5 resulted in a Class 1 impairment with a grade C or default value of one percent permanent impairment; the CDX for mild motor deficit at C6 resulted in a Class 1 impairment with a grade C or default value of five percent permanent impairment; and the CDX for mild motor deficit at C7 with a grade C or default value of five percent permanent impairment. He related that this applied to the right and left sides. Dr. Chung related that pursuant to *The Guides Newsletter*, page 3, adjustments are made only for a grade modifier for functional history (GMFH) (Table 15-7) and a grade modifier clinical studies (GMCS) (Table 15-9). He then noted that the GMFH was 1 for a mild problem, and the GMCS was also 1. Dr. Chung applied the net adjustment formula (1-1) + (1-1) = 0 to find no net adjustment from the default values. He, therefore, concluded that appellant had 11 percent permanent impairment of each upper extremity.

On August 4, 2021, OWCP routed the medical record, including Dr. Chung's June 3, 2021 report, to Dr. David J. Slutsky, a Board-certified orthopedic surgeon, serving as a DMA, for review

and an opinion regarding appellant's bilateral upper extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and the date of MMI. It also requested that he consider appellant's prior schedule awards totaling 12 percent permanent impairment of the left upper extremity in reaching his impairment rating.

In an August 17, 2021 report, Dr. Slutsky reviewed the medical record. He also noted appellant's prior schedule awards for the left upper extremity under OWCP File No xxxxxx825, totaling 12 percent permanent impairment. Utilizing the A.M.A., *Guides* and *The Guides Newsletter*, he found seven percent permanent impairment of the right upper extremity and seven percent permanent impairment of the left upper extremity. The DMA found five percent permanent impairment for a CDX of right C5 radiculopathy, one percent permanent impairment for a CDX of right C6 radiculopathy, and one percent permanent impairment for a CDX of right C7 radiculopathy, for a total seven percent permanent impairment of the right upper extremity. Likewise, regarding permanent impairment of the left upper extremity, the DMA found a total of seven percent permanent impairment of the left upper extremity. He advised that the current seven percent left arm permanent impairment rating should be considered in addition to the previously received left arm schedule award compensation. The DMA determined that appellant reached MMI on August 3, 2021, the date of Dr. Chung's impairment evaluation. He noted that Dr. Chung solely relied on an electromyogram (EMG) study performed on June 21, 2000 to assess the GMCS, but this test result was not available in the submitted medical records. The DMA also noted that the GMFH was not applicable as there was no *Quick*DASH score. Thus, the DMA maintained that a net adjustment calculation for each of the impairments could not be performed due to a lack of information.

By decision dated September 22, 2021, OWCP granted appellant a schedule award for seven percent permanent impairment of the right upper extremity. It also granted him an additional schedule award for 7 percent permanent impairment of the left upper extremity, for a total of 19 percent left upper extremity permanent impairment. The award ran for 43.68 weeks for the period August 3, 2021 through June 4, 2022, and was based on the opinion of the DMA, Dr. Slutsky.

On September 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 November 10, 2021, a second OWCP hearing representative set aside the September 22, 2021 decision, finding that the case was not in posture for a hearing. The hearing representative instructed OWCP to administratively combine OWCP File Nos. xxxxxx619, xxxxxx275, xxxxxx566, and xxxxxx825. OWCP was then to update the SOAF and refer the combined case record, including the June 21, 2020 EMG study to its DMA for a supplemental report regarding the extent of appellant's permanent impairment.

OWCP subsequently administratively combined the OWCP files, revised the SOAF, and referred the case record back to Dr. Slutsky for a supplemental opinion.

In a December 19, 2021 supplemental report, Dr. Slutsky reviewed the updated SOAF and the medical record, including the June 21, 2000 EMG study. In performing his ratings, he cited Table 15-8, page 408 of the A.M.A., *Guides* and related that the grade modifier for physical examination (GMPE) was not relevant as neurologic findings were used to define impairment

