United States Department of Labor
Employees' Compensation Appeals Board

V.O., Appellant	)	
	)	**Docket No. 20-0287**
and	)	**Issued: June 1, 2021**
	)	
U.S. POSTAL SERVICE, SOUTH PORTLAND CARRIER ANNEX, South Portland, ME, Employer	)	

Appearances:
William Bothwell, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On November 21, 2019 appellant, through his representative, filed a timely appeal from an October 29, 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 to consider 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 issuance of the October 29, 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 his burden of proof to establish more than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On August 20, 2004 appellant, then a 37-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained left shoulder rotator cuff tendinitis due to his federal employment duties. OWCP assigned the claim OWCP File No. xxxxxx724 and accepted it for left shoulder tendinitis. It authorized diagnostic glenohumeral arthroscopy, debridement of a partial-thickness rotator cuff tear, and arthroscopic subacromial decompression with acromioplasty and resection of the distal clavicle, which occurred on November 16, 2004. Appellant returned to limited-duty work on November 30, 2004. By decision dated October 12, 2006, OWCP granted him a schedule award for 13 percent permanent impairment of his left upper extremity.

On December 31, 2007 appellant, then a 41-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 24, 2007 he injured his left arm, sustained a ring finger sprain and fracture below his left thumb, and experienced left elbow and shoulder pain when he slipped on ice as he climbed back into his truck while in the performance of duty. He stopped work on December 27, 2007 and returned to work on December 31, 2007. OWCP assigned the claim OWCP File No. xxxxxx023, and accepted it for left sprain of the proximal interphalangeal joint of the fourth finger, grade 1 left acromioclavicular (AC) separation, and left wrist injury/navicular fracture. On April 3, 2008 appellant returned to full-time limited-duty work. OWCP File Nos. xxxxxx724 and xxxxxxx023 have been administratively combined with the latter serving as the master file.

On July 30, 2009 appellant filed a claim for an additional schedule award (Form CA-7) and submitted medical evidence.

After further development of the medical evidence, OWCP, by decision dated February 4, 2010, denied appellant's claim for an additional schedule award, finding that the weight of the medical evidence established that he had no more than the previously awarded 13 percent permanent impairment of his left upper extremity

On January 5, 2012 appellant underwent OWCP-authorized left shoulder arthroscopy, subacromial decompression, and arthroscopic distal clavicle excision. He returned to full-time modified-duty work on March 16, 2012.

On May 11, 2012 appellant filed another Form CA-7 for an additional schedule award and submitted medical evidence in support of his claim.

After further development of the medical evidence, OWCP, by decision dated January 28, 2013, again denied appellant's schedule award claim, finding that the medical evidence of record was insufficient to establish he had greater than 13 percent permanent impairment of his left upper extremity previously awarded.

On February 4, 2013 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

On June 24, 2013 OWCP expanded the acceptance of appellant's claim to include inferior trunk plexopathy (injury to the brachial plexus).

An OWCP hearing representative, by decision dated July 30, 2013, set aside the January 28, 2018 decision and remanded the case to OWCP for further development of the medical evidence regarding the extent of appellant's left upper extremity permanent impairment.

On remand OWCP continued to develop the medical evidence.

By decision dated January 24, 2014, OWCP continued to deny appellant's claim for an additional schedule award, finding that the weight of the medical evidence established that he had no more than the previously awarded 13 percent permanent impairment of his left upper extremity. The January 24, 2014 decision was affirmed on November 3, 2014 by an OWCP hearing representative. By decision dated August 27, 2015, OWCP denied appellant's request for reconsideration pursuant to 5 U.S.C. § 8128(a).

OWCP received an August 15, 2017 report by Dr. Frank A. Graf, an attending Board-certified orthopedic surgeon.[4] Dr. Graf reviewed appellant's medical records and provided findings on physical examination. He determined that appellant had reached maximum medical improvement (MMI). Dr. Graf reiterated his prior opinion that appellant had 23 percent permanent impairment of his left upper extremity.[5] He reasoned that his examination documented residuals of the original employment-related cervical spine, left shoulder, and peripheral nerves injuries with ongoing permanent impairment. Dr. Graf disagreed with the opinion of an OWCP district medical adviser (DMA) regarding the use of electromyogram/nerve conduction velocity (EMG/NCV) studies in rating permanent impairment. He maintained that such studies should not be used rigidly as they have high specificity when positive, but low sensitivity and did not reflect the multi-focal nature of the ongoing nerve dysfunction present in appellant at both the spinal nerve root, brachial plexus, and peripheral nerve.

On September 12, 2017 appellant continued to file a Form CA-7 for an additional schedule award.

