United States Department of Labor
Employees' Compensation Appeals Board

H.C., Appellant	)	
and	)	**Docket No. 13-1333**
	)	**Issued: February 18, 2014**
U.S. POSTAL SERVICE, SOUTHEASTERN PROCESSING & DELIVERY CENTER, 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:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On May 15, 2013 appellant, through counsel, filed a timely appeal of a February 19, 2013 merit decision of the 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 over the merits of the case.

ISSUE

The issue is whether appellant established bilateral brachial plexopathy or other bilateral injuries in his upper extremities causally related to his employment, as alleged.

On appeal, appellant, through counsel contended that the record does not prove that the impartial medical examiner was properly chosen. He also contends that appellant should have been referred to a neurologist for an impartial medical examination. Counsel argued that the statement of accepted facts did not accurately portray appellant's employment duties. He also

[1] 5 U.S.C. § 8101 *et seq.*

discussed the medical evidence of record and contended that there was abundant evidence that appellant suffered from bilateral plexus and upper extremity conditions as a result of performing his repetitive employment duties.

FACTUAL HISTORY

This case has previously been before the Board. In a decision dated September 28, 2009, the Board found that the opinion of appellant's Board-certified orthopedic surgeon, Dr. Scott M. Fried, was sufficient to require further development of the record.[2] The Board noted that although Dr. Fried indicated that appellant had prior surgery on his shoulder causally related to another accepted claim,[3] he opined that it was not that surgery, but rather postsurgery motion of the shoulder, that caused the nerve damage. The Board found that Dr. Fried's report was sufficient, in the absence of any opposing medical evidence, to require further development of the record.

By letter dated November 13, 2009, appellant's counsel asked to participate in the selection of an impartial specialist, should a referral be necessary. He noted that the reason for the request was to assure that appellant received an impartial evaluation. Counsel reiterated this request repeatedly throughout the extensive history of this case.

On December 10, 2009 OWCP referred appellant to Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon, for a second opinion. In a January 5, 2010 report, Dr. Hanley diagnosed: (1) impingement syndrome, left shoulder, characterized by left shoulder strain/sprain, tenosynovitis of the biceps and arthritis of the acromioclavicular (AC) joint; and (2) ill-defined symptoms in both upper extremities consistent with ulnar neuropathy. He opined that there was no sign that appellant suffered from a work-related brachioplexus condition. Although Dr. Hanley recommended further testing, he doubted that it would show brachioplexus pathology. In response to questions from OWCP, in a March 23, 2010 letter, Dr. Hanley noted that he did not believe that the proposed brachioplexus pathology, if it existed, had anything to do with the initial case or subsequent work exposure.

In a March 10, 2010 electrodiagnostic impression, Dr. Ernest M. Baran, a Board-certified physiatrist, noted that the electrophysiologic studies supported a diffuse right brachial plexopathy and on the left side an irritative lesion of the brachial plexus. He further explained that, from the physical examination, he strongly suspected that the right arm/shoulder symptoms were the basis of a plexopathy rather than a radiculopathy, and stated that a cervical spine MRI scan study may wish to be considered to rule out that a lesion might be contributing to the upper extremity symptoms.

In a decision dated March 31, 2010, OWCP denied appellant's claim because the requirements were not met for establishing that he sustained an injury as defined by FECA. It

[2] Docket No. 09-597 (issued September 28, 2009). On January 4, 2008 appellant, then a 60-year-old mail clerk, filed an occupational disease claim (Form CA-2) for bilateral brachial plexus and a shoulder condition.

[3] OWCP No. xxxxxx973. Appellant's traumatic injury claim was accepted by OWCP for left shoulder condition, sustained on May 3, 2005, for which appellant underwent surgery on April 7, 2007. Following this surgery, he returned to light-duty work.

found that the weight of the medical evidence was represented by the report of Dr. Hanley. On April 6, 2010 appellant requested an oral hearing before an OWCP hearing representative.

