United States Department of Labor
Employees' Compensation Appeals Board

M.E., Appellant	)	
and	)	**Docket No. 23-0193**
	)	**Issued: September 25, 2023**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION, Fort Worth, TX, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On November 22, 2022 appellant, through counsel, filed a timely appeal from a November 10, 2022 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 November 10, 2022 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 greater than one percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board.[4] The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On June 2, 1986 appellant, then a 24-year-old correctional officer, filed a traumatic injury claim (Form CA-1) alleging that he sustained a left knee injury on that date when he lost his footing and landed on his left knee while in the performance of duty.[5] On July 11, 2013 OWCP accepted the claim for closed fracture of the right upper end tibia and fibula, and right injury to the peroneal nerve.

On September 5, 2013 appellant filed a claim for compensation (Form CA-7) for a schedule award. In support of his claim, he submitted a May 1, 2013 medical report from Dr. John W. Ellis, a Board-certified emergency and family medicine specialist, who diagnosed fractured right fibula, and internal derangement, traumatic arthritis and chondromalacia, and laxity of the medial collateral ligament of the right knee. Dr. Ellis opined that appellant's June 2, 1986 employment injury contributed to, aggravated, or caused the diagnosed conditions. He noted that factors of appellant's federal employment had aggravated his accepted employment injury as he continued to work until 2004. Thus, Dr. Ellis recommended that appellant file a new claim for a consequential right knee injury as of 2004 due to his accepted employment injury.

By decision dated September 9, 2013, OWCP denied appellant's schedule award claim, finding that he had not reached maximum medical improvement (MMI).

On February 11, 2015 appellant requested reconsideration.

OWCP, by decision dated April 1, 2016, affirmed in part and modified in part the September 9, 2013 decision, finding that additional medical evidence submitted established that appellant had reached MMI. However, it denied his schedule award claim, finding that the weight of the medical evidence rested with the February 5, 2016 report of Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon, serving as an OWCP second opinion physician, and March 23, 2016 report of Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), who concluded that appellant had zero percent permanent impairment of the right lower extremity.

[4] Docket No. 16-1216 (issued December 2, 2016); Docket No. 19-0452 (issued July 22, 2019).

[5] OWCP assigned the present claim OWCP File No. xxxxxx926. Appellant has a prior claim for a February 19, 1993 traumatic injury, assigned OWCP File No. xxxxxx722, accepted for lumbar disc displacement. OWCP has administratively combined these claims, with OWCP File No. xxxxxx926 designated as the master file. Appellant retired from the employing establishment on April 15, 2007.

On May 23, 2016 appellant, through counsel, appealed to the Board. By decision dated December 2, 2016,[6] the Board affirmed the April 1, 2016 decision, finding that the weight of the medical evidence of record established that appellant had no ratable permanent impairment of his right leg, causally related to his accepted employment-related conditions.

OWCP continued to receive medical evidence in 2017.

By decision dated April 3, 2018, OWCP continued to deny appellant's schedule award claim. It found that the medical evidence submitted was insufficient to establish permanent impairment of a scheduled member or function of the body, warranting a schedule award.

On April 12, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on September 17, 2018.

By decision dated November 30, 2018, an OWCP hearing representative affirmed the April 3, 2018 decision, finding that the medical evidence of record was insufficient to establish appellant's entitlement to a schedule award for his right lower extremity.

On December 26, 2018 counsel, on behalf of appellant, appealed to the Board. By decision dated July 22, 2019,[7] the Board set aside the November 30, 2018 decision. The Board determined that a conflict existed in the medical opinion evidence between Dr. Neil Allen, an attending Board-certified internist and neurologist, and Dr. Orenstein, OWCP's DMA, regarding the extent, if any, of appellant's right lower extremity permanent impairment. The Board remanded the case to OWCP for referral of appellant to an impartial medical examiner (IME), pursuant to 5 U.S.C. § 8123(a), to resolve the conflict in medical opinion evidence.

OWCP, by decision dated March 5, 2020, denied appellant's schedule award claim, finding that the special weight of the medical evidence rested with the February 5, 2020 report of Dr. Larry R. Lett, a Board-certified neurologist, selected as the IME, who determined that appellant had no permanent impairment of a scheduled member or function of the body warranting a schedule award.

On March 10, 2020 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated June 2, 2020, after preliminary review, an OWCP hearing representative vacated the March 5, 2020 decision, finding that the February 5, 2020 report of Dr. Lett, the IME, was insufficient to resolve the conflict in medical opinion. The hearing representative remanded the case for OWCP to refer appellant to a new IME.

On February 25, 2021 OWCP cancelled the impartial medical examination, and instead referred appellant to a second opinion examination, because it determined that the medical opinion evidence forming the basis for the conflict was more than a year old, thereby warranting further medical development.

