United States Department of Labor
Employees' Compensation Appeals Board

L.D., Appellant	)	
and	)	**Docket No. 15-0220**
	)	**Issued: August 5, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On November 5, 2014 appellant, through counsel, filed a timely appeal of a July 28, 2014 merit decision of Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUES

The issues are: (1) whether appellant has established that she developed a cervical condition as a result of her employment duties; (2) whether she has met her burden of proof to establish a recurrence of disability on or after May 27, 2010 due to her accepted employment injuries; and (3) whether appellant has more than 26 percent permanent impairment of her right upper extremity for which she received a schedule award.

On appeal counsel argues that the report of the impartial medical examiner (IME) was not entitled to the weight of the medical evidence as he was not properly selected. He contends that

[1] 5 U.S.C. § 8101 *et seq.*

there was no screen shot of the IME's selection and no record of physicians who were bypassed, only the Form ME023. In the alternative, counsel argues that the IME's report supported residual disability due to a cervical condition, that his report was not consistent with the statement of accepted facts (SOAF), and that he did not address the May 27, 2010 recurrence of disability associated with the removal of the spinal cord stimulator.

FACTUAL HISTORY

This case has previously been before the Board. Appellant has two occupational disease claims before OWCP. The relevant facts of both claims follows.

On August 8, 2006 appellant, then a 39-year-old clerk, filed an occupational disease claim alleging that she developed carpal tunnel syndrome and a ganglion cyst as a result of her duties of casing letters and flats on a daily basis in OWCP File No. xxxxxx758. An electromyogram (EMG) study demonstrated mild carpal tunnel syndrome in the right hand. OWCP accepted this claim for right carpal tunnel syndrome and dorsal ganglion cyst, right wrist. Appellant underwent a right carpal tunnel release with tenosynovial biopsy and distal forearm fasciotomy on September 19, 2006.

Appellant filed a claim for a recurrence of disability on July 30, 2007 due to her accepted conditions. On August 10, 2007 OWCP accepted the additional condition of reflex sympathetic dystrophy (RSD) of the right upper extremity. Appellant underwent the surgical insertion of two separate spinal stimulator leads on July 30, 2007 for a trial. She underwent permanent insertion of spinal stimulators on September 19, 2007 due to chronic regional pain syndrome (CRPS) in the right upper extremity. Appellant returned to light-duty work on January 24, 2008.

By decision dated April 30, 2009, OWCP granted appellant a schedule award for 26 percent impairment of the right upper extremity. An OWCP hearing representative affirmed this decision on December 2, 2009.

Appellant appealed to the Board. The Board issued an *Order Remanding Case* on March 22, 2011,[2] finding that OWCP had improperly applied the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[3] (A.M.A., *Guides*), to appellant's medical evidence of permanent impairment and remanded for review of the case under the sixth edition of the A.M.A., *Guides*.[4]

Appellant filed a second occupational disease claim on October 30, 2009 alleging that she sustained a cervical spine injury as a result of heavy lifting and other work-related duties in OWCP File No. xxxxxx072. She underwent a computerized tomography (CT) scan of the cervical spine on September 24, 2009 which demonstrated central disc protrusions at C4-5 and C5-6. The disc protrusion at C5-6 resulted in marked spinal canal narrowing. In a note dated October 5, 2009, Dr. Steven Rosen, a Board-certified neurologist, reported that appellant

[2] Docket No. 10-1138 (issued March 22, 2011).

[3] A.M.A., *Guides*, 5th ed. (2001).

[4] *Id.* at 6th ed. (2009).

experienced increased severe left neck and upper extremity pain due to the herniated disc in addition to her chronic upper extremity pain. He found that she was totally disabled. On October 5, 2009 Dr. Rosen stated that this condition began in August 2009 and stated that appellant's CT scan demonstrated a large central herniation at C5-6.

Dr. Paul J. Marcotte, a Board-certified neurosurgeon, examined appellant on November 2, 2009 and noted her course of treatment and reported that appellant had progressive neck and arm symptoms which were in keeping with the lower cervical problem demonstrated on her CT scan. Appellant underwent an additional CT scan, which Dr. Marcotte had recommended on December 4, 2009. It demonstrated cervical spinal stenosis at C5-6 and nonfilling of the C6 nerve root sleeves due to filling defect and disc herniation. On December 14, 2009 Dr. Marcotte reviewed this diagnostic study and opined that a discectomy and fusion was indicated. Appellant underwent an anterior cervical discectomy interbody fusion with iliac crest bone graft and plating at C5-6 on January 19, 2010.