In an April 5, 2010 report, Dr. Steven J. Valentino, an osteopath, diagnosed appellant with residual impingement syndrome of the shoulder, brachial plexopathy, multiple neuropathies and cervical degenerative disc disease. He believed that the majority of appellant's complaints were coming from nerve irritation in the brachial plexus as well as the neuropathies identified on his electromyogram (EMG). Dr. Valentino noted that while appellant has aggravated cervical degenerative disc disease, he believed that this was playing less of a role than brachial plexus abnormalities.

At the hearing held on July 20, 2010, appellant's counsel argued that appellant's bilateral carpal tunnel syndrome, his ulnar and brachial plexopathy and shoulder conditions should be accepted. In the alternative, he argued that a new second opinion should be required as Dr. Hanley did not provide a report with any probative value.

Appellant continued to submit reports from Dr. Fried. In a comprehensive July 26, 2010 report, Dr. Fried concluded that appellant sustained significant injury to his right and left upper extremities secondary to his work at the employing establishment. He noted that although appellant had a traumatic injury to his left shoulder in May 2005 which resulted in the need for an open operative repair in April 2007, he also sustained significant injury to both right and left upper extremities. Dr. Fried stated that the activities he performed from the repetitive reaching, grasping, pulling, pushing and lifting activities with both right and left upper extremities resulted in a cumulative trauma disorder with repetitive strains to his neck, shoulders, both elbows and forearms and hands and wrists, which resulted in traumatic neuropathies and progressive rotator cuff tendinitis. He further noted that appellant developed a progressive adhesive capsulitis at the left shoulder and rotator cuff injury on the right secondary to his work activities and an aggravation of his left shoulder May 2005 injury. Dr. Fried noted continued and progressive aggravations of appellant's bilateral upper extremity conditions including the brachial plexopathy, rotator cuff injuries right and left, and the median nerve carpal tunnel involvement secondary to the repetitive activities he performed.

By decision dated October 4, 2010, the hearing representative vacated OWCP's March 31, 2010 decision and remanded the case. He noted that Dr. Hanley did not have all of the evidence needed to form a rationalized medical opinion, and that another second opinion evaluation was necessary. The hearing representative also ordered that case file numbers xxxxxx920 and xxxxxx973 be combined.

The record contains a second opinion report by Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, dated October 4, 2010, which was requested in OWCP File No. xxxxxx973. He examined appellant on October 4, 2010 and diagnosed preexisting degenerative disease, cervical spine, left shoulder; diffuse neurologic abnormalities per available records, concerning a component of diabetic peripheral neuropathy, cannot relate, to a reasonable degree of medical certainty; relationship to left shoulder surgery; and status post left shoulder arthroscopic treatment, chronic shoulder pain, debridement of degenerative disease, impingement, biceps tenotomy, distal clavicle excision. Dr. Gordon opined that it was reasonable to relate the left shoulder sprain, biceps tenosynovitis, and left shoulder arthritis to the date of injury; but stated

that the biceps tenosynovitis and shoulder arthritis were an aggravation of underlying degenerative problems. He noted that he could not relate the neurologic issues directly to the date of injury and would defer to an opinion of a neurologist regarding this specific component. Dr. Gordon recommended a neurologic independent medical evaluation to determine if appellant's neurologic complaint was related to the date of injury or was incidental and related to chronic disease, diabetic peripheral neuropathy.

On remand, OWCP referred appellant for a second opinion examination by Dr. Steven Mandel, a Board-certified neurologist, which occurred on December 7, 2010. Dr. Mandel opined on December 8, 2010 that, based on appellant's clinical symptomatology, supported by the EMG study, his diagnosis was left brachial plexopathy, left cubital tunnel and left median neuropathy attributable to his accepted injury of May 3, 2005. He noted that supporting appellant's clinical complaints were objective physical findings and EMG findings. Dr. Mandel noted that appellant initially injured his left shoulder and that consistent with left shoulder injury was involvement of the left brachial plexus. He noted that appellant had difficulty with the use of the left arm and that may result in additional entrapments, based upon the presence of a brachial plexopathy, and therefore, the cubital tunnel and ulnar neuropathy were considered to be employment related. Dr. Mandel opined that appellant was not expected to return to a preinjury level from a neurological perspective, with the neurological sequelae of the work-related injury being permanent.