ranges. Citing Table 15-7, page 406 of the A.M.A., *Guides*, he explained that the GMFH was not applicable as there was no *Quick*DASH score, and the rating report did not document appellant having to perform functional modifications in order to achieve self-care activities. Regarding the right C5 nerve root, he utilized the diagnosis-based impairment (DBI) rating method and applied *The Guides Newsletter*, to find that the CDX for mild sensory deficit due to right C5 radiculopathy was a Class 1, grade C impairment with a default value of one percent impairment. Dr. Slutsky also found that the CDX for 4/5 motor deficit due to right C5 radiculopathy resulted in a Class 1, grade C impairment with a default value of four percent impairment. He assigned a GMCS of 0, as a June 21, 2000 EMG study showed no fibrillation potentials. Dr. Slutsky utilized the net adjustment formula (GMCS - CDX) = (0 - 1) = -1 and moved each one space to the left of the default value of C to the default value of B, therefore finding that appellant had a zero percent impairment rating for mild sensory deficit, and a two percent permanent impairment rating for mild motor deficit. He added the zero percent impairment rating for mild sensory deficit and two percent impairment rating for mild motor deficit, which resulted in two percent right upper extremity permanent impairment. Regarding the right C6 radiculopathy, Dr. Slutsky found that the CDX for sensory deficit due to right C6 radiculopathy was a Class 1, grade C impairment with a default value of one percent. Dr. Slutsky assigned a GMCS of zero based on the June 21, 2000 EMG study, with no fibrillation potentials. He applied the net adjustment to the sensory deficit of one percent, and found that appellant had a grade B, or zero percent impairment. He also found that the CDX for right C6 motor deficit due to right C6 radiculopathy was zero percent permanent impairment as there was no documented weakness of the muscles supplied by C6 and weakness of a clenched fist was not ratable. Dr. Slutsky combined the zero percent sensory impairment rating and zero percent motor impairment rating, which resulted in zero percent right upper extremity permanent impairment due to C6 radiculopathy. Regarding the right C7 radiculopathy, he found that the CDX for sensory deficit due to right C7 radiculopathy resulted in a Class 1, grade C impairment with a default value of one percent impairment. Dr. Slutsky also determined that the CDX for right C7 motor deficit due to right C7 radiculopathy was zero percent as there was no documented weakness of the muscles supplied by C7. He assigned a GMCS of 0 based on the June 21, 2000 EMG study, with no fibrillation potentials. Dr. Slutsky utilized the net adjustment formula and moved the sensory deficit rating one space to the left of the default value of C to the default value of B, zero percent. He combined the zero percent sensory impairment rating and zero percent motor impairment rating, resulting in zero percent right upper extremity permanent impairment due to C7 radiculopathy. Dr. Slutsky thus concluded that appellant had a total of two percent permanent impairment of the right upper extremity.

Regarding permanent impairment to the left upper extremity, Dr. Slutsky found that the CDX for sensory deficit due to left C5 radiculopathy was a Class 1, grade C impairment with a default value of one percent impairment. He further found that the CDX for 4/5 motor deficient due to left C5 radiculopathy was a Class 1, grade C impairment with a default value of four percent impairment. Dr. Slutsky again explained that the GMFH was not applicable as there was no *Quick*DASH score, and the rating report did not document appellant having to perform functional modifications in order to achieve self-care activities. He assigned a GMCS of 2 based on the June 21, 2000 EMG study, with 2+ fibrillation potentials. Dr. Slutsky applied the net adjustment formula and moved each one space to the right of the default value of C to the default value of D. He added the one percent sensory impairment rating and six percent motor impairment rating, resulting in seven percent permanent impairment of the left upper extremity due to C5 radiculopathy. Dr. Slutsky found that the CDX for sensory deficit due to left C6 radiculopathy

was a Class 1, grade C impairment with a default value of one percent impairment. He also found that the CDX for motor deficit due to left C6 radiculopathy was zero percent as there was no documented weakness of the muscles supplied by C6 and weakness of a clenched fist was not ratable. Dr. Slutsky assigned a GMCS of 0 based on the June 21, 2000 EMG study, with no fibrillation potentials. He applied the net adjustment formula and moved the sensory deficit one space to the left of the default value of C to the default value of B. Dr. Slutsky combined a zero percent sensory impairment and zero percent motor impairment, resulting in zero percent permanent impairment of the left upper extremity due to C6 radiculopathy. He found that the CDX for sensory deficit due to left C7 radiculopathy was a Class 1, grade C impairment with a default value of one percent impairment. Dr. Slutsky also found that the CDX for motor deficit due to left C7 radiculopathy was zero percent as there was no documented weakness of the muscles supplied by C7. He continued to assign a GMCS of 0 based on the June 21, 2000 EMG study, with no fibrillation potentials. Dr. Slutsky applied the net adjustment formula and moved the sensory deficit one space to the left of the default value of C to the default value of B. He combined the zero percent sensory impairment rating and the zero percent motor impairment rating, resulting in zero percent permanent impairment of the left upper extremity due to C7 radiculopathy. Dr. Slutsky, therefore, concluded that appellant had a left upper extremity permanent impairment rating of seven percent. The DMA reiterated that appellant reached MMI on August 3, 2021.

On December 28, 2021, OWCP requested that Dr. Chung review the updated SOAF and additional medical evidence of record, including Dr. Slutsky's December 19, 2021 report, and provide a supplemental report to include impairment ratings for appellant's bilateral upper extremity permanent impairment.