[6] Docket No. 16-1216 (issued December 2, 2016).

[7] Docket No. 19-0452 (issued July 22, 2019).

On June 11, 2021 OWCP referred appellant, a statement of accepted facts (SOAF), a copy of the case record, and a series of questions, to Dr. John L. Stanton, an orthopedic surgeon, for a second opinion evaluation regarding his right lower extremity permanent impairment for schedule award purposes.

In a July 28, 2021 report, Dr. Stanton noted a history of the accepted June 2, 1986 employment injury and appellant's medical treatment. He diagnosed a treated, improved, and healed right proximal fibula fracture, and no residuals as of December 1986; and mild-to-moderate peroneal nerve sensory involvement with diminished sensation on the right small toe and lateral side of the fourth toe. Dr. Stanton utilized the diagnosis-based impairment (DBI) rating method of the sixth edition of the American Medical Association, *Guides the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[8] and referred to Table 16-3. He identified a diagnosis of proximal tibia shaft fracture, the closest diagnosis for a nondisplaced fracture with no significant objective abnormal findings at MMI, which resulted in a class of diagnosis (CDX) of Class 0 impairment and zero percent right lower extremity permanent impairment. Dr. Stanton explained that appellant had normal motion, no ligament instability on diagnostic testing or on physical examination, and no tenderness in the fracture area. Utilizing Table 16-12, he identified the diagnosis of superficial peroneal and sensory nerve deficits as a Class 1 impairment. Dr. Stanton assigned a grade modifier for functional history (GMFH) of 0 under Table 16-6 as there was no abnormal gait. He assigned a grade modifier for clinical studies (GMCS) of 0 under Table 16-8 due to normal nerve electrodiagnostic studies. Dr. Stanton did not assign a grade modifier for physical examination findings (GMPE) in accordance with section 16.4c(3)(b) on page 533 of the A.M.A., *Guides*. He determined that appellant had a grade A or one percent permanent impairment of the right lower extremity due only to peroneal nerve sensory deficit without motor involvement. Dr. Stanton advised that his abnormal sensation at the lateral aspect of the right lower extremity was inconsistent with peroneal nerve involvement but, it had been seen on several occasions in patients with spinal stenosis. He determined that appellant had reached MMI on December 2, 1986.

On September 2, 2021 OWCP routed Dr. Stanton's July 28, 2021 report, a statement of accepted facts (SOAF), and the case record to Dr. James W. Butler, a Board-certified orthopedic surgeon, serving as a DMA, for review and determination regarding appellant's right lower extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and the date of MMI.

In his October 5, 2021 report, Dr. Butler reviewed the SOAF and medical evidence of record, including Dr. Stanton's July 28, 2021 report. He found that MMI occurred on December 2, 1986. The DMA concurred with Dr. Stanton's one percent right lower extremity impairment rating.

By decision dated January 28, 2022, OWCP granted appellant a schedule award for one percent permanent impairment of the right lower extremity. The award ran for 2.88 weeks from December 2 through 22, 1986 and was based on the opinions of Dr. Stanton, OWCP's second opinion physician, and Dr. Butler, the DMA.

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

On February 3, 2022 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on May 18, 2022.

By decision dated July 21, 2022, an OWCP hearing representative affirmed the January 28, 2022 decision. The hearing representative found that the weight of the medical evidence rested with the opinion of OWCP's second opinion physician, Dr. Stanton, as supported by the opinion of the DMA, Dr. Butler.