Dr. John M. Fenlin, a Board-certified orthopedic surgeon, examined appellant at the request of Dr. Fried, and treated him from February 8, 2008 through September 11, 2009 for a residual brachial plexus injury and adhesive capsulitis. Dr. Fried injected appellant with Lidocaine and Lenalog for symptomatic release and encouraged him to do his exercises more frequently for his adhesive capsulitis.

On March 24, 2011 OWCP referred appellant to Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon, for a second opinion. In a report dated April 21, 2011, Dr. Didizian noted that neurologically, appellant was intact in both upper extremities and that he ruled out any evidence of brachial plexopathy, ulnar and median nerve pathology. He opined that appellant's ongoing symptomatology could be explained on the basis of advance degenerative disease of the cervical spine. Dr. Didizian noted that appellant did have limitations of motion of the operated left shoulder and subjective complaints. He opined that, for the right shoulder, appellant had adhesive capsulitis secondary to diabetes, but that the right shoulder had no involvement as far as employment was concerned. Dr. Didizian opined that appellant did not have any repetitive-type injury based on his job. He opined that operative findings of bicipital tenosynovitis were cured by the surgery as was his left shoulder strain and sprain. Primary osteoarthritis was present at the time of surgery and is part of his genetic makeup. Dr. Didizian opined that the upper extremity symptomotology was the direct sequelae of the left shoulder surgery. He concluded that appellant did not sustain any occupational disease as a result of his employment with the employing establishment, and that his current condition was related to his left shoulder surgery, which was the accepted injury.

By decision dated May 20, 2011, OWCP denied appellant's claim for an occupational disease. By letter dated May 26, 2011, appellant, through counsel, requested a hearing.

In a decision dated August 16, 2011, OWCP's hearing representative determined that the case was not in posture for decision due to an unresolved conflict between Dr. Fried and Dr. Didizian with regard to whether appellant had brachial plexopathy and remanded the case for further development of the medical record.

In a September 26, 2011 comprehensive report, Dr. Fried noted that his first evaluation of appellant was on September 17, 2007. He discussed appellant's work duties and reviewed his treatment of appellant. Dr. Fried noted that he strongly disagreed with Dr. Didizian's reports and comments. He noted that appellant's treatment has been based on a detailed clinical history, clinical examinations, onset of clinical symptoms, operative findings, MRI scan positive finding, EMG nerve conduction studies, positive Roos' test, Hunter's test, Tinel's test and compression tests which found consistently positive findings consistent with brachial plexus injury and ongoing significant dysfunction and disability. Dr. Fried further found positive findings at shoulder and arm on left, and findings on the right consistent with appellant's clinical history and examinations showing ongoing positive dysfunction. He noted that appellant remains with ongoing dysfunction, disability and has permanent restrictions.

On September 14, 2011 OWCP referred appellant to Dr. Andrew Gelman, a Board-certified orthopedic surgeon, for an impartial medical examination. The record contains a list of previous physicians involved in the case (Form ME-M) as well as a Form ME023 -- Appointment Schedule Notification. In an October 10, 2011 report, Dr. Gelman indicated that based on his examination, he would not be able to definitively diagnose an impression of brachial plexopathy. He stated that, from an examination perspective, Tinel's above and/or below the clavicle, bilaterally, is negative, while appellant's difficulties are more so intrinsic and immediately extrinsic to both shoulders. Dr. Gelman noted that he was aware as to the various impressions per electrodiagnostic testing, but would be unable to support impressions of brachial plexopathy. He noted that the sole diagnosis that had been accepted was that of left shoulder strain and would maintain that was the sole diagnosis from May 3, 2005. Dr. Gelman did note that appellant had left shoulder residuals, and that it did appear that he had some residuals attributable to acromioclavicular (AC) joint pathology. He noted that this was further compromised by diabetes mellitus, which contributed towards the adhesive capsulitis residuals.

