United States Department of Labor
Employees' Compensation Appeals Board

E.S., Appellant	)	
and	)	**Docket No. 20-0559**
	)	**Issued: October 29, 2020**
U.S. POSTAL SERVICE, QUINCY POST OFFICE, Quincy, MA, Employer	)	

Appearances:
John DeGeneres, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On January 14, 2020 appellant, through counsel, filed a timely appeal from a December 2, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[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] Appellant timely requested oral argument pursuant to section 501.5(b) of the Board's *Rules of Procedure*. 20 C.F.R. § 501.5(b). By order dated October 26, 2020, the Board exercised its discretion and denied the request, finding that the argument on appeal could adequately be addressed in a decision based on the case record. *Order Denying Request for Oral Argument,* Docket No. 20-0559 (issued October 26, 2020).

[3] 5 U.S.C. § 8101 *et seq.*

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than 21 percent permanent impairment of his right lower extremity, for which he previously received a schedule award; and (2) whether OWCP abused its discretion in denying appellant's request for subpoenas.

FACTUAL HISTORY

OWCP accepted that on July 9, 2009 appellant, then a 63-year-old letter carrier, sustained a right hip occupational injury due to factors of federal employment. By decision dated August 5, 2009, it accepted the claim for aggravation of preexisting osteoarthritis of the right hip, but later found a permanent aggravation.

On April 21, 2009 Dr. Peter Dewire, appellant's treating physician and a Board-certified orthopedic surgeon, performed an OWCP-approved total right hip replacement.

In a March 12, 2014 report, Dr. Dewire reported that appellant was referred by his attorney for an evaluation of the left hip and knees. He reported that his examination revealed full painless range of motion of the right hip and full painless range of motion of the left hip. Dr. Dewire noted that it had been nearly four years since appellant's total right hip replacement and he was doing well postoperatively. He found that evaluation of the left hip joint revealed normal findings and radiographs also confirmed normal left hip findings.

On March 25, 2014 appellant filed a claim for a schedule award (Form CA-7). In support of his claim, he submitted a March 4, 2014 impairment evaluation from Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon. Dr. Hartunian provided right hip examination findings, noting mild discomfort at the combined flexion and rotation. He reported that the range of motion (ROM) of right hip was measured with a goniometer and performed three times with the highest range recorded which amounted to 87 degrees flexion, 8 degrees extension, 14 degrees internal rotation, 20 degrees external rotation, 27 degrees abduction, and 16 degrees adduction. Dr. Hartunian diagnosed status post right total hip replacement for end stage degenerative arthritis and determined that maximum medical improvement (MMI) had been reached. In accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*),[4] Table 16-4 on page 515, he identified the diagnosis as class 3 hip replacement, which yielded a default impairment value of 37 percent. When determining the impairment class, Dr. Hartunian noted a class 3 diagnosis was used for total hip replacement due to mild motion deficit based on the right hip ROM findings of 87 degrees flexion, 14 degrees internal rotation, and 20 degrees external rotation.[5] He discussed grade modifiers and explained that functional history (GMFH) would amount to a grade modifier of one for an antalgic limp and a mild problem for gait derangement. However, Dr. Hartunian reported that appellant's American Academy of Orthopedic Surgery (AAOS) Lower Limb Questionnaire indicated a grade three modifier due to severe deficit, explaining that the higher grade modifier should be used in the

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

[5] *Id.* at 549, Table 16-24.

calculation based on the A.M.A., *Guides*.[6] He did not assign a grade modifier for physical examination (GMPE) as it was used to determine class placement. Dr. Hartunian further explained that grade modifier for clinical studies (GMCS) was excluded from the net adjustment formula as postoperative x-rays taken at the one year follow-up merely confirmed the diagnosis. Application of the net adjustment formula amounted to no adjustment resulting in a grade C default value of 37 percent permanent impairment of the right lower extremity. Dr. Hartunian determined that MMI was reached on April 30, 2010, the date of Dr. Dewire's examination.