By decision dated January 20, 2010, OWCP denied appellant's claim for an occupational cervical disease in OWCP File No. xxxxxx072, finding that the evidence was insufficient to establish that the events had occurred as alleged and that the record did not contain any medical evidence that provided a diagnosis that could be connected to the claimed events.

On May 28, 2010 Dr. Marcotte performed a surgical removal of appellant's spinal cord stimulator. He examined appellant on June 30, 2010 and found that appellant's neck and arm pain had improved, but that she continued to experience residual pain in her neck and burning dysesthesias in her hands. Dr. Marcotte stated, "The origin of her ongoing symptoms is unclear."

Appellant was involved in a rear-end collision on June 30, 2010 and that she thereafter experienced diffuse pain in her neck, arms, and back. Dr. Marcotte opined that appellant had likely incurred a cervical strain as a result of the rear-end collision. Dr. Michael Martin Cohen, a Board-certified neurologist, examined appellant on August 26, 2010 and described her June 30, 2010 motor vehicle accident. He diagnosed bilateral C6-7 radiculopathy, cervical strain with fibromyositis, lumbar strain with fibromyositis, and post-traumatic cephalgia.

Appellant filed a claim for a recurrence of disability on September 16, 2010 in OWCP File No. xxxxxx758, alleging that beginning on May 27, 2010 she was totally disabled due to her previously accepted conditions of right carpal tunnel syndrome, dorsal ganglion cyst, and RSD.[5] She sought treatment beginning September 21, 2010 through December 18, 2012 from Dr. Thomas M. Fagan, chiropractor, for neck and back pain.

Appellant requested reconsideration on October 4, 2010 of the denial of her occupational cervical disease claim, OWCP File No. xxxxxx072.

[5] On February 29, 2008 Dr. Ira H. Solomon, a clinical psychologist, examined appellant and diagnosed adjustment disorder with mixed anxiety, depressed mood, and a chronic pain syndrome. He opined that this condition was the direct result of her January 20, 2004 employment injury.

Appellant submitted September 14, 20, and October 19, 2010 reports from Dr. Michael R. McCoy, a Board-certified family practitioner, who noted that she had been working for the employing establishment for 24 years. Dr. McCoy noted that for several months prior to September 24, 2009, appellant had been developing worsening neck and upper extremity pain and weakness into her right lower extremity and was on limited duty due to her carpal tunnel syndrome, RSD, and neck pain. He opined that appellant ruptured a disc in her neck, and on September 24, 2009 had a CT scan performed, which documented a disc herniation at C5-6. Dr. McCoy noted that she underwent cervical fusion and bone allograft. He diagnosed cervical disc herniation at C5-6, right upper extremity radiculopathy, right lower extremity myelopathy secondary to disc herniation at C5-6, and status post cervical fusion. Dr. McCoy opined that appellant was symptomatic and disabled as a direct result of her work injuries. He reported, "It is my opinion that her injuries are work related. [Appellant] has no degenerative changes of the cervical spine that would cause her to have disc herniation. Thus, I must conclude that her disability is due to her work injuries." Dr. McCoy concluded that appellant was misdiagnosed with carpal tunnel syndrome and RSD and that all of her symptoms were related to her cervical disc herniation.

Dr. Todd Marc Kelman, an osteopath, examined appellant on September 21, 2010 and noted her neck pain, bilateral shoulder pain, and low back pain. He reported that appellant's neck pain radiated down both arms into her hands. Dr. Kelman noted that appellant believed her symptoms were improving following her spinal surgery, but then she was involved in a motor vehicle accident on June 30, 2010 which resulted in back pain as well as pain traveling down both legs. He diagnosed post-traumatic exacerbation of bilateral cervical radiculopathy following C5-6 fusion, cervical strain and sprain with myofasciitis, bilateral shoulder tendinitis, and lumbar bilateral radiculopathy with lumbar strain.

Counsel argued on October 28, 2010 that appellant's recurrence of disability of her carpal tunnel syndrome claim was due to the removal of the spinal cord stimulator on May 28, 2010.

By decision dated November 24, 2010, OWCP denied appellant's claim for recurrence of disability in OWCP File No. xxxxxx758, on or after May 27, 2010, finding that her disability appeared to be due to disc herniations. Appellant requested a hearing.

By decision dated January 12, 2011, OWCP denied modification of its January 20, 2010 decision regarding the occupational cervical claim in OWCP File No. xxxxxx072. The claims examiner found that the evidence failed to establish that factors of appellant's employment caused her current cervical disc condition.

On January 30, 2011 appellant requested reconsideration, or in her words "expansion," of the January 12, 2011 decision. In letters dated February 11 and March 2, 2011, she requested that her claim be expanded to include a herniated disc at C5-6. Appellant explained her treatment and her belief that she was misdiagnosed resulting in the accepted diagnoses.