By decision dated December 15, 2011, OWCP denied appellant's claim. On December 21, 2011 appellant, through counsel, requested a hearing.

In a March 15, 2012 decision, OWCP's hearing representative found that the case was not in posture for decision due to deficiencies in the report of the impartial medical examiner, Dr. Gelman. She noted that Dr. Gelman did not obtain a current EMG/NCS of the upper extremities, did not adequately address the previous electrodiagnostic test results to definitively rule out the presence of bilateral brachial plexopathy, and based his conclusion concerning causal relationship solely on the May 3, 2005 traumatic injury and the accepted left shoulder condition under that claim but failed to address whether appellant's other conditions were causally related in any way to his work duties prior to the May 3, 2005 injury or the limited clerk duties he performed up until his retirement in May 2009. The hearing representative further indicated that the statement of accepted facts did not provide a description of the physical requirements of the work activities performed by appellant. She determined that a supplemental report from Dr. Gelman was necessary.

By letter dated March 29, 2012, appellant indicated that OWCP erred when it noted that he returned to light-duty work; rather that when he returned to work he performed his regular job. He noted that his supervisor refused to let others help him, and that Dr. Fried threatened to pull him off work unless he was given a suitable job assignment.

On June 14, 2012 Dr. Frank B. Sarlo, a Board-certified physiatrist, conducted motor nerve study, sensory nerve study, F-wave study and EMG study on appellant, which Dr. Sarlo found to be essentially normal. He noted no evidence to suggest entrapment of the median nerve at the wrist or elbow, no evidence to suggest ulnar nerve root entrapment at the wrist or elbow at this time in both upper extremities, no evidence to suggest ulnar nerve entrapment at the wrist or elbow, no evidence to suggest peripheral polyneuropathy in the upper extremities with the exception of mildly reduced SNAP amplitudes which is most likely due to the history of diabetes; and no evidence to suggest neurogenic thoracic outlet syndrome.

By letter dated June 18, 2012, OWCP referred appellant to Dr. Gelman for a repeat examination and supplemental opinion. The letter forwarded to appellant the entire file for review of background material.

In a June 29, 2012 report, Dr. Gelman noted that he conducted an updated physical evaluation and reviewed the medical reports, including new medical evidence. He noted that appellant had not received any active care regarding his musculoskeletal system for approximately two to three years. Dr. Gelman noted that his examination was similar, if not identical, to the one he conducted before. He reviewed Dr. Sarlo's report and determined that he noted mild features likely due to diabetes mellitus and/or thoracic outlet syndrome, and stated that such testing would be consistent with his prior evaluation as well as the current examination which would not be supportive of a brachial plexopathy of either upper extremity. Dr. Gelman stated that he was able to support a causal relationship with regard to appellant's left shoulder and the employment injury of May 3, 2005, but was otherwise unable to relate any of appellant's other difficulties to the May 3, 2005 employment injury. He further opined that, pursuant to his clinical assessment and the correlating electrodiagnostic testing of June 14, 2012, he would not be able to make the diagnosis of bilateral brachial plexus pathology. Dr. Gelman noted that appellant had disease processes attributable to attrition. He concluded that he would be supportive of Dr. Didizian's comments pertaining to no evidence of brachial plexopathy, but would not be able to support Dr. Fried's opinion. Dr. Gelman also stated that the independent objective electrophysiologic assessment of Dr. Sarlo did not identify any evidence of brachial plexopathy of either upper extremity.

In a decision issued on July 23, 2012, OWCP again denied appellant's claim because the evidence did not establish brachial plexopathy in either extremity. As it determined that there was no diagnosed condition, it did not address causal relationship.