Following review by an OWCP district medical adviser (DMA), the case was referred to Dr. Christopher Geary, a Board-certified orthopedic surgeon, for a second opinion evaluation and opinion on permanent impairment of the right lower extremity on October 30, 2014.

In an October 30, 2014 report, Dr. Geary reported that appellant walked with a mildly antalgic gait. He noted right hip findings of 90 degrees forward flexion, 10 degrees internal rotation, and 25 degrees external rotation. Dr. Geary determined that appellant sustained a permanent aggravation of his right hip degenerative joint disease (DJD) as a result of his 2009 work-related accident. He found that utilizing Table 16-4, Hip Regional Grid, of the A.M.A., *Guides*, a diagnosis-based impairment (DBI) of total hip replacement with a good result represented a class 2 impairment value.[7] Dr. Geary assigned grade modifiers of one for GMFH, one for GMPE, and two for GMCS. Application of the net adjustment formula amounted to a net grade modifier of negative two, warranting movement two places to the left of the default value equaling 21 percent permanent impairment of the right lower extremity. Dr. Geary concluded that MMI was reached on April 30, 2010.

The file was reviewed by a DMA who agreed with Dr. Geary's rating of 21 percent permanent impairment of the right lower extremity.

In reports dated June 4, 2014 and August 30, 2015 report, Dr. Hartunian disagreed with the 21 percent impairment rating of the right hip and contended that Dr. Geary failed to provide a medical examination in accordance with the A.M.A., *Guides.*

By decision dated October 17, 2016, OWCP granted appellant a schedule award for 21 percent permanent impairment of the right lower extremity.

On November 10, 2016 appellant, through counsel, requested an oral hearing.

By decision dated June 6, 2017, a hearing representative set aside the October 17, 2016 decision and remanded the case for a referee examination due to a conflict in medical opinion between Dr. Hartunian for appellant and Dr. Geary for the government.

On remand OWCP referred appellant to Dr. John Chaglassian, a Board-certified orthopedic surgeon, for an impartial medical examination (IME) on September 6, 2017 to resolve the conflict in the case. In his September 6, 2017 report, Dr. Chaglassian reported that right hip ROM testing

[6] *Id.* at 515, Table 16-4.

[7] *Id.*

revealed 90 degrees flexion, 0 degrees extension, 30 degrees abduction, 10 degrees internal rotation in flexion, and 35 degrees external rotation in flexion. He reported that impairment was assessed based upon the need for a hip replacement with subsequent pain, limp, and loss of ROM. Dr. Chaglassian assigned a class 2 diagnosis for total hip replacement with good results. He assigned grade modifiers of one for GMFH, one for GMPE, and one for GMCS. Following application of the net adjustment formula, Dr. Chaglassian determined that a class 2 grade A diagnosis for total right hip replacement amounted to 21 percent permanent impairment of the right lower extremity.[8]

By decision dated October 4, 2017, OWCP denied entitlement to a schedule award greater than the 21 percent permanent impairment of the right lower extremity previously received.

On October 16, 2017 appellant, through counsel, requested an oral hearing.

By decision dated June 6, 2018, an OWCP hearing representative set aside the October 4, 2017 decision and remanded the case for further development. The hearing representative requested that Dr. Chaglassian provide a supplemental report with additional rationale explaining his calculations, and further instructed that the report of the referee physician should be reviewed by a DMA to determine the A.M.A., *Guides* were properly applied to his examination findings.

On June 13, 2018 Dr. Chaglassian's report was reviewed by a DMA who opined that the ROM findings amounted to mild motion impairment for assignment of a class 3 diagnosis for total right hip arthroplasty with a fair result, amounting to 37 percent permanent impairment of the right lower extremity.

