United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 20-0907**
	)	**Issued: February 12, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Wilmington, DE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 20, 2020 appellant, through counsel, filed a timely appeal from an October 23, 2019 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.[3]

[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.*

[3] The Board notes that following the October 23, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

ISSUE

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

FACTUAL HISTORY

This case has previously been before the Board.[4] 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 October 4, 2007 appellant, then a 46-year-old automation clerk, filed an occupational disease claim (Form CA-2) alleging that she developed a neck and right shoulder condition due to factors of her federal employment including repetitively picking up, pulling, lifting, and carrying trays of mail at work. She stopped work on October 27, 2007. OWCP subsequently accepted her claim for temporary aggravation of C5-6 disc herniation and right shoulder sprain.[5] It paid wage-loss compensation benefits on the supplemental rolls beginning October 27, 2007. On August 19, 2011 appellant accepted a full-time, modified-duty job offer as a mail processor.

On September 16, 2014 appellant filed a claim for a schedule award (Form CA-7).

Appellant submitted a June 30, 2014 report by Dr. Arthur Becan, an orthopedic surgeon, who reviewed appellant's medical records and recounted her complaints of cervical pain and stiff with radicular pain down her right upper extremity and tingling in her fingers. Upon physical examination of appellant's cervical spine, Dr. Becan noted that sensory examination revealed a perceived sensory deficit over the C4, C5, and C6 nerve root distributions involving the right upper extremity when compared to the left upper extremity. Semmes-Weinstein monofilament testing revealed decreased sensibility at 4.3 mgs on the right and 3.3 mgs on the left. Dr. Becan diagnosed chronic cervical sprain, herniated cervical discs at C4-5 and C5-6, bulging cervical discs at C3-4 and C6-7, right C4, C5, and C6 radiculopathy, chronic post-traumatic subacromial impingement syndrome to the right shoulder, and chronic post-traumatic rotator cuff tendinopathy of the right shoulder.

Dr. Becan referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] and utilized the diagnosis-based impairment (DBI) rating method to find that under Table 1 of *The Guides Newsletter,* Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*), the class of diagnosis (CDX) for right severe sensory deficit at C5 resulted in a class 1 impairment with a default value of four. He assigned a grade modifier for functional history (GMFH) of 2 and a grade modifier for clinical studies (GMCS) of 2. Dr. Becan utilized the net adjustment formula (GMFH – CDX) + (GMCS – CDX) = (2 – 1) + (2 – 1) = +2, which resulted in a grade E or four

[4] Docket No. 16-0847 (issued March 24, 2017).

[5] OWCP administratively combined this case with a previous claim under File No. xxxxxx640. Under File No. xxxxxx640, OWCP accepted appellant's traumatic injury claim (Form CA-1) for cervical radiculitis and right trapezius strain as causally related to a February 3, 2007 employment incident.

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

percent permanent impairment of the right upper extremity. He also indicated that under Table 1 of *The Guides Newsletter*, appellant had severe sensory deficit at C6, which fell under a CDX of class 1 impairment with a default value of six. Dr. Becan assigned a GMFH of 2 and a GMCS of 2. He applied the net adjustment formula, resulting in a net adjustment of +2, which equaled six percent permanent impairment of the right upper extremity. Dr. Becan added the percentages for a total of 10 percent right upper extremity permanent impairment due to severe sensory deficit at the right C5 and C6 nerve roots. For appellant's right shoulder condition, he referred to Table 15-5 (Shoulder Regional Grid), page 401, and indicated that under the DBI method for rating impairment, the CDX for right shoulder impingement syndrome with residual loss resulted in a class 1 impairment with a default value of three. Dr. Becan assigned a GMFH of 1 and a grade modifier for physical examination (GMPE) of 1. He applied the net adjustment formula, resulting in two percent right upper extremity impairment for right shoulder impingement syndrome. Dr. Becan concluded that appellant had a total combined right upper extremity impairment rating of 12 percent. He noted a date of maximum medical improvement (MMI) of June 30, 2004.[7]

OWCP referred appellant, along with a statement of accepted facts (SOAF) and the record, to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion examination. In an April 27, 2015 report, Dr. Smith utilized the A.M.A., *Guides* and *The Guides Newsletter* to determine that appellant had a total of eight percent permanent impairment of her right upper extremity.[8]