OWCP, by development letter dated September 21, 2017, advised appellant that no medical evidence had been submitted in support of his schedule award claim. It requested that he submit a report from his treating physician addressing whether he had reached MMI and evaluating the

[4] The Board notes that Dr. Graf previously served as an OWCP referral physician and submitted reports dated June 5 and July 3, 2012 and October 23 and December 19, 2013. On September 7, 2012 OWCP found a conflict in the medical opinion evidence between Dr. Graf who opined that appellant had 23 percent permanent impairment of the left upper extremity and an OWCP DMA who opined that appellant had 12 percent permanent impairment of the same extremity and referred him for an impartial medical examination.

[5] In his June 5 and July 3, 2012 reports, Dr. Graf determined that appellant had 12 percent permanent impairment of his left upper extremity under the ROM rating method and12 percent permanent impairment of the same extremity under the diagnosis-based impairment (DBI) rating method based on a diagnoses of neural stretch injuries to the inferior trunk of the brachial plexus and C8 spinal nerve root. He combined the range of motion (ROM) and DBI impairment ratings which yielded 23 percent permanent impairment of the left upper extremity.

extent of permanent impairment, if any, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[6] OWCP afforded appellant 30 days to submit the necessary evidence.

By letter dated November 2, 2017, OWCP requested that Dr. Graf provide a medical report which included an impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the requested evidence.

In response, Dr. Graf related in a November 13, 2017 letter that his prior opinion on appellant's permanent impairment was based on the sixth edition of the A.M.A., *Guides* and his rating of 23 percent impairment of his left upper extremity remained unchanged.

On January 2, 2018 OWCP referred appellant, together with a statement of accepted facts (SOAF) and the medical record, to Dr. Lawrence M. Leonard, a Board-certified orthopedic surgeon, for a second opinion impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*.

On February 12, 2018 OWCP again expanded the acceptance of appellant's claim to include injury to brachial plexus.

In a February 27, 2018 letter, Dr. Leonard reviewed appellant's medical records and noted examination findings. He diagnosed left shoulder arthrosis and bursitis. Dr. Leonard opined that appellant had reached MMI on April 26, 2012, the date that Dr. Vincent P. Herzog, an attending Board-certified physiatrist, opined that appellant could perform regular-duty work and his normal activities. Utilizing the DBI rating method found at Table 15-5 on page 403 of the A.M.A., *Guides*, he noted that appellant had a class of diagnosis (CDX) of 1 for distal clavicle resection. He had a *Quick*DASH score of 57.5. Dr. Leonard assigned a grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 2, and a grade modifier for clinical studies (GMCS) of 2. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) which resulted in a net adjustment of grade E, 12 percent permanent impairment of the left upper extremity. Dr. Leonard also utilized the ROM rating method and found that, under Table 15-34 on page 475, 90 degrees of flexion yielded 9 percent permanent impairment, 30 degrees of extension yielded 1 percent permanent impairment, 95 degrees of abduction yielded 3 percent permanent impairment, 30 degrees of adduction yielded 3 percent permanent impairment, 80 degrees of internal rotation yielded 0 percent permanent impairment, and 85 degrees of external rotation yielded 0 percent permanent impairment, totaling 14 percent permanent impairment of the left upper extremity with a grade modifier 2. He then found that, under Table 15-3, a 14 percent left upper extremity rating was consistent with a grade 2 modifier, and accordingly no modification of the permanent impairment was indicated. Next, Dr. Leonard utilizing Table 15-36 adjusted the impairment rating using the grade modifier 2 for GMFH by 1.4 percent (10 percent x 14 percent or 1.4), 1 percent + 14 percent or 15 percent left upper extremity permanent impairment. He explained that as the ROM method resulted in a higher rating than the DBI method, the ROM calculation should be used. Dr. Leonard noted that appellant had previously received a schedule for 13 percent permanent impairment of his left upper extremity and advised that he was entitled

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

to an additional schedule award for 2 percent permanent impairment due to his October 2000 employment injury.