In a June 18, 2018 report, Dr. Chaglassian reviewed the DMA's recommendation and revised his impairment rating to 37 percent permanent impairment of the right lower extremity. He found that the ROM findings for flexion and internal rotation qualified as mild motion impairment, which justified a class 3 diagnosis for total right hip replacement with fair result.

On July 6, 2018 a DMA reviewed Dr. Chaglassian's June 18, 2018 report and revised his prior assessment, noting that the class 3 diagnosis for total hip replacement would actually amount to 31 percent permanent impairment of the right lower extremity. He explained that application of the grade modifiers in the net adjustment formula warranted movement two places to the left of the grade C default value to grade A.

Following the DMA's July 6, 2018 report, OWCP requested clarification from Dr. Chaglassian pertaining to his impairment rating. In an August 8, 2018 report, Dr. Chaglassian revised his impairment rating back to 21 percent permanent impairment of the right lower extremity.

By decision dated August 14, 2018, OWCP denied an increased schedule award finding that appellant had previously been granted a schedule award for 21 percent permanent impairment of the right lower extremity, and that the special weight of medical evidence rested with

[8] *Id.*

Dr. Chaglassian, serving as the referee physician, who indicated that appellant had no more than 21 percent permanent impairment of the right lower extremity.

By decision dated December 3, 2018, OWCP's hearing representative set aside the August 14, 2018 decision and remanded the case for further development. She determined that Dr. Chaglassian failed to adequately resolve the conflict of medical opinion in the case and should not have been afforded the weight of the medical evidence. The hearing representative further found that Dr. Chaglassian offered conflicting opinions with regard to impairment and provided no explanation to support the difference in the impairment ratings. The case was remanded for referral to a new impartial medical examiner to resolve the conflict originally identified between Dr. Hartunian and Dr. Geary.

On remand OWCP referred appellant to Dr. Robert R. Pennell, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the continuing conflict regarding the extent of appellant's right lower extremity impairment.

In a March 14, 2019 report, Dr. Pennell provided physical examination and ROM findings using a goniometer for both the right and left hip joints while measured with appellant in the supine position in accordance with the A.M.A., *Guides*. He indicated that he had appellant use both hands to stabilize one knee as each hip was measured. Each measurement was repeated three times, and the measurements were reproducible. Dr. Pennell's examination findings indicated that in the supine position, the right hip could flex 95 degrees with slight discomfort, the left hip could flex 100 degrees, and there was no flexion contracture. He reported that passively, both hip joints allowed 30 degrees of abduction and 15 degrees of adduction. Dr. Pennell indicated that while in the prone position, the right hip measured 30 degrees of internal rotation, 35 degrees of external rotation, and five degrees of hyperextension, while the left hip measured 20 degrees of internal rotation, 30 degrees of external rotation, and 10 degrees of hyperextension.

Dr. Pennell explained that the basis of the conflict between Dr. Hartunian and Dr. Geary involved range of motion pertaining to the right hip, noting that a mild loss of ROM would result in class 3 placement while a normal ROM would result in class 2 placement of Table 16-4 of the A.M.A., *Guides*.[9] He referenced page 544 of the A.M.A., *Guides* under ROM measurements which provides that both extremities should be compared, noting that, if the contralateral joint is uninjured, it may serve as defining normal for the individual."[10] Dr. Pennell also referenced page 461 of the A.M.A., *Guides* which provides that if the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual, and any losses should be made in comparison to the opposite normal extremity.[11] He reported that neither Dr. Hartunian nor Dr. Geary examined the left hip joint with ROM measurements, which show a greater loss of motion on the left than the right. Dr. Pennell explained that when ROM measurements of both hip joints document "mild" impairment, as in appellant's case, Table 16-24 of the A.M.A., *Guides* considers it to reflect no impairment for the purposes of the rating. Therefore, he determined that

[9] *Id.*

[10] *Id.* at 544.

[11] *Id.* at 461.

appellant's right hip warranted a class 2 diagnosis for a good result of the right hip joint replacement.