In a June 8, 2015 report, Dr. Morley Slutsky, a Board-certified preventive and occupational medicine physician serving as DMA, disagreed with Dr. Smith's impairment rating for appellant's right shoulder. He explained that according to the A.M.A., *Guides*, the DBI method was the preferred rating method over ROM. Dr. Slutsky utilized the DBI method and determined that under Table 15-5, page 401, appellant had one percent permanent impairment of the right upper extremity for the (CDX) of right shoulder sprain. He also indicated that pursuant to Table 1 of *The Guides Newsletter* appellant had two percent right upper extremity permanent impairment due to loss of sensory and motor function in the right C5-6 distribution, for a total of three percent permanent impairment of the right upper extremity.[9]

By decision dated June 25, 2015, OWCP granted appellant a schedule award for three percent permanent impairment of the right upper extremity. The period of the award ran for 9.36 weeks for the period April 27 to July 1, 2015, and was based on the opinion of the DMA.

[7] OWCP routed Dr. Becan's June 30, 2014 and the case file to an OWCP district medical adviser (DMA), who recommended a second opinion examination. The DMA also noted that the physical examination findings of Dr. Becan were different from other physicians of record who reported normal upper extremity sensation and motor strength.

[8] Dr. Smith determined that, pursuant to Table 1 of *The Guides Newsletter*, appellant had two percent permanent impairment due to loss of sensory and motor function in the right C5-6 distribution. He referenced Table 15-34 (Shoulder Range of Motion), page 475, and indicated that under the range of motion (ROM) method, appellant had six percent right upper extremity permanent impairment due to her right shoulder condition.

[9] On May 20, 2015 appellant filed a new occupational disease claim under OWCP File No. xxxxxx680 alleging that she developed pain on the right side of her neck and shoulder as a result of her repetitive employment duties. OWCP accepted this claim for aggravation of preexisting cervical disc disease at C5-6 and right trapezius strain. It paid her wage-loss compensation on the supplemental rolls, beginning May 18, 2015.

On July 6, 2015 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on September 15, 2015.

Appellant subsequently submitted additional diagnostic reports. In a September 2, 2015 neuromusculoskeletal ultrasound procedure report, Dr. Scott Fried, an osteopath Board-certified in orthopedic surgery, noted that the brachial plexus showed the nerves were grossly intact. He also reported evidence of plexus compression between the anterior and middle scalene consistent with plexus compression and thoracic outlet syndrome. An ultrasound of the right radial nerve and forearm also showed findings consistent with nerve compression and hypochoic changes. Dr. Fried diagnosed aggravation of cervical disc at C5-6, cervical radiculitis, disc space narrowing at C4-5 and C5-6 with radiculopathy, radial and median neuropathy on the right, and brachial plexopathy and cervical radiculopathy on the right.

In a November 4, 2015 decision, an OWCP hearing representative affirmed the June 25, 2015 schedule award decision.

Appellant filed an appeal before the Board. By decision dated March 24, 2017, the Board set aside the November 4, 2015 decision.[10] The Board found that OWCP had inconsistently applied Chapter 15 of the A.M.A., *Guides* regarding the proper use of either the DBI or ROM methodology in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision after development of a consistent method for calculating permanent impairment of the upper extremities.

On June 2, 2017 OWCP requested that Dr. Kenechukwu Ugokwe, a Board-certified neurological surgeon serving as the DMA, review the enclosed SOAF and medical evidence, and determine the extent of appellant's permanent impairment under the reprinted 2009 sixth edition of the A.M.A., *Guides.* It related that, if the A.M.A., *Guides* allowed a rating method using both the DBI and ROM methods, the impairment should be independently calculated using both methods. OWCP advised that three independent ROM measurements must be obtained and the greatest ROM measurements should be used to determine the extent of impairment. If the medical evidence of record was insufficient to render a rating based on the ROM method, where allowed, the DMA was advised to note the medical evidence necessary to complete the ROM rating method and render an impairment rating using the DBI method, if possible, given the available evidence.