In a March 3, 2011 decision, OWCP denied appellant's January 30, 2011 request for reconsideration as the evidence submitted was insufficient to warrant merit review. Dr. McCoy continued to opine that appellant's cervical symptoms and disability were due to her work-related injury.

An OWCP hearing representative issued a decision on June 28, 2011 in OWCP File No. xxxxxx758, finding that appellant had not established a recurrence of disability on May 27, 2010 causally related to her accepted right upper extremity injuries and affirming OWCP's November 24, 2010 decision. Appellant filed another request for reconsideration.

OWCP's medical adviser reviewed appellant's schedule award claim in OWCP File No. xxxxxx758 on July 5, 2011 and reported that an October 5, 2009 CT scan demonstrated a large central disc herniation at C5-6, but that this was not consistent with appellant's mechanism of injury and was not an accepted condition. He noted, "The fact that the claimant has improved with stellate ganglion blocks represents a therapeutic test confirm the diagnosis of RSD and complex regional pain syndrome of the left upper extremity." The medical adviser applied the sixth edition of the A.M.A., *Guides* to appellant's diagnosed conditions of carpal tunnel syndrome and RSD and found a class 2 impairment of the median nerve.[6] OWCP's medical adviser stated that the default value grade C was 17 percent impairment. He found that appellant's complex regional pain syndrome was class 2, moderate, grade C with a default value of 20 percent.[7] OWCP's medical adviser found that appellant had grade modifier 2 for functional history,[8] physical examination,[9] and clinical studies.[10] He concluded that appellant had 20 percent impairment of the right upper extremity.

By decision dated July 18, 2011, OWCP reviewed appellant's schedule award claim as directed by the Board in its March 22, 2011 *Order Remanding Case* in Docket No. 10-1138 and found that, under the sixth edition of the A.M.A., *Guides*, appellant had 20 percent rather than 26 percent impairment of her right upper extremity.

Counsel requested an oral hearing before an OWCP hearing representative regarding the July 18, 2011 decision.

Dr. McCoy submitted reports dated January 12 and 31, as well as June 29 and July 26, 2011 and opined that appellant had work-related neck pain and radicular symptoms into both upper extremities. He reported that appellant initially worked at the employing establishment in a heavy-duty capacity and suffered a disc herniation which was not diagnosed. Dr. McCoy documented in his report, "It is my opinion within a reasonable degree of medical certainty that [appellant] remains symptomatic and disabled as a direct result of her work injury."

On September 27, 2011 appellant again requested reconsideration under xxxxxx758.

In an October 3, 2011 narrative report, Dr. McCoy opined that appellant's medical care had been substandard. He reported, "Given the four-year delay in her treatment of the nerve

[6] A.M.A., *Guides*, 436, Table 15-21.

[7] *Id.* at 454, Table 15-26.

[8] *Id.* at 406, Table 15-7.

[9] *Id.* at 408, Table 15-8.

[10] *Id.* at 410, Table 15-9.

damage to her nervous system secondary to cervical cord compression has left her with some permanent residuals of pain, numbness, tingling, and weakness in her arms and legs." Dr. McCoy noted that appellant's symptoms continued due to the delay in her accurate diagnosis of cervical disc herniation with radiculopathy. He opined that her diagnosed cervical condition was solely due to her work activities.

On December 20, 2011 OWCP denied modification of its June 28, 2011 decision which found that appellant had not submitted sufficient medical opinion evidence to establish a recurrence of disability on May 27, 2010 due to her August 8, 2006 claim accepted for right carpal tunnel syndrome, ganglion cyst, and RSD.

OWCP hearing representative issued a decision on January 10, 2012 finding that appellant had no more than 26 percent impairment of her right upper extremity for which she had received a schedule award.

Appellant appealed OWCP's December 20, 2011 and January 10, 2012 decisions in OWCP File No. xxxxxx758 to the Board. The Board assigned Docket No. 12-1061.

Counsel requested reconsideration of appellant's cervical claim, OWCP File No. xxxxxx072, on March 22, 2012 based on Dr. McCoy's October 3, 2011 report.

By decision dated April 11, 2012, OWCP denied modification of the January 12, 2011 cervical decision.

Dr. Rosen continued to provide a series of bilateral transforaminal injections throughout 2012 to treat appellant's brachial plexitis and persistent pain and radiculitis following cervical fusion. On August 21, 2012 Dr. McCoy reported appellant's neck and right upper extremity pain. He found continued weakness in the right upper extremity with limited grip, pinch, and apposition strength. Dr. McCoy diagnosed right carpal tunnel syndrome on September 19, 2012. In a note dated December 18, 2012, he repeated his diagnosis and added right sciatic RSD.