In a January 13, 2022 report, Dr. Chung explained that the discrepancy between his and Dr. Slutsky's impairment ratings was, in large part, due to his finding of weakness of appellant's grip in both hands. He related that he assigned a mild deficit at C6 and C7 due to weakness of grip in both hands. Dr. Chung further related that grip strength involves, among other muscles and tendons, those of the extensor carpi longus and brevis and those of the flexor digitorum sublimis, which implies involvement of C6 and C7 for the wrist extensors, and C7, C8, and T1 for the finger flexors. He explained that he assigned the deficit to C6 and C7 as appellant had good finger strength. Dr. Chung also related that as appellant was right hand dominant it did not seem appropriate to ignore the weakness in his right hand. He also added that assignment of a functional history adjustment made no difference to the final adjustment, as the final adjustment due to GMFH was zero.

OWCP, on January 28, 2022, requested that its DMA, Dr. Slutsky, review Dr. Chung's January 13, 2022 report and provide a supplemental opinion.

In a February 13, 2022 supplemental report, Dr. Slutsky reviewed Dr. Chung's January 13, 2022 report and explained that weakness of grip in both hands could not be rated under the A.M.A., *Guides* because there are many non-neurological factors that can affect grip strength, and there was no provision for rating grip strength as an isolated finding, pursuant to Table 15-8. The DMA further explained that according to the A.M.A., *Guides*, page 433, reliable objective examination findings were muscle atrophy and neurological weakness, not weakness due to pain produced by grip strength testing. He added that *The Guides Newsletter* guidelines do not allow for an impairment rating based on personal opinion, "[r]ather than assuming that loss of grip strength

correlates with weakness of the flexor digitorium sublimis and extensor digitorium communist muscles, Dr. Chung can simply test each of these muscles individually and grade them according to Table 15-14. He reiterated his prior calculations and opinion from his December 19, 2021 report that appellant had two percent permanent impairment of the right upper extremity and seven percent permanent of the left upper extremity.

By decision dated December 1, 2022, OWCP denied appellant's claim for an increased schedule award, finding that the medical evidence of record was insufficient to establish greater than the permanent impairment of each arm previously awarded.

On December 2, 2022, 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, 2023.

By decision dated July 20, 2023, OWCP's hearing representative set aside the December 1, 2022 decision. The hearing representative noted that Dr. Slutsky failed to explain the changes in the right and left upper extremity impairment ratings set forth in his August 17 and December 19, 2021 and February 13, 2022 reports. The hearing representative remanded the case for OWCP to obtain a supplemental opinion from the DMA regarding whether appellant had greater than 7 percent permanent impairment of the right upper extremity and 19 percent permanent impairment of the left upper extremity based on the A.M.A., *Guides*, and any other further development as deemed necessary, to be followed by a *de novo* decision.

In a report dated October 16, 2023, Dr. Slutsky explained that at the time of his August 27, 2021 report, the June 21, 2000 EMG was not available for his review and, thus, a net adjustment calculation could not be performed. He explained that at the time of his December 19, 2021 report, he reviewed the June 21, 2000 EMG and performed a net adjustment calculation which changed his impairment ratings. The DMA restated his prior calculations based on cervical spine deficits and his prior opinion that appellant had two percent permanent impairment of the right upper extremity, and seven percent permanent impairment of the left upper extremity, resulting in 19 percent left upper extremity permanent impairment. Regarding his February 13, 2022 report, the DMA explained that there were no material changes in the data, therefore, his impairment ratings remained the same at two percent permanent impairment of the right upper extremity and seven percent permanent impairment of the left upper extremity as set forth in his December 19, 2021 report.

By *de novo* decision dated January 26, 2024, OWCP denied appellant's claim for an increased schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

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.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] 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.[9]

Neither FECA nor its implementing regulations provide for a schedule award for impairment to the back or to the body as a whole.[10] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[11] The sixth edition of the A.M.A., *Guide*s (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[12]

In addressing extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* require identifying the CDX, which is then adjusted by a GMFH and/or GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in

---

[7] *Id. See also Ronald R. Kraynak,* 53 ECAB 130 (2001).

[8] *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).

[9] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera,* 12 ECAB 348 (1961).

[10] *K.Y.*, Docket No. 18-0730 (issued August 21, 2019); *L.L.*, Docket No. 19-0214 (issued May 23, 2019); *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[11] *Supra* note 8 at Chapter 2.808.5c(3) (March 2017).

[12] *Supra* note 8 at Chapter 3.700, Exhibit 4 (January 2010); *see L.H.,* Docket No. 20-1550 (issued April 13, 2021); *N.G.,* Docket No. 20-0557 (issued January 5, 2021).

[13] A.M.A., *Guides* 494-531; *see R.V.,* Docket No. 20-0005 (issued December 8, 2020); *J.B.,* Docket No. 09-2191 (issued May 14, 2010).