Utilizing Table 16-4, Dr. Pennell assigned a class 2 impairment of the right lower extremity as a result of a total hip joint replacement with a good result, good position, stable, functional, and no loss of motion. He applied a GMFH of one due to an occasional limp, a GMPE of one due to minimal palpatory findings of mild tenderness over the trochanteric bursa, and a GMCS of zero due to no relevant findings. Utilizing the net adjustment formula warranted movement two places to the left of the default value to grade A, totaling 21 percent permanent impairment of the right lower extremity. Dr. Pennell explained that the main conflict between Dr. Geary and Dr. Hartunian centered on whether or not appellant had loss of motion of his right hip joint, which would place him in a class 2 or class 3 assignment for a right total hip replacement. In that regard, he found that neither Dr. Geary nor Dr. Hartunian followed the instructions of the A.M.A., *Guides* by examining the opposite left hip joint to include in their motion rating and impairment calculations. Dr. Pennell also noted a large difference between appellant's symptoms, the level of functioning as reported in the lower limb questionnaire that he signed on March 4, 2014, and his reported level of functioning during his current evaluation.

On May 21, 2019 Dr. Arthur Harris, a Board-certified orthopedic surgeon serving as a DMA, reviewed Dr. Pennell's report and the corresponding evidence of record for an opinion on permanent partial impairment of appellant's right lower extremity. He concurred with Dr. Pennell's assessment of 21 percent permanent impairment of the right lower extremity based on a class 2, grade A impairment for a right hip replacement arthroplasty with a good result.

By decision dated June 28, 2019, OWCP found that appellant was entitled to no more than the previously awarded schedule award for 21 percent permanent impairment of the right lower extremity.

On July 15, 2019 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. Appellant, through counsel, requested the issuance of subpoenas to compel Dr. Pennell and Dr. Katz to testify during the oral hearing. Counsel asserted that the anticipated testimony of these physicians was necessary to determine which findings formed the basis of their decision and whether the weight of the medical evidence was properly afforded to them.

In a September 16, 2019 informational letter, OWCP's hearing representative denied appellant's request for subpoenas. In denying the request, she explained that appellant had not demonstrated that evidence from Drs. Pennell and Katz could not be obtained without the use of subpoenas, including obtaining such evidence in writing if further clarification was deemed necessary to resolve the underlying issue of the present case. The hearing representative indicated that her denial of appellant's subpoena request did not constitute a formal, appealable decision, and advised that any unfavorable decision issued after the requested hearing was held would contain a specific finding on the subpoena matter.

A telephone hearing was held on October 22, 2019. Counsel asserted that it was not necessary to compare the right lower extremity to the left lower extremity and noted his bases for disagreement with Dr. Pennell's application of the A.M.A., *Guides.*

The record was held open for 30 days to allow for the submission of additional evidence.

On October 23, 2019 counsel submitted a post-hearing memorandum, a copy of a November 20, 2008 CT scan of the right hip and pelvis, and an August 4, 2009 progress report which indicated that appellant had a prior medical history of left hip osteoarthritis. The November 20, 2008 right hip and pelvis CT scan indicated that the study also provided axial images of the pelvis and left hip showing degenerative changes at the hip joint with a prominent degenerative cyst in the acetabulum.

By decision dated December 2, 2019, OWCP's hearing representative affirmed the June 28, 2019 decision finding that appellant was entitled to no more than the previously awarded schedule award for 21 percent permanent impairment of the right lower extremity. The hearing representative also finalized its prior denial of appellant's request for issuance of subpoenas to Drs. Pennell and Katz.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA and its implementing regulations 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.[12] 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.[13] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[14]

In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the hip, the relevant portion of the leg for the present case, reference is made to Table 16-4 (Hip Regional Grid) beginning on page 512.[15] After the class of diagnosis (CDX) is determined from the Hip 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).[16]

[12] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[13] 20 C.F.R. § 10.404; *L.T.*, Docket No. 18-1031 (March 5, 2019); *see also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[14] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

[15] A.M.A., *Guides* 512-15.