Appellant underwent a magnetic resonance imaging (MRI) scan on November 6, 2012 which demonstrated her cervical fusion at C5-6 and disc protrusions at C4-5 and C6-7. On November 9, 2012 Dr. Rosen reported that appellant did well following her cervical fusion in January 2010, but requested treatment on May 8, 2012 following a motor vehicle accident in June 2010. He diagnosed a new disc herniation at C6-7 and sympathetically mediated pain.

On November 26, 2012 the Board issued an *Order Remanding Case*[11] finding that appellant's cervical condition and upper extremity condition claims should be combined and that OWCP should issue *de novo* decisions on the issues of recurrence of disability and permanent impairment.

Upon return of the case record, OWCP combined the claims, with OWCP File No. xxxxxx758 as the master file, and undertook further development.

[11] Docket No. 12-1061 (issued November 26, 2012).

By decision dated February 28, 2013, OWCP denied appellant's claims for a recurrence of disability beginning May 27, 2010 and a schedule award. It found that the medical evidence did not establish that appellant had an employment-related disc herniation as Dr. McCoy did not implicate specific work duties. OWCP stated that appellant's claim for an increased schedule award was denied as her disc herniation was not an accepted condition.

Counsel initially requested an oral hearing before an OWCP hearing representative, which he changed to a request for a review of the written record on June 24, 2013.

Dr. McCoy examined appellant on March 19, 2013 and diagnosed carpal tunnel syndrome as well as cervical strain/sprain.

Appellant appealed the April 11, 2012 decision denying her claim for cervical injury to the Board on November 2, 2012. In a decision dated May 7, 2013,[12] the Board found that appellant's cervical condition claim was not in posture for a decision noting that Drs. McCoy and Rosen consistently indicated that appellant sustained an employment-related cervical condition. The Board further found that appellant had provided sufficient details of her job activities. The Board remanded the case for OWCP to formulate a SOAF and refer appellant for additional medical examination.

Dr. Rosen examined appellant on May 14, 2013 and reported that appellant had an anterior cervical fusion from C4-7 in January 2013. He noted that she had pain from herniated discs and neuropathic pain consistent with a sympathetically mediated pain syndrome as well as a brachial plexus injury. Dr. Rosen also noted that appellant developed increasing back, buttock, and leg pain following her June 2010 automobile accident.

OWCP referred appellant for a second opinion evaluation with Dr. Robert F. Draper, a Board-certified orthopedic surgeon on June 12, 2013. In a report dated June 27, 2013, Dr. Draper noted that appellant's current claim was for herniated cervical disc due to her employment. He reviewed her job duties, medical treatment, and prior claims. Dr. Draper found that appellant exhibited exaggerated responses throughout her physical examination including shaking her hands in a nonphysiologic manner. He found that appellant evinced generalized diffuse global weakness in all muscles tested which he believed to be exaggerated responses. Dr. Draper noted that appellant did not put forth maximum effort for range of motion testing for the lumbar spine and demonstrated normal stance and gait. He also found global diffuse weakness in all muscles tested in the lower extremities. Dr. Draper found a slightly positive Tinel's sign in the median nerve of the right wrist with no thenar or hypothenar atrophy.

In regard to appellant's cervical disc disease, Dr. Draper opined that this condition was preexisting and nonemployment related. He reported that this condition was not related to appellant's job functions or employment and was not permanently aggravated by employment activities. Dr. Draper opined that appellant's cervical disc disease was the natural result of the aging process. He noted, "I do not conclude that the cervical spine disc pathology and associated cervical spine surgeries should be added to the accepted conditions." Dr. Draper found that

[12] Docket No. 12-1518 (issued May 7, 2013).

appellant could not perform her date-of-injury position due to her accepted conditions and provided work restrictions.

On August 22, 2013 OWCP issued a decision denying appellant's claim for an additional employment-related cervical condition. It noted that Dr. Draper, the second opinion physician, did not support that appellant's cervical condition was related to her employment. Instead he found that appellant had a preexisting, nonemployment-related degenerative disc disease at C4-5, C5-6, and C6-7.

OWCP hearing representative conducted a review of the written record and issued a decision on September 9, 2013 vacating OWCP's decisions on the issues of recurrence of disability and increased schedule award, finding that to avoid piecemeal adjudication OWCP must first determine whether appellant's cervical condition was causally related to her employment.