In a June 22, 2017 report, Dr. Ugokwe reviewed appellant's history of injury, including the SOAF, and conducted an examination. Utilizing the ROM method for appellant's right shoulder condition, he referred to Table 15-34, page 475, and determined that appellant had three percent permanent impairment due to 100 degrees of shoulder flexion, zero percent permanent impairment due to 50 degrees of shoulder extension, three percent permanent impairment due to 110 degrees of shoulder abduction, and zero percent permanent impairment due to 60 degrees of shoulder adduction for a total of six percent permanent impairment. Under the DBI method, Dr. Ugokwe referred to Table 15-18, page 429, and determined that appellant had two percent right upper extremity permanent impairment because appellant had a C5 nerve injury with only motor symptoms. He explained that as the ROM method rendered the higher impairment rating, appellant had six percent right upper extremity permanent impairment.

[10] *Supra* note 3.

By *de novo* decision dated June 23, 2017, OWCP granted appellant a schedule award for an additional three percent right upper extremity permanent impairment, for a total of six percent right upper extremity permanent impairment, based on the June 22, 2017 report of the DMA.

On July 12, 2017 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on November 15, 2017. By decision dated February 5, 2018, the hearing representative remanded the case for OWCP to administratively combine the present claim with appellant's other claims which also affected appellant's neck and right upper extremity. On remand, OWCP was instructed to update the SOAF to include all claims and accepted conditions and to request an impairment rating report from Dr. Fried, appellant's treating physician.

On March 5, 2018 OWCP administratively combined File Nos. xxxxxx640 and xxxxxx354 with File No. xxxxxx680, with the latter serving as the master file.

In a March 7, 2018 letter, OWCP requested that Dr. Fried review the updated SOAF[11] and provide a reasoned medical opinion regarding whether appellant had reached MMI with respect to her accepted neck and right upper extremity conditions. It also requested that if he found that appellant had reached MMI that he provide an impairment rating in accordance with the A.M.A., *Guides* and *The Guides Newsletter*.

OWCP received a March 24, 2018 report by Dr. Fried who indicated that a functional capacity evaluation (FCE) performed on December 21, 2017 had revealed significantly increased symptoms with repetitive activities in the upper extremities and increased symptoms with driving simulation activities.

By *de novo* decision dated May 23, 2018, OWCP denied appellant's schedule award claim. It found that the medical evidence of record was insufficient to establish that her accepted conditions had reached MMI, a requirement for payment of a schedule award.

On May 31, 2018 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on November 28, 2018.

Appellant also submitted a March 31, 2014 note by Dr. Pramod K. Yadhati, a Board-certified anesthesiologist, who reported that as of that date, appellant had reached MMI relative to her February 3, 2007 work-related injury.

By decision dated February 12, 2019, the hearing representative vacated the May 23, 2018 decision and remanded appellant's schedule award claim for referral to a second opinion examiner.

OWCP referred appellant, along with a SOAF and the medical record, to Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, for a second opinion evaluation in order to determine whether she had sustained a ratable permanent impairment due to her accepted cervical and right upper extremity conditions under the A.M.A., *Guides* and *The Guides Newsletter*. In a March 14, 2019 report, Dr. Gordon reviewed appellant's history and noted that her claims were

[11] On March 7, 2018 OWCP issued an updated SOAF, which included all of appellant's claims and her accepted conditions for temporary aggravation of herniated disc at C5-6, right shoulder sprain, cervical radiculopathy, right trapezius strain, and aggravation of preexisting cervical disc disease at C5-6.

accepted for temporary aggravation of herniated disc at C5-6, right shoulder sprain, cervical radiculopathy, and right trapezius strain. He noted appellant's current complaints of intermittent symptoms with respect to her neck and dorsal pain in her right shoulder. Upon examination of appellant's cervical spine, Dr. Gordon observed no focal tenderness and negative Spurling's test. He reported that evaluation of both shoulders revealed no focal tenderness, atrophy, or weakness. Dr. Gordon indicated that ROM testing was performed three times and demonstrated 180 degrees forward flexion, 90 degrees extension, 90 degrees internal rotation, 90 degrees external rotation, 180 degrees abduction, and full adduction bilaterally. He diagnosed aggravation of cervical spondylosis, status post cervical fusion with right mild sensory upper extremity radiculopathy and chronic right shoulder strain.

Dr. Gordon indicated that appellant had reached MMI regarding her neck and right upper extremity as of March 14, 2019. Regarding appellant's cervical spine, he referred to *The Guides Newsletter* and determined that, under Table 1, page 4, the CDX of C6, mild sensory neuropathy resulted in a class one impairment with a default value of one. Dr. Gordon assigned a GMFH of 1, a GMPE of 1, and a GMCS of 1 and calculated that appellant had one percent permanent impairment for sensory deficits. He explained that he found no motor findings, which resulted in zero percent permanent impairment. Thus, Dr. Gordon reported that appellant had one percent right upper extremity permanent impairment with respect to her cervical spine.