[14] *G.W.*, Docket No. 24-0844 (issued November 21, 2024); A.M.A., *Guides* 430, *The Guides Newsletter.* The A.M.A., *Guides* and *The Guides Newsletter* provide that in applying the peripheral nerve rating process the physical examination adjustment should be excluded since the neurologic examination findings define the impairment values.

accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[15]

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 impartial medical examiner (IME)), who shall make an examination.[16] For a conflict to arise, the opposing physicians' opinions must be of virtually equal weight and rationale.[17] In situations where the case is properly referred to an IME for the purpose of resolving the conflict, the opinion of such IME, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18]

ANALYSIS

The Board finds that this case is not in posture for decision.

Appellant, through counsel, submitted a February 14, 2020 report by Dr. D'Auria, who noted the accepted conditions of enthesopathy, right and left, neck sprain, and brachial neuritis. He also diagnosed tendinitis of the left shoulder and right elbow, cervical sprain/strain, and cervical radiculopathy. Dr. D'Auria utilized *The Guides Newsletter* and determined that appellant had 11 percent permanent impairment of the right upper extremity and 32 percent permanent impairment of the left upper extremity due to cervical spine nerve deficits. Regarding permanent impairment of the right upper extremity, he found 2 percent permanent impairment for right C5 moderate sensory deficit, 6 percent permanent impairment for right C8 mild motor deficit, and 3 percent permanent impairment for right T1 mild motor deficit for a total of 11 percent permanent impairment of the right upper extremity. Regarding permanent impairment to the left upper extremity, Dr. D'Auria found 4 percent permanent impairment for left C5 mild motor deficit, 5 percent permanent impairment for left C6 mild motor deficit, 3 percent permanent impairment for left C6 moderate sensory deficit, 5 percent permanent impairment for left C7 mild motor deficit, 2 percent permanent impairment for left C7 moderate sensory deficit, 6 percent permanent impairment for left C8 mild motor deficit, 2 percent permanent impairment for left C8 moderate sensory deficit, 3 percent permanent impairment for left T1 mild motor deficit, and 2 percent permanent impairment for left T1 moderate sensory deficit for a total of 32 percent permanent impairment of the left upper extremity. He noted that the sixth edition of the A.M.A., *Guides* did not allow the use of the ROM method to rate permanent impairment to the cervical spine. Dr. D'Auria opined that appellant reached MMI on the date of his impairment evaluation.

---

[15] *See supra* note 8 at Chapter 2.808.6f (February 2013). *See also D.S.,* Docket No. 20-0670 (issued November 2, 2021); *P.W.*, Docket No. 19-1493 (issued August 12, 2020); *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).

[16] 5 U.S.C. § 8123(a); *see E.L.,* Docket No. 20-0944 (issued August 30, 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).

[17] *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *see also Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts,* 30 ECAB 1010 (1980).

[18] *See D.M.,* Docket No. 18-0746 (issued November 26, 2018); *R.H.,* 59 ECAB 382 (2008); *James P. Roberts*, *id*.

In a report dated October 16, 2023, Dr. Slutsky explained that at the time of his August 27, 2021 report, the June 21, 2000 EMG was not available for his review and, thus, a net adjustment calculation could not be performed. He reviewed the June 21, 2000 EMG and performed a net adjustment calculation which changed his impairment ratings. The DMA restated his prior calculations based on cervical spine deficits and his prior opinion that appellant had two percent permanent impairment of the right upper extremity, and seven percent permanent impairment of the left upper extremity, resulting in 19 percent left upper extremity permanent impairment. The DMA explained that there were no material changes in the data, therefore, his impairment ratings remained the same at two percent permanent impairment of the right upper extremity and seven percent permanent impairment of the left upper extremity as set forth in his December 19, 2021 report.

Thus, the Board finds that a conflict exists in the medical opinion evidence between Dr. D'Auria and the DMA, Dr. Slutsky, with regard to the extent of any additional/increased permanent impairment due to the accepted employment injury. This conflict in medical opinion necessitates referral to an IME for resolution of the conflict in accordance with 5 U.S.C. § 8123(a).[19]

On remand, OWCP shall refer appellant, together with an updated SOAF, the medical record, and a series of questions to a specialist in the appropriate field of medicine for a reasoned opinion resolving the conflict.[20] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[19] *Supra* note 16. *See also S.L.,* Docket No. 24-0522 (issued June 17, 2024); *S.G.,* Docket No. 24-0529 (issued June 12, 2024).

[20] *See S.W.,* Docket No. 22-0917 (issued October 26, 2022); *K.D.,* Docket No. 19-0281 (issued June 30, 2020).

ORDER

IT IS HEREBY ORDERED THAT the January 26, 2024 decision of the Office of Workers' Compensation Programs is set aside and this case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 24, 2025
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board