Dr. Rosen continued to provide transforaminal injections. On October 1, 2013 he stated that appellant's right hand pain decreased at least 70 percent. Dr. Rosen diagnosed spreading CRPS and recommended surgical reimplantation of her stimulator.

Appellant requested a hearing of the August 22, 2013 decision.

By decision dated November 7, 2013, OWCP hearing representative found a conflict of medical opinion evidence between Drs. McCoy and Draper and remanded the claim for additional development.

OWCP referred appellant for an impartial medical examination with Dr. Stanley Askin, a Board-certified orthopedic surgeon, on February 6, 2014. The record contains the Form ME023, appointment schedule notification identifying Dr. Askin as the selected referee dated February 6, 2014. There is also documentation that no bypasses were available and that Dr. Askin was located 1.69 miles from appellant's zip code dated February 6, 2014. This documentation states, "This report serves as certification that the Medical Management application in the integrated Federal Employees' Compensation System (iFECS) was used to schedule this appointment."

Dr. Askin submitted a report dated February 26, 2014 and reported that he examined appellant and reviewed the SOAF. He noted that appellant stated her June 30, 2010 automobile accident resulted in low back pain only. Dr. Askin found no signs of RSD in examination of her hands. He stated that appellant was inconsistent in the manner in which she moved, as she moved more freely and spontaneously than when directed to do so. Dr. Askin noted that appellant offered little effort in muscle testing, but all muscle were contractile. He found no muscle spasm in the lower back and noted that appellant reported pain over the entire lower portion of her neck, over both trapezii, posterior shoulders, and anterior shoulders. Dr. Askin mentioned Dr. McCoy's March 19, 2013 report. He diagnosed right carpal tunnel syndrome, dorsal ganglion cyst right wrist, compartment syndrome of the right upper extremity, benign neoplasm, and RSD of the right upper limb. Dr. Askin opined that appellant's objective conditions were degenerative processes that were likely present independent of her employment activities. He opined, "It does not make sense to continue to invoke carpal tunnel syndrome as

an explanation of her complaints." Dr. Askin also opined that appellant's disc disease was not an explanation of her complaints as appellant had undergone surgical treatment with no reduction of symptoms.

Dr. Askin noted that he was to provide an opinion with reasoning as to whether appellant's cervical condition was related to her employment. He stated that it was possible for baseline degenerative changes to be provoked by an injury or even by overuse activities, but found that these possibilities were not consistent with appellant's history. Dr. Askin further noted that appellant had received treatment for disc disease, but continued to have persistent complaints which "should mean that cervical disc disease has been conclusively ruled out as an explanation for her complaints notwithstanding any potential attribution to her employment." He found no explanation for a consequential disc disease due to employment or medical treatment.

Dr. Askin concluded that with respect to physical maladies appellant had fully recovered. He noted that appellant had received appropriate treatment for carpal tunnel syndrome, that there were no objective signs of RSD, and no manifestation of compartment syndrome.

By decision dated March 5, 2014, in File No. xxxxxx072, OWCP denied appellant's claim for a cervical condition based on Dr. Askin's report. It found that she had not established a causal relationship between her diagnosed cervical condition and her employment duties.

In appellant's claim accepted for right upper extremity injuries, File No. xxxxxx758, OWCP issued a second decision on March 10, 2014 finding that, based on Dr. Askin's report, appellant's cervical condition was not causally related to her employment. It noted that Dr. Askin found that appellant's demonstrated abilities were inconsistent as her range of motion was better spontaneously than that demonstrated when tested. OWCP determined that appellant had not established a recurrence of disability beginning May 27, 2010. It further found that appellant had not established entitlement to an increased schedule award as the condition of disc herniation was not accepted as employment related.

Counsel on March 14, 2014 requested an oral hearing before an OWCP hearing representative.

Appellant underwent reinsertion of her spinal cord stimulator on March 5, 2014 and experienced pain relief in her hands and lower extremities. She continued to experience neck pain. Dr. Rosen reprogramed her stimulator to provide coverage in her neck, shoulder, arms, both legs, and trunk.

An oral hearing before an OWCP hearing representative took place on June 9, 2014. Counsel argued that Dr. Askin's report was not sufficiently well reasoned to constitute the weight of the medical opinion evidence. He referenced Dr. McCoy's October 3, 2011 report and stated that Dr. Askin did not address the issues raised by that report. Counsel stated that Dr. Askin did not address a conflict between Drs. Draper and McCoy regarding whether cervical disc herniation with right radiculopathy should have been an accepted condition due to the 2004 occupational disease claim. He asserted that Dr. Askin did not review the relevant reports from Dr. McCoy.