Regarding appellant's right shoulder, Dr. Gordon first utilized the ROM method to determine the degree of appellant's permanent impairment. Referring to Table 15-34 (Shoulder Range of Motion), page 475, of the A.M.A., *Guides,* he indicated that appellant had zero percent permanent impairment. Utilizing the DBI method to determine the degree of appellant's permanent impairment, Dr. Gordon referred to Table 15-5 (Shoulder Regional Grid), page 401, he indicated that a condition of shoulder pain equated to a CDX of 1 with a default value of one percent right upper extremity impairment. He assigned a GMFH of 1, a GMPE of 1, and a GMCS of 1, which resulted in no net adjustment for a total of one percent right upper extremity permanent impairment. Dr. Gordon explained that because the DBI method resulted in a greater permanent impairment than the ROM method, appellant had one percent right upper extremity permanent impairment due to her right shoulder condition. He concluded that combining appellant's one percent right upper extremity permanent impairment for her right shoulder and the one percent right upper extremity permanent impairment due to sensory deficits of her cervical condition resulted in a total of two percent right upper extremity permanent impairment.

OWCP forwarded the case record to Dr. Herbert White, Jr., a Board-certified occupational medicine physician serving as a DMA for review. In a March 31, 2019 report, the DMA noted that he agreed with Dr. Gordon's March 14, 2019 impairment rating of two percent right upper extremity permanent impairment. Utilizing the DBI method, he determined that under Table 15-5, page 401, of the A.M.A., *Guides* appellant had one percent right upper extremity permanent impairment due to a diagnosis of shoulder pain. Utilizing the ROM method, the DMA found that under Table 15-34, page 475, appellant had zero percent permanent impairment of the right upper extremity. He explained that since the DBI method produced the higher rating of one percent right upper extremity permanent impairment, the DBI method must be used. Regarding appellant's cervical condition, the DMA utilized the DBI method, and determined that under *The Guides Newsletter,* Table 1, appellant had one percent right upper extremity permanent impairment due to mild sensory impairment at C6. He referred to the Combined Values Chart and concluded that appellant had a total of two percent right upper extremity impairment. The DMA reported a date of MMI of March 14, 2019.

By *de novo* decision dated April 25, 2019, OWCP denied appellant's claim for an increased schedule award. It accorded the weight of the medical evidence to Dr. Gordon and Dr. White, the DMA, who had determined that appellant did not have greater permanent impairment than the six percent previously awarded for the right upper extremity.

On May 2, 2019 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on August 9, 2019. Counsel asserted that Dr. Becan's June 30, 2014 report reflected a more thorough examination and properly applied the A.M.A., *Guides* to determine appellant's impairment rating.

Appellant subsequently submitted a July 24, 2019 addendum report by Dr. Becan who noted his disagreement with Dr. Gordon's March 14, 2019 second opinion report. Dr. Becan pointed out that although Dr. Gordon reported that motor and sensory examination of appellant's upper extremities were intact, he did not mention which specific muscles were tested nor did he use the Semmes-Weinstein Monofilament testing to document sensory deficit. He indicated that his June 30, 2014 impairment rating report was based on physical examination that showed positive Hawkins impingement testing. Dr. Becan also noted that Semmes-Weinstein Monofilament testing had revealed sensory deficit in the right C5 and C6 distribution. He concluded that he still affirmed his previous impairment rating of 12percent right upper extremity impairment.

By decision dated October 23, 2019, the hearing representative affirmed the April 25, 2019 decision, finding that the weight of the medical evidence rested with the March 14, 2019 second opinion report of Dr. Gordon.

LEGAL PRECEDENT

The schedule award provisions of FECA[12] and its implementing regulations[13] 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.[14] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[15]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[16] Furthermore, the

[12] 5 U.S.C. § 8107.

[13] 20 C.F.R. § 10.404.