On October 14, 2022 appellant, through counsel, requested reconsideration of the July 21, 2022 decision before OWCP. In support of the request, counsel submitted a June 22, 2022 report by Dr. Ellis, his attending family practitioner. Dr. Ellis noted a history of appellant's accepted June 2, 1986, February 19, 1993, and September 6, 2003 employment injuries. He also reviewed the medical record. Dr. Ellis noted the accepted conditions of peroneal nerve injury at the lower right leg level, initial encounter; and unspecified closed fracture of the right upper tibia, initial encounter. He provided range of motion (ROM) measurements of 50 degrees for flexion and full extension of the right knee. Utilizing the DBI rating method of the sixth edition of the A.M.A., *Guides*, at Table 16-3, page 510, Dr. Ellis identified a CDX of mild laxity of the medial collateral ligament of the right knee, which resulted in Class 1 impairment. He assigned a grade modifier for GMFH of 2, a GMPE of 3, and a GMCS of 0. Dr. Ellis utilized the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (2 - 1) + (3 - 1) + (0-1) = 2, which resulted in a grade E or 13 percent permanent impairment of the right knee. Utilizing Table 16-12 (Peripheral Nerve Impairment), page 535, he identified a CDX of common peroneal nerve as a Class 1 sensory impairment. Dr. Ellis assigned a GMFH of 2, a GMPE of 1, and a GMCS of 2. Utilizing the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (3 - 1) + (2-1) = 3, resulted in a grade D or 4 percent permanent impairment of the right knee. Dr. Ellis also identified a CDX of common peroneal nerve as a Class 3 motor impairment under Table 16-12, page 535. He assigned a GMFH of 2 due to a moderate deficit under Table 16-5, page 515, a GMPE of 3 based on severe instability of mild laxity of the MCL of the right knee under Table 16-7, page 517, and a GMCS of 0 as there were no clinical studies available under Table 16-8, pages 519-20. Dr. Ellis applied the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (1 - 1) + (3 - 1) + (2-1) = 3, which resulted in a grade A or 26 percent permanent impairment of the right knee. He then combined these impairment ratings which yielded 29 percent right lower extremity permanent impairment. Dr. Ellis combined the 13 percent impairment rating for the diagnosis of mild laxity of the medial collateral ligament of the right knee and the 29 percent combined nerve impairment rating which yielded 38 percent right lower extremity permanent impairment based on the DBI method. Additionally, he utilized the ROM method at Table 16-26, page 549, to find 35 percent permanent impairment of the right lower extremity. Dr. Ellis opined that appellant had 38 percent permanent impairment of the right lower extremity as the DBI impairment rating was greater than the 35 percent permanent impairment rating based on the ROM method. He advised that MMI was reached on the date of his impairment evaluation.

On October 18, 2022 OWCP routed Dr. Ellis' June 22, 2022 report, a SOAF, and the case record to Dr. Herbert White, Jr., a Board-certified occupational medicine specialist, serving as a DMA, for review and determination regarding appellant's right lower extremity permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and the date of MMI.

In an October 29, 2022 report, Dr. White, the DMA, reviewed the SOAF and medical record, including the June 22, 2022 report of Dr. Ellis. Utilizing the DBI rating method, he identified appellant's CDX of medial collateral cruciate ligament injury of the right knee as a Class 0 impairment under Table 16-3, page 510. The DMA noted that laxity could not be used to rate impairment due to inconsistent findings of Dr. Stanton and Dr. Ellis. He noted that Dr. Stanton's July 28, 2021 report found no ligament instability, while Dr. Ellis' June 22, 2022 report found moderate medial collateral ligament and mild anterior cruciate ligament (ACL) laxity. The DMA determined that appellant had zero percent permanent impairment of the right knee based on his medial collateral cruciate ligament injury. He also noted that the ROM method could not be used, referring to page 552 of the A.M.A., *Guides*, which stated that the ROM method was only to be used if no other approach was available for rating. The DMA related that the DBI method was clearly available to rate appellant's permanent impairment. He further identified a CDX for common peroneal nerve sensory deficit as a Class 0 impairment based on Table 16-12, page 535. The DMA noted that sensation could not be used to rate appellant's impairment based on page 517 due to the inconsistent findings of Dr. Stanton who found mildly decreased sensation while Dr. Ellis found absent sensation which was very severe. He determined that appellant had zero percent permanent sensory impairment of the right lower extremity. The DMA again referred to Table 16-12 and identified a CDX of common peroneal nerve as a Class 0 for motor impairment. Referring to page 517, he advised that motor findings could not be used to rate appellant's impairment due to inconsistent findings of Dr. Stanton who found normal strength and Dr. Ellis who found no movement against gravity. The DMA determined that appellant had zero percent right lower extremity motor impairment. He explained that the ROM method could not be used to rate appellant's CDX of common peroneal nerve because the peripheral nerve impairment grid did not contain an asterisk. The DMA concluded that MMI was reached on June 22, 2022, the date of Dr. Ellis' impairment evaluation.

By decision dated November 10, 2022, OWCP denied modification of the July 21, 2022 decision, finding that Dr. Ellis' June 22, 2022 report was insufficient to establish greater permanent impairment of appellant's right lower extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[9] and its implementing regulations[10] 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.[11] As of May 1, 2009, schedule awards are

[9] *Id.* at § 8107.

[10] 20 C.F.R. § 10.404.

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

determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[12] 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.[13]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.[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 knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[15] After the CDX is determined from the Knee 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] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[17]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[18]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical examiner/specialist) who shall make an examination.[19] In situations where the case is properly referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of

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

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

[14] A.M.A., *Guides* 3, section 1.3.

[15] *See id*. at 509-11.

[16] *Id*. at 494-531.

[17] *Id*. at 23-28.