In the decision dated July 28, 2014, OWCP hearing representative found that appellant had not established a recurrence of disability in 2009 due to increasing neck and upper extremity pain as a result of her accepted employment injuries. She affirmed OWCP's March 10, 2014 decision in this regard. The hearing representative also found that the March 5, 2014 decision denying appellant's occupational cervical disease claim was correct in finding that Dr. Askin was entitled to special weight. She also affirmed the March 10, 2014 denial of an increased schedule award based on cervical symptomatology.

LEGAL PRECEDENT -- ISSUE 1

OWCP regulations define an occupational disease as "a condition produced by the work environment over a period longer than a single workday or shift."[13] To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The evidence required to establish causal relationship is rationalized medical opinion evidence, based upon a complete factual and medical background, showing a causal relationship between the claimed condition and identified factors. The belief of a claimant that a condition was caused or aggravated by the employment is not sufficient to establish causal relation.[14]

When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination and resolve the conflict of medical evidence.[15] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[16]

In situations where there are opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[17]

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[13] 20 C.F.R. § 10.5(q).

[14] *Lourdes Harris*, 45 ECAB 545, 547 (1994).

[15] 5 U.S.C. §§ 8101-8193, 8123; *M.S.*, 58 ECAB 328 (2007); *B.C.*, 58 ECAB 111 (2006).

[16] *R.C.*, 58 ECAB 238 (2006).

[17] *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

ANALYSIS -- ISSUE 1

Appellant alleged that as a result of her employment duties she developed an additional cervical spine condition. Dr. Rosen first diagnosed a herniated cervical disc in October 2009. Dr. Marcotte attributed appellant's neck and arm symptoms to disc herniation and cervical spinal stenosis in December 2009. Dr. McCoy provided a series of reports attributing appellant's cervical condition to her employment and alleging that her initially diagnosed conditions of carpal tunnel syndrome and RSD were misdiagnoses. In the May 7, 2013 decision, the Board found that Drs. McCoy and Rosen supported appellant's claim for an employment-related cervical condition and remanded the case for OWCP to undertake further development of the medical evidence.

Following the Board's decision, OWCP referred appellant for a second opinion evaluation with Dr. Draper, who reviewed appellant's job duties, medical treatment, and performed a physical examination. Dr. Draper found that appellant was not reliable in her response to testing. He opined that appellant's cervical condition was preexisting and not related to her employment. Dr. Draper concluded that her cervical disc disease was the natural result of the aging process.

The Board finds that there was a conflict of medical opinion evidence between appellant's physicians, Drs. McCoy and Rosen, and the second opinion physician, Dr. Draper, regarding the causal relationship of appellant's cervical disc disease to her employment. Due to this conflict of medical evidence, the Board finds that OWCP properly referred appellant to an impartial medical examiner to resolve the conflict pursuant to 5 U.S.C. § 8123(a).

On appeal counsel argues that Dr. Askin was not properly selected to serve as the IME. Contrary to counsel's argument, the Board finds that there is sufficient evidence of record which documents that Dr. Askin was selected through the appropriate rotational system to ensure against bias and prejudice.[18] To select an impartial medical examiner, OWCP uses the Medical Management Application (MMA) with a strict rotational feature.[19] In this case, it utilized the MMA, as evidence by the ME023 form, provided information that no additional physicians were selected or bypassed through the MMA, and included documentation that the MMA was used to schedule the appointment with Dr. Askin. Therefore the Board finds that Dr. Askin was properly selected to serve as IME.

The Board further finds that Dr. Askin's February 26, 2014 report is entitled to the weight of the medical evidence and does not support appellant's claim for cervical disc disease as a result of her employment duties. Dr. Askin reviewed the statement of accepted facts and examined appellant. He found that appellant was inconsistent in the manner in which she moved. Dr. Askin opined that appellant's cervical condition was present independent of her employment activities. He noted that, while it was possible for baseline degenerative changes to be provoked by overuse activities, this was not consistent with appellant's history. Dr. Askin

[18] *B.B.*, Docket No. 14-1575 (issued February 18, 2015).

[19] *H.W.*, Docket No. 14-1319 (issued February 3, 2015); Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.6 (May 2013).

also discounted that appellant's cervical disc disease was responsible for her current symptomatology as she had received two surgical treatments for this condition.