[16] *Id*. at 515-22.

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[17] For a conflict to arise, the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[18] Where OWCP has referred the case to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[19]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision.[20]

OWCP determined that a conflict arose between Dr. Hartunian, an attending physician, and Dr. Geary, the second opinion physician, regarding the extent of appellant's permanent impairment of the right lower extremity. It ultimately referred him to Dr. Pennell, a Board-certified orthopedic surgeon, for an impartial medical examination.

The record reflects that Dr. Hartunian calculated 37 percent permanent impairment for a total right hip replacement based on a class 3 assignment for mild motion deficits. Dr. Geary calculated 21 percent permanent impairment based on a class 2 assignment for a total right hip arthroplasty with good results. The significant difference in opinion affecting the calculation of the disparate impairment ratings of 37 and 21 percent pertained to the issue of the right hip examination findings, including whether appellant had a normal range of motion or mild motion deficits on examination of the right hip, whether he had fair or good results from surgery, and whether his impairment should be placed at a class 2 or class 3 diagnosis as a result.[21] The Board notes that the two physicians also disagreed on the application and assignment of the grade modifiers involved.

Following development of the claim, appellant was referred to Dr. Pennell for an impartial medical examination to resolve the conflict in the case. Dr. Pennell reported that neither Dr. Hartunian nor Dr. Geary examined appellant's left hip joint, which showed a greater loss of motion than on the right. Utilizing the ROM measurements of both the left and right hip, Dr. Pennell assigned a class 2 diagnosis for total right hip joint replacement with a good result, a good position that was stable, functional, and had no loss of motion. Assigning grade modifiers of one for GMFH, one for GMPE, and zero for GMCS amounted to a class 2 grade A value resulting in 21 percent permanent impairment of the right lower extremity. On May 21, 2019 Dr. Katz, serving as a DMA, reviewed Dr. Pennell's report and agreed with his rating for 21 percent permanent impairment of the right lower extremity.

[17] 5 U.S.C. § 8123(a); *A.R.*, Docket No. 18-0632 (issued October 19, 2018).

[18] *C.H.*, Docket No. 18-1065 (issued November 29, 2018).

[19] *W.M.*, Docket No. 18-0957 (issued October 15, 2018).

[20] *A.R.*, Docket No. 19-1284 (issued January 14, 2020); *D.B.*, Docket No. 18-0409 (issued October 28, 2019).

[21] *See A.I.*, Docket No. 19-0193 (issued May 1, 2019).

The Board notes that review of Dr. Hartunian and Dr. Geary's medical reports indicate that the physicians did not evaluate the left hip joint when calculating the right hip motion deficits and impairment rating. Dr. Pennell contended that the unaffected left hip joint established normal range of motion when compared to the measurements from the right hip joint. He asserted that the A.M.A., *Guides* provide that, both extremities should be compared, and if the contralateral joint is uninjured, it may serve as defining normal for the individual.[22] Dr. Pennell further asserted that, if the opposite member is not involved or previously injured, any losses should be made in comparison to the opposite normal extremity.[23] However, based on the record before the Board, it is unclear if appellant's left hip joint is unaffected such that it would be used to classify any right hip motion deficit for assignment of the class. The record reflects that, following the October 22, 2019 hearing, appellant submitted an August 4, 2009 progress report, which indicated a prior medical history of left hip osteoarthritis. He also submitted a November 20, 2008 CT scan of the right hip and pelvis, which provided axial images of the pelvis and left hip showing degenerative changes at the hip joint with a prominent degenerative cyst in the acetabulum. The Board notes that, while these documents provide support for a left hip injury, the record also contains evidence to support a contrary finding, which reflects no exiting injury or disability to the left hip. In a March 12, 2014 report, Dr. Dewire reported that appellant was referred by his attorney for an evaluation of the left hip and knees. He found that appellant had full painless range of motion of the left hip and radiographs also confirmed normal left hip findings. In this instance, it remains unclear if appellant's left hip joint measurements should be included in the impairment evaluation of the right lower extremity. Given that the stand alone measurements of the right hip could warrant assignment of a class 3 diagnosis for mild motion deficit, as indicated in Dr. Hartunian's report, OWCP must determine if the left hip joint constitutes an unaffected or uninjured extremity such that it could be used for consideration of appellant's right hip impairment rating. As such, Dr. Pennell's report cannot carry the weight of the medical evidence and serve as a basis for the schedule award.[24] Consequently, the Board finds that further development of the medical evidence is required to determine the extent of appellant's permanent impairment for schedule award purposes.[25]