On July 25, 2012 appellant, through counsel, requested a hearing. At the hearing held on November 29, 2012, appellant's counsel contended that Dr. Gelman was the wrong specialist as appellant should have been referred to a neurologist; that there was no proof that Dr. Gelman was properly selected as an impartial medical examiner; that the questions proposed to Dr. Gelman were misleading in that they quoted Dr. Didizian's report extensively; and that Dr. Gelman missed the point in that he is focused on the May 3, 2005 employment injury.

By decision dated February 19, 2013, an OWCP hearing representative denied appellant's claim as it found that appellant had not established that he suffered from the brachial plexus condition.

LEGAL PRECEDENT

An employee seeking compensation under FECA[4] has the burden of establishing the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence,[5] including that he or she is an "employee" within the meaning of FECA[6] and that he or she filed his or her claim within the applicable time limitation.[7] The employee must also establish that he or she sustained an injury in the performance of duty as alleged and that his or her disability for work, if any, was causally related to the employment injury.[8] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[9]

To establish that an injury was sustained in the performance of duty in a claim for occupational disease, an employee must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[10]

The medical evidence required to establish causal relationship is usually rationalized medical evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[11]

Where there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the

[4] 5 U.S.C. §§ 8101-8193.

[5] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 57 (1968).

[6] *See M.H.*, 59 ECAB 461 (2008); *Emiliana de Guzman (Mother of Elpedio Mercado)*, 4 ECAB 357, 359 (1951); *see* 5 U.S.C. § 8101(1).

[7] *R.C.*, 59 ECAB 427 (2008); *Kathryn A. O'Donnell*, 7 ECAB 227, 231 (1954); *see* 5 U.S.C. § 8122.

[8] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[9] *See Irene St. John*, 50 ECAB 521 (1999); *Michael E. Smith*, 50 ECAB 313 (1999).

[10] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

[11] *Judith A. Peot*, 46 ECAB 1036 (1995); *Ruby I. Fish*, 46 ECAB 276 (1994).

conflict in the medical evidence.[12] 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.[13]

A physician selected by OWCP to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, OWCP has developed specific procedures for the selection of impartial medical specialist designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialist will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exits between a particular physician and OWCP.[14] The Medical Management Application (MMA), which replaced the Physician Directory System (PDS), allows users to access a database of Board-certified specialist physicians and is used to schedule referee examination. The application contains an automatic and strict rotational scheduling feature to provide for consistent rotation among physicians and to record the information needed to document the selection of the physician. If an appointment cannot be scheduled in a timely manner or cannot be scheduled for some other reason such as a conflict or the physician is of the wrong specialty, the scheduler will update the application with an appropriate bypass code. Upon the entering of a bypass code, the MMA will select the next physician in the rotation.[15]

ANALYSIS

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

Initially, the Board finds that OWCP did not establish that Dr. Gelman was selected in a fair an unbiased manner. It is well established that OWCP has an obligation to verify that it selected Dr. Gelman in a fair and unbiased manner. It maintains records for this very purpose.[16] The current record includes a ME-M which listed the previous physicians involved in the case and a report of a telephone call setting the appointment. Three are no other documents, screen captures, or any other evidence to establish how the MMA system was used to select the referee physician. Board case law provides that these forms are not sufficient documentation that OWCP properly followed its selection procedures.[17] The Board has placed great importance on

[12] *K.S.*, Docket No. 12-43 (issued March 12, 2013).

[13] *Anna M. Delaney*, 53 ECAB 384 (2002).

[14] *T.T.*, Docket No. 12-736 (issued February 4, 2013).

[15] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.550.5 (December 2012); *see also J.G.*, Docket No. 13-965 (issued December 11, 2013).

[16] *J.N.*, Docket No. 13-289 (issued November 15, 2013); *M.A.*, Docket No. 07-1344 (issue February 18, 2008).

[17] *L.M.*, Docket No. 12-1396 (issued January 25, 2013); *D.A.*, Docket No. 12-311 (issued July 25, 2012); *C.P.*, Docket No. 10-1247 (issued September 28, 2011), *petition for recon. denied*, Docket No. 10-1247 (issued May 15, 2012).

the appearance as well as the fact of impartiality, and only if the selection procedures which were designed to achieve this result are scrupulously followed may the selected physician carry the special weight accorded to an impartial specialist.[18] OWCP has not met its affirmative obligation to establish that it properly followed its selection procedures.