Dr. Askin's report was based on a proper factual background and included a review of the medical evidence. There is no requirement, as posited by counsel, that Dr. Askin list all the reports or address all arguments in his report. The Board finds that Dr. Askin's report was consistent with the SOAF. Dr. Askin provided findings on examination and reviewed appellant's diagnoses and treatments. He reported that appellant's cervical condition was neither caused nor aggravated by her employment based on a review of her employment and medical history. As Dr. Askin provided a clear opinion discounting a causal relationship between appellant's cervical disc disease and her employment and supported this opinion with medical reasoning, the Board finds that this report is entitled to the special weight of the medical evidence and does not support appellant's claim for cervical disc disease resulting from her employment.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[20]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establish that he or she can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative, and substantial evidence a recurrence of total disability and show that he or she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty requirements.[21] This burden includes the necessity of furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to employment factors and supports that conclusion with sound medical reasoning.[22]

[20] 20 C.F.R. § 10.5(x).

[21] *Terry R. Hedman*, 38 ECAB 222 (1986).

[22] *See Nicolea Bruso*, 33 ECAB 1138, 1140 (1982).

ANALYSIS -- ISSUE 2

Appellant returned to light-duty work on January 24, 2008 following her August 8, 2006 occupational disease claim accepted for right carpal tunnel syndrome, dorsal ganglion cyst right wrist, as well as RSD of the right upper extremity. She filed a recurrence of disability on September 16, 2010 alleging that beginning on May 27, 2010 she was totally disabled due to these conditions.

Dr. Marcotte surgically removed appellant's spinal cord stimulator on May 28, 2010. In a note dated June 30, 2010, he stated that appellant's neck and arm pain had improved, but that she continued to experience residual pain in her neck and hands. Dr. Marcotte stated that the origin of appellant's symptoms was unclear. His report does not support a recurrence of total disability due to appellant's accepted employment-related injuries. Dr. Marcotte did not opine that appellant was totally disabled and did not offer any reasoning relating her condition or disability to her work.

On June 30, 2010 appellant was involved in a rear-end collision in an automobile which resulted in cervical strain according to Dr. Marcotte. Dr. Cohen reported appellant's automobile accident and diagnosed bilateral C6-7 radiculopathy, cervical strain, lumbar strain, and post-traumatic cephalgia. Dr. Kelman reported that appellant's symptoms were improving until her June 30, 2010 automobile accident. He diagnosed post-traumatic exacerbation of bilateral cervical radiculopathy, cervical strain, bilateral shoulder tendinitis, and lumbar radiculopathy as a result of this accident. The reports from Drs. Marcotte, Cohen, and Kelman do not support that appellant sustained a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury. Instead Drs. Kelman, Marcotte, and Cohen attribute the change in appellant's condition after June 30, 2010 to her nonemployment-related automobile accident and resulting injuries.

Counsel argued that appellant's recurrence of disability beginning on May 27, 2010 was the result of Dr. Marcotte's surgical removal of her spinal cord stimulator. The record does not contain any medical evidence in support of this argument and counsel's opinion is not medical evidence and so it is insufficient to meet appellant's burden of proof in establishing a recurrence of disability.

Appellant also sought treatment from Dr. Fagan, a chiropractor, beginning September 21, 2010. Under FECA a chiropractor is a physician only to the extent that the reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[23] Appellant's chiropractic records from Dr. Fagan did not provide x-rays demonstrating a subluxation of the spine. Accordingly, the Board finds that these reports are not considered probative medical evidence and cannot establish

[23] Section 8101(2) of FECA provide as follows: (2) "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners with the scope of their practice as defined by State law. The term physician includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Secretary. *See Merton J. Sills*, 39 ECAB 572, 575 (1988); *P.R.*, Docket No. 14-1007 (issued August 13, 2014).

a recurrence of disability. The Board therefore finds that appellant has not met her burden of proof to establish that beginning on May 27, 2010 she was totally disabled due to these conditions.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 3

The schedule award provision of FECA[24] and its implementing regulations[25] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for the loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[26]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[27] In Table 15-23, grade modifier levels (ranging from 0 to 4) are described for the categories functional history, physical examination, and clinical studies. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[28]

The A.M.A., *Guides* provide specific guidelines for an impairment rating to the upper extremities from CPRS including RSD. The diagnosis of CRPS must be confirmed based on the diagnostic criteria provided in Table 15-24.[29] If the diagnosis is confirmed, the number of objective diagnostic criteria points is determined under Table 15-25.[30] The impairment is then

[24] 5 U.S.C. §§ 8101-8193, 8107.

[25] 20 C.F.R. § 10.404.

[26] For new decisions issued after May 1, 2009, OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[27] A.M.A., *Guides* 449, Table 15-23.

[28] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the function scale score. A.M.A., *Guides* 448-49.

[29] A.M.A., *Guides* 453, Table 15-24.