[18] *See supra* note 12 at Chapter 2.808.6(f) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

[19] 5 U.S.C. § 8123(a); *see E.L.*, Docket No. 20-0944 (issued August 30, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[20]

ANALYSIS

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

Preliminarily, the Board notes that findings made in prior Board decisions are *res judicata* absent further review by OWCP under section 8128 of FECA. It is, therefore, unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's November 30, 2018 decision as the Board considered that evidence in its July 22, 2019 decision.[21]

OWCP referred appellant for a second opinion evaluation with Dr. Stanton on July 28, 2021. Dr. Stanton provided findings on examination of appellant's right knee and found that he had reached MMI. He determined that, under the DBI method for rating impairment appellant had zero percent permanent impairment for a CDX of proximal tibia shaft fracture, resulting in a Class 0 impairment, which was the closest diagnosis for a nondisplaced fracture with no significant objective abnormal findings at MMI, in accordance with Table 16-3. Dr. Stanton also determined that appellant had a grade A one percent permanent impairment of the right lower extremity for a CDX of superficial peroneal sensory nerve deficit, for a Class 1 impairment in accordance with Table 16-12. He concluded that appellant had one percent right lower extremity permanent impairment due to the accepted peroneal nerve sensory loss.

In accordance with its procedures,[22] OWCP properly routed the case record to its DMA, Dr. Butler. In his October 5, 2021 report, Dr. Butler concurred with Dr. Stanton's one percent right lower extremity permanent impairment rating.

OWCP also received a June 22, 2022 report from Dr. Ellis, appellant's treating physician, who determined that appellant had 38 percent right lower extremity permanent impairment based on the DBI method. Dr. Ellis referred to Table 16-3, page 510, and found that a CDX for mild laxity of the medial collateral ligament of the right knee resulted in a Class 1 impairment. He assigned a GMFH of 2, a GMPE of 3, and a GMCS of 0. Dr. Ellis applied the net adjustment formula, which resulted in a net adjustment of 2, and found that appellant had 13 percent permanent impairment of the right knee due to laxity of the medial collateral ligament. He referred to Table 16-12, page 535, and found that a CDX for sensory impairment of the common peroneal nerve resulted in a Class 1 impairment. Dr. Ellis assigned a GMFH of 2, a GMPE of 1, and a GMCS of 2. Utilizing the net adjustment formula, he found that appellant had four percent permanent sensory impairment of the right knee. Dr. Ellis again utilized Table 16-12 for a CDX common peroneal nerve motor deficit, which resulted in a Class 3 impairment. He assigned a GMFH of 2 due to a moderate deficit under Table 16-5, page 515, a GMPE of 3 based on severe

[20] *See D.M.*, Docket No. 18-0746 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

[21] *M.S.*, Docket No. 20-1095 (issued March 29, 2022); *C.D.*, Docket No. 19-1973 (issued May 21, 2020); *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

[22] *Id.*

instability of mild laxity of the MCL of the right knee Table 16-7, page 517, and a GMCS of 0. Dr. Ellis applied the net adjustment formula, which resulted in a net adjustment of 3, and found 26 percent permanent motor impairment of the right knee. He then combined the peroneal nerve impairment ratings which yielded 29 percent right lower extremity permanent impairment. Dr. Ellis combined the 13 percent impairment rating for the medial collateral ligament impairment of the right knee, and the 29 percent combined nerve impairment which yielded 38 percent right lower extremity permanent impairment based on the DBI method.

In an October 29, 2022 report, the DMA explained that in accordance with the DBI method, laxity could not be used to rate impairment of appellant's medial collateral cruciate ligament of the right knee due to inconsistent findings of Dr. Stanton, who found no ligament instability, and Dr. Ellis who found moderate medial collateral ligament and mild ACL laxity. Additionally, the DMA explained that sensory and motor findings could not be used to rate impairment of appellant's common peroneal nerve, again based on inconsistent findings of Dr. Stanton, and Dr. Ellis who found absent sensation which was very severe.

The Board finds that as noted by the DMA, Dr. Stanton and Dr. Ellis provided conflicting physical examination findings. These conflicting physical examination findings resulted in a conflict as to appellant's right lower extremity permanent impairment rating. As a conflict exists in the medical opinion evidence between OWCP's second opinion physician, and appellant's treating physician, OWCP should have referred appellant for an impartial medical evaluation.[23]

Therefore, to resolve the conflict in the medical opinion evidence regarding appellant's right lower extremity permanent impairment, the case will be remanded to OWCP for referral of appellant, the case record, and a statement of accepted facts, to a specialist in the appropriate field of medicine for an impartial medical examination. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[23] *Supra* note 20.

ORDER

IT IS HEREBY ORDERED THAT the November 10, 2022 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: September 25, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board