The Board finds that counsel's arguments contesting the description of appellant's employment duties in the statement of accepted facts are without merit. OWCP was not required, under its procedure manual, to include in the statement of facts an extensive description of appellant's employment duties. In securing the opinion of a medical specialist, OWCP's procedures note that a statement of accepted facts and questions are to be prepared by the claims examiner for use by the physician.[19] Specifically, the claims examiner is required to correctly set forth the relevant facts of the case, including the employee's date of injury, age, job held when injured, the mechanism of the injury and any conditions claimed or accepted by OWCP.[20] The procedural manual also provides that appellant's employment history is not an essential issue that must be provided in a statement of facts.[21] Accordingly, the Board does not find that the statement of accepted facts was deficient.

The Board further finds that appellant should have been referred to a neurologist in addition to an orthopedic surgeon when the case was referred for an impartial medical examination. There are extensive opinions in the record that appellant has brachial plexopathy. Dr. Valentino, an osteopath, diagnosed brachial plexopathy, in addition to residual impingement syndrome of the shoulder, multiple neuropathies and cervical degenerative disc disease. Dr. Baran, a Board-certified physiatrist, noted that the electrophysiologic studies support a diffuse right brachial plexopathy and on the left an irritative lesion of the brachial plexus. Dr. Fenlin, a Board-certified orthopedic surgeon, treated appellant for brachial plexus injury. Dr. Fried, appellant's treating Board-certified orthopedic surgeon, submitted numerous medical reports wherein he indicated that appellant had progressive aggravations of his bilateral upper extremity conditions including brachial plexopathy, rotator cuff injuries and medial nerve carpal tunnel involvement. Dr. Gordon, another Board-certified orthopedic surgeon, noted that he would defer to a neurologist on the neurologic complaints of appellant. Subsequent to Dr. Gordon's opinion, Dr. Mandel, a Board-certified neurologist, diagnosed left brachial plexopathy along with left cubital tunnel and left median neuropathy. On the other hand, Drs. Hanley and Didizian, both Board-certified orthopedic surgeons and OWCP-appointed second opinion physicians, disagreed. Dr. Hanley opined that appellant did not have a work-related brachioplexus condition, although he did recommend further testing. Dr. Didizian ruled out any evidence of brachial plexopathy, ulnar and median nerve pathology. The objective tests in the record, including those discussed by Dr. Baran and those of Dr. Sarlo, are also in disagreement. The Board finds that it was necessary to refer appellant to both a Board-certified

[18] *See D.M.*, Docket No. 11-1231 (issued January 25, 2012); *D.L.*, Docket No. 11-660 (issued October 25, 2011).

[19] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statement of Accepted Facts*, Chapter 2.809.12 (October 2005).

[20] *Id*. Other information pertaining to medical treatment received the employee's personal habits and off-duty or family activities may be included as the case warrants; *see A.C.*, Docket No. 09-389 (issued October 7, 2009).

[21] Federal (FECA) Procedure Manual, *supra* note 16 at Chapter 2.809.13 (October 2005).

orthopedic surgeon and a Board-certified neurologist to resolve the conflict in the medical evidence, pursuant to 5 U.S.C. § 8123(a).

On remand, OWCP shall refer appellant to specialists in the appropriate field of medicine for impartial medical examinations. Those specialists shall be selected through the MMA, with any appropriate participation by appellant's counsel as he repeatedly requested. Following any necessary further development, OWCP shall issue a *de novo* decision on the issue of whether appellant established that he sustained bilateral brachial plexopathy or other bilateral injuries in his upper extremities, causally related to factors of his federal employment.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 19, 2013 is set aside and the case is remanded for further proceedings consistent with this opinion.

Issued: February 18, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board