[30] *Id.* at Table 15-25.

calculated using Table 15-26 for the arms.[31] The default value is adjusted in accord with grade modifiers for functional history, physical examination, and clinical studies. The rating for CRPS is not combined with any other impairment for the same extremity.[32]

ANALYSIS -- ISSUE 3

On April 30, 2009 OWCP granted appellant a schedule award for 26 percent impairment of the right upper extremity under the fifth edition of the A.M.A., *Guides* based on her accepted employment injuries of right carpal tunnel syndrome, RSD and dorsal ganglion on the right. On March 22, 2011 the Board remanded the case for OWCP to apply the proper edition of the A.M.A., *Guides*.

By decision dated July 18, 2011, OWCP found that appellant had 20 percent impairment of the right upper extremity. On November 26, 2012 the Board issued a second *Order Remanding Case*[33] finding that appellant's cervical condition and upper extremity condition claims should be combined and that OWCP should issue *de novo* decisions on the issues of recurrence of disability and increased schedule award. Following the Board's directives, OWCP and its hearing representatives issued decisions on March 10 and July 28, 2014 respectively, finding that appellant was not entitled to an increased schedule award based on cervical symptomatology.

As previously found, the Board notes that appellant has not established that she sustained an additional cervical disc condition as a result of her accepted employment duties. Therefore, appellant is not entitled to a schedule award for this condition on these grounds. She would also be entitled to a schedule award for impairment to her upper extremity for her cervical condition if it was a preexisting condition.[34] The record does not establish that appellant's cervical condition was preexisting such that any impairment to her extremities as a result of this condition should be included in her impairment rating. Dr. McCoy opined that appellant had no preexisting cervical condition prior to her 2006 employment injury, while Dr. Draper suggested that appellant's cervical condition was age related and thus did not preexist her 2006 occupational disease claim.

OWCP's medical adviser reviewed appellant's schedule award claim on July 5, 2011 and evaluated the accepted conditions of carpal tunnel syndrome and RSD. He reviewed the sixth edition of the A.M.A., *Guides* and found a class 2 impairment of the median nerve.[35] OWCP medical adviser stated that the default value grade C was 17 percent impairment. He did not apply the provisions of the A.M.A., *Guides* specifically related to carpal tunnel syndrome. The Board is unable to determine why he based his impairment rating of this condition solely on

[31] *Supra* note 7.

[32] *Id.* at 452.

[33] Docket No. 12-1061 (issued November 26, 2012).

[34] *P.M.*, Docket No. 14-1437 (issued December 18, 2014).

[35] A.M.A., *Guides* 436, Table 15-21.

Table 15-21, Peripheral Nerve Impairment, rather than applying the Entrapment Neuropathy provisions as recommended by the A.M.A., *Guides*.[36] Therefore, the medical adviser did not appropriately evaluate appellant's right carpal tunnel syndrome in accordance with the A.M.A., *Guides*.

OWCP's medical adviser also found that appellant's RSD was class 2, moderate, grade C with a default value of 20 percent.[37] He found that appellant had grade modifier 2 for functional history,[38] physical examination,[39] and clinical studies.[40] The medical adviser concluded that appellant had 20 percent impairment of the right upper extremity.

The Board notes that the medical adviser did not provide the specific diagnostic criteria for RSD requested by the A.M.A., *Guides,* and did not determine the number of objective diagnostic criteria points for this condition as required by the A.M.A., *Guides*. The Board is unable to apply the appropriate Table 15-26, CRPS: Upper Extremity Impairments, to OWCP medical adviser's findings and determine whether he reached an accurate permanent impairment calculation.[41] The Board therefore finds that the extent of appellant's permanent impairment is not in posture for decision.

On remand, OWCP should request a proper application of the delineated provisions of the A.M.A., *Guides* and issue a *de novo* decision regarding appellant's permanent impairment for schedule award purposes.

CONCLUSION

The Board finds that appellant has not established that she developed cervical disc disease as a result of her accepted employment injury. The Board further finds that appellant has not established that she sustained a recurrence of disability on or after May 27, 2010 due to her accepted employment injuries. The Board also finds that further development of the medical evidence is necessary to determine appellant's permanent impairment for schedule award purposes.

[36] *Id.* at 432, 440, Table 15-23.

[37] *Supra* note 7.

[38] *Id.* at 408, Table 15-7.

[39] *Id.* at 410, Table 15-8.

[40] *Supra* note 10.

[41] *T.J.*, Docket No. 13-751 (issued July 3, 2013); *W.B.*, Docket No. 11-088 (issued January 9, 2012).

ORDER

IT IS HEREBY ORDERED THAT the July 28, 2014 decision of Office of Workers' Compensation Programs is affirmed in part and remanded in part consistent with this decision of the Board.

Issued: August 5, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board