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

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

[16] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

back is specifically excluded from the definition of organ under FECA.[17] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairment consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that the July/August 2009 edition of *The Guides Newsletter* is to be applied.[18]

In addressing impairment of the upper extremities, the sixth edition of the A.M.A., *Guides* requires identifying the impairment for the CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[19] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[20] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[21]

The A.M.A., *Guides* also provide that the ROM impairment is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[22] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[23] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[24]

Regarding the application of ROM or DBI impairment 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).
>
> "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*

[17] *See id.* at § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[18] *Supra* note 16 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

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

[20] *Id.* at 411.

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

[22] A.M.A., *Guides* 461.

[23] *Id.* at 473.

[24] *Id.* at 474.

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.)[25]

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."[26]

ANALYSIS

The Board finds that the case is not in posture for decision as there remains an unresolved conflict in the medical opinion evidence regarding whether appellant has greater than six percent right upper extremity permanent impairment due to her accepted conditions.[27]

In support of her schedule award claim, appellant submitted a June 30, 2014 report by her treating physician, Dr. Becan, who utilized the DBI-rating method and determined that under Table 15-5, page 401, appellant had three percent right upper extremity permanent impairment for right shoulder impingement syndrome. With regard to appellant's cervical condition, Dr. Becan, initially found that appellant had 10 percent right upper extremity permanent impairment due to severe sensory deficits at the right C5 and C6 nerve root. In his June 30, 2014 report, he noted that sensory examination revealed a perceived sensory deficit over the C4, C5, and C6 nerve root distributions in the right upper extremity. Dr. Becan noted that, under the DBI rating method and Table 1 of *The Guides Newsletter*, the CDX for right severe sensory deficit at C5 resulted in a class 1 impairment with a default value of four. He assigned a GMFH of 2 and a GMCS of 2. Dr. Becan applied the net adjustment formula, which resulted in four percent right upper extremity permanent impairment. He also indicated that appellant's condition fell under a CDX of class 1 impairment due to severe sensory deficit at C6 with a default value of six. Dr. Becan assigned a GMFH of 2 and a GMCS of 2. He applied the net adjustment formula, which raised the default value to six percent right upper extremity permanent impairment. Dr. Becan concluded that appellant had a total of 10 percent right upper extremity permanent impairment due to severe sensory deficit at right C5 and C6 nerve roots.

In contrast, Dr. Gordon, an OWCP second opinion examiner, determined in a March 14, 2019 report, that appellant had one percent right upper extremity permanent impairment under the DBI methodology and zero percent right upper extremity permanent impairment under the ROM methodology. He concluded that the DBI methodology yielded the greater impairment. In a March 31, 2019 report, the DMA noted that he agreed with Dr. Gordon's March 14, 2019 impairment rating of one percent right upper extremity permanent impairment rating based upon the DBI methodology and zero percent right upper extremity permanent impairment under the ROM methodology. He also agreed that the DBI methodology represented the greater right upper extremity permanent impairment rating. Dr. Gordon utilized the DBI rating method and referred

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

[26] *Id.*

[27] *See D.D.*, Docket No. 19-1037 (issued November 6, 2019).

to Table 1 of *The Guides Newsletter* in order to determine that findings of C6 mild sensory neuropathy resulted in a class one impairment with a default value of one percent and assigned a GMFH of 1, a GMPE of 1, and a GMCS of 1. After applying the net adjustment formula, he calculated that appellant had one percent permanent impairment for sensory deficits.

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 an impartial medical examiner (IME), who shall make an examination.[28] The Board finds that there is a conflict in medical opinion between Dr. Becan and Dr. Gordon.[29] Both physicians provided examination findings and based their impairment ratings on the appropriate tables of the A.M.A., *Guides* and *The Guides Newsletter*. Consequently, the case must be referred to an IME to resolve the above-described conflict in the medical opinion evidence between Dr. Becan and Dr. Gordon regarding appellant's right upper extremity permanent impairment due to her accepted conditions.[30] On remand OWCP shall refer appellant, along with the case file and an updated SOAF, to a specialist in the appropriate field of medicine for an impartial medical evaluation and report including a rationalized opinion on this issue. After this and other such further development as deemed necessary, it shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

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

[28] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[29] *See S.C.*, Docket No. 18-1450 (issued March 4, 2019).

[30] *See S.J.*, Docket No. 19-0623 (issued October 28, 2019); *see also B.C.*, Docket No. 15-0992 (issued August 11, 2015).

ORDER

IT IS HEREBY ORDERED THAT the October 23, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: February 12, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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