On December 11, 2018 OWCP referred the medical evidence and a SOAF to Dr. David J. Slutsky, a Board-certified orthopedic surgeon serving as a DMA for OWCP, to review the findings in the February 27, 2018 report by Dr. Leonard and evaluate appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. In a December 30, 2018 report, the DMA utilized the DBI rating method under Table 15-5 on page 403 and determined that a CDX of 1 for left distal clavicle resection represented a class 1 impairment with a default value of 10 percent. He assigned a GMFH of 3 due to moderate shoulder pain and a *Quick*DASH score of 57.5, under Table 15-7 on page 406. The DMA assigned a GMPE of 1 due to mild tenderness to palpation posteriorly, under Table 15-8 on page 408. He assigned a GMCS of 1 due an inconclusive March 15, 2010 magnetic resonance imaging (MRI) scan and x-rays consistent with AC joint separation on December 27, 2007, under Table 15-9 on page 410. The DMA applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (2 - 1) + (2 - 1) = 0, resulting in a class 1, grade C, 10 percent permanent impairment of the left upper extremity. Additionally, he utilized the ROM rating method to determine permanent impairment to the left upper extremity and found that, under Table 15-34 on page 475, 90 degrees of flexion yielded 3 percent permanent impairment, 30 degrees of extension yielded 1 percent permanent impairment, 95 degrees of abduction yielded 3 percent permanent impairment, 20 to 30 degrees of adduction yielded 1 percent permanent impairment, 80 degrees of internal rotation yielded 0 percent permanent impairment, and 85 degrees of external rotation yielded 0 percent permanent impairment, totaling 8 percent permanent impairment of the left upper extremity. The DMA determined that, under Table 15-36 on page 477, a grade modifier 1 for 12 percent left upper extremity ROM permanent impairment rating. He found a net modifier of 2 for GMFH under the same table. The DMA multiplied 10 percent impairment by 8 percent impairment, which totaled .8 percent or 9 percent permanent impairment of the left upper extremity for loss of ROM. He concluded that appellant had no additional permanent impairment. The DMA found that he reached MMI on February 27, 2018, the date of Dr. Leonard's impairment evaluation. He noted discrepancies in Dr. Leonard's impairment ratings. The DMA indicated that Dr. Leonard awarded nine percent permanent impairment for abduction of 95 degrees, but according to Table 15-34, this represented three percent impairment.

By letter dated January 15, 2019, OWCP requested that Dr. Leonard review the DMA's December 30, 2018 findings. In a February 8, 2019 letter, Dr. Leonard agreed with the DMA's assessment that he had incorrectly calculated nine percent permanent impairment rating for 95 degrees of abduction. He noted that, according to Table 15-34, the rating should be three percent permanent impairment for the left upper extremity.

On February 25, 2019 OWCP requested that the DMA review the findings in the August 15, 2017 report by Dr. Graf. In a March 11, 2019 report, the DMA referenced findings in Dr. Graf's July 3, 2012 report in which he found that appellant had 23 percent permanent impairment of the left upper extremity based on the DBI rating method. He disagreed with Dr. Graf's 12 percent left upper extremity permanent impairment rating for a diagnosis of left distal clavicle resection, noting his determination that appellant had 10 percent left upper extremity permanent impairment based on such diagnosis under the DBI rating method and he had 9 percent left upper extremity permanent impairment under the ROM rating method. Further, the DMA noted that there was no clinical or electrodiagnostic evidence of a lower trunk plexopathy or C8

radiculopathy. The DMA indicated that Dr. Graf reported negative diagnostic test results for carpal tunnel syndrome and did not perform additional diagnostic testing to determine a diagnoses of cubital tunnel syndrome or assess upper extremity muscle strength. He noted that other diagnostic test results of record were negative for these conditions. Therefore, the DMA concluded that there was no clinical basis for the diagnosis of carpal tunnel syndrome, cubital tunnel syndrome, or a brachial plexopathy based on physical examination. He referenced page 445 of the A.M.A., *Guides* to support his opinion. The DMA determined that appellant had zero percent permanent impairment for the diagnosis of either focal neuropathy or brachial plexopathy. He disputed Dr. Graf's rationale for not using EMG/NCV studies as vague and meaningless based on his above-noted rationale. Additionally, he noted that the whole point behind using the A.M.A. *Guides* was to determine an impairment rating was to rigidly adhere to impairment criteria it laid out.

By decision dated March 28, 2019, OWCP denied appellant's claim for an additional schedule award based on the opinion of its DMA.

On April 3, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held on August 13, 2019.

By decision dated October 29, 2019, OWCP's hearing representative affirmed the March 28, 2019 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] 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 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.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] 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.[11]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

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

[10] *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 & Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[11] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

to be rated. With regard to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid) beginning on page 401. After the CDX is determined from the Shoulder Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

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).
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> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)
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> "If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow 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.
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> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[14]

[12] *See* A.M.A., *Guides* (6th ed.) 405-12. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM assessment stands alone and is not combined with a DBI rating. *Id.* at 401-05, 475-78.

