United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 25-0263**
	)	**Issued: March 19, 2025**
U.S. POSTAL SERVICE, CENTRAL IRVING POST OFFICE, Irving, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On September 23, 2024 appellant filed a timely appeal from a June 25, 2024 merit decision and a July 17, 2024 nonmerit 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 this case.[2]

ISSUES

The issues are: (1) whether appellant has greater than 11 percent permanent impairment of the right upper extremity, for which he previously received a schedule award; and (2) whether

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the July 17, 2024 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*.

OWCP properly denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On April 20, 2021 appellant, then a 63-year-old city carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained right-sided pain at the base of his neck traveling down into his right shoulder, forearm, elbow, and hand as a result of factors of his federal employment including use of his right hand to case mail and service mailboxes. He noted that he first became aware of his condition on February 1, 2020 and realized its relation to his federal employment on April 20, 2021. Appellant further noted that he had retired in June 2020. OWCP accepted the claim for strain of the ligaments of the cervical spine, sprain of parts of the right shoulder girdle, cervical radiculopathy, strain of the muscles and tendons of the rotator cuff of the right shoulder, impingement syndrome of the right shoulder, right shoulder primary osteoarthritis, right shoulder bursitis, cervical disc displacement, and cervical root disorders.

In a follow-up report dated June 21, 2022, Dr. Charles Willis, II, a Board-certified anesthesiologist, examined appellant for complaints of cervical and right shoulder pain. On physical examination of the cervical spine, he observed mild-to-moderate tenderness at the C6-7 paraspinals. Muscle testing involving the elbow extensors at C7 revealed no deficits. Physical examination of the right shoulder demonstrated a high shoulder and mild-to-moderate tenderness on the anterior/posterior shoulder.

In a report dated March 20, 2023, Dr. Antonio Rozier, Board-certified in physical medicine and rehabilitation, reviewed appellant's history of injury and conducted a physical examination of appellant's bilateral upper extremities. On physical examination of the right shoulder, he observed positive Apley's scratch, Hawkins, Neer's, empty can, and supraspinatus press tests. Dr. Rozier noted trigger points at the bilateral spinus capitus, scalene, supraspinatus, infraspinatus, anterior deltoid, rhomboid, and pectoralis muscles, as