The Board will, therefore, remand the case to OWCP to further develop the medical evidence as to the extent of appellant's right lower extremity permanent impairment.[26] OWCP shall determine if the right hip ROM measurements establish normal range of motion or mild motion deficit for definition of a class 2 or class 3 diagnosis for total right hip replacement, and provide a motion deficit rating based on measurements for the right hip alone. OWCP shall thereafter determine if the left hip is an uninjured or unaffected extremity, and whether left hip motion measurements should be factored into evaluation of the right hip motion deficits. Given the varying opinions provided in the application of the net adjustment formula, OWCP should also

[22] A.M.A., *Guides* 544.

[23] *Id.* at 461.

[24] *V.H.*, Docket No. 18-0848 (issued February 25, 2019).

[25] *J.M.*, Docket No. 19-0114 (issued June 12, 2019).

[26] *R.S.*, Docket No. 17-0344 (issued February 15, 2019).

request additional information pertaining to the use and assignment of grade modifiers.[27] Following such further development as deemed necessary, OWCP shall issue a *de novo* decision.[28]

LEGAL PRECEDENT -- ISSUE 2

In requesting a subpoena, a claimant must explain why the testimony is relevant to the issues in the case and why a subpoena is the best method or opportunity to obtain such evidence because there is no other means by which the testimony could have been obtained.[29] The hearing representative of OWCP's Branch of Hearings and Review has discretion to approve or deny a subpoena request.[30] Abuse of discretion is generally shown through proof of manifest error, a clearly unreasonable exercise of judgment, or actions taken which are clearly contrary to logic and probable deductions from established facts.[31]

ANALYSIS -- ISSUE 2

The Board finds that OWCP's hearing representative did not abuse her discretion when she denied appellant's subpoena requests for the testimony of Drs. Pennell and Katz. In denying the request, the hearing representative explained that appellant had not demonstrated that evidence from Drs. Pennell and Katz could not be obtained without the use of subpoenas, including obtaining such evidence in writing if further clarification was deemed necessary to resolve the underlying issue of the present case. The Board finds that there is no reason to find that the hearing representative's denial of appellant's request for subpoenas constituted an abuse of discretion under the above-noted standard.[32]

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.

CONCLUSION

The Board finds that the case is not in posture for decision with respect to the schedule award determination. The Board also finds that OWCP did not abuse its discretion in denying appellant's request for subpoenas.

[27] *M.M.*, Docket No. 18-0235 (issued September 10, 2019).

[28] *See A.P.*, Docket No. 17-0813 (issued January 3, 2018).

[29] *See* 20 C.F.R. § 10.619.

[30] *See id.*

[31] *B.M.*, Docket No. 17-1157 (issued May 22, 2018); *Gerald A. Carr*, 55 ECAB 225 (2004).

[32] *E.C.*, Docket No. 18-1808 (issued May 16, 2019).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated December 2, 2019 is affirmed, in part, and set aside, in part. The case is remanded for further proceedings consistent with this opinion.

Issued: October 29, 2020
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board