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

[14] *See supra* note 10 at Chapter 2.808.6(f) (March 2017); *see D.J.*, Docket No. 19-0352 (issued July 24, 2020).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

In his December 30, 2018 report, the DMA properly calculated appellant's left upper extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* based on the clinical findings of the second opinion physician, Dr. Leonard. Utilizing the DBI rating method, under Table 15-5, page 403, the DMA found that appellant's diagnosis of left distal clavicle resection represented a CDX of 1 with a default value of 10 percent impairment. He assigned a GMFH of 3 under Table 15-7, page 406, a GMPE of 1 under Table 15-8, page 408, and a GMCS of 1 under Table 15-9, page 410. The DMA applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (2 - 1) + (2 - 1) = 0, yielding a class 1, grade C, 10 percent permanent impairment of the left upper extremity. Additionally, he utilized the ROM rating method to determine permanent impairment to the left upper extremity and found that, under Table 15-34 on page 475, 90 degrees of flexion yielded three percent permanent impairment, 30 degrees of extension yielded one percent permanent impairment, 95 degrees of abduction yielded three percent permanent impairment, 20 to 30 degrees of adduction yielded one percent permanent impairment, 80 degrees of internal rotation yielded zero percent permanent impairment, and 85 degrees of external rotation yielded zero percent permanent impairment, totaling eight percent permanent impairment of the left upper extremity. The DMA determined that, under Table 15-36 on page 477, a grade modifier 1 for 12 percent left upper extremity ROM permanent impairment rating. He found a net modifier of 2 for GMFH under the same table. The DMA multiplied 10 percent impairment by 8 percent impairment, which totaled .8 percent or 9 percent permanent impairment of the left upper extremity for loss of ROM. He concluded that appellant had no additional permanent impairment. The Board finds that the DMA correctly calculated appellant's permanent impairment utilizing both the DBI and ROM rating methods to find that he had no more than 13 percent permanent impairment of his left upper extremity for which he previously received a schedule award.

The case record contains reports of Dr. Graf, appellant's attending physician, and Dr. Leonard, the second opinion physician, which includes higher impairment rating calculations for the left upper extremity, but the Board finds that their impairment rating analysis are of little probative value because neither physician properly utilized the standards of the sixth edition of the A.M.A., *Guides*.[15] The DMA properly identified the deficiencies in both physicians' impairment rating analysis. He explained that Dr. Leonard, who opined in his February 27, 2018 report that appellant had 15 percent left upper extremity permanent impairment based on the ROM rating method, incorrectly found under Table 15-34 that 95 degrees of abduction yielded nine percent permanent impairment rather than three percent permanent impairment. Moreover, the Board notes that Dr. Leonard, in a subsequent report dated February 8, 2019, agreed with the DMA's assessment of his incorrect application of appellant's ROM measurement to Table 15-34.

[15] *See J.H.*, Docket No. 19-0395 (issued August 10, 2020); *N.A.*, Docket No. 19-0248 (issued May 17, 2019); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

In an August 15, 2017 report, Dr. Graf opined that appellant had 12 percent permanent impairment of his left upper extremity under the ROM rating method and 12 percent permanent impairment of the same extremity under the DBI rating method based on a diagnosis of neural stretch injuries to the inferior trunk of the brachial plexus and C8 spinal nerve root. He combined these impairment ratings which yielded 23 percent permanent impairment of the left upper extremity. The DMA disagreed with Dr. Graf's 12 percent left upper extremity permanent impairment rating for a left distal clavicle resection as he properly determined that appellant had 10 percent left upper extremity permanent impairment based on the distal clavicle resection diagnosis under the DBI rating method and he had nine percent left upper extremity permanent impairment under the ROM rating method. Further, the DMA explained that there was no clinical basis for Dr. Graf's diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, or a brachial plexopathy as he reported negative diagnostic test results for carpal tunnel syndrome and did not perform additional diagnostic testing to determine a diagnosis of cubital tunnel syndrome or assess upper extremity muscle strength. Additionally, he noted that other diagnostic test results of record were negative for these conditions. The DMA referenced page 445 of the A.M.A., *Guides* to support his opinion and opined that appellant had zero percent permanent impairment for the diagnosis of either focal neuropathy or brachial plexopathy. He disagreed with Dr. Graf's rationale for not using EMG/NCV studies as vague and meaningless based on his above-noted rationale for the importance of diagnostic testing and the purpose for using the A.M.A. *Guides* to rate impairment.

The Board finds that the DMA, Dr. Slutsky, properly applied the A.M.A., *Guides* to find that appellant had no more than 13 percent permanent impairment of the left upper extremity, for which he previously received schedule award compensation. His reports are detailed, well rationalized, and based on a proper factual background, and thus his opinion represents the weight of the medical evidence.[16] As such, the Board finds that appellant has not met his burden of proof to establish greater left upper extremity permanent impairment than what was previously awarded.

On appeal appellant's representative contends that a conflict remains in the medical opinion evidence and that the case should be remanded for referral of appellant to a referee physician to resolve the conflict. For the reasons explained above, the Board finds that the evidence of record is insufficient to establish that appellant has more than 13 percent permanent impairment of the left upper extremity.

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

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 13 percent permanent impairment of his left upper extremity, for which he previously received a schedule award.

[16] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the October 29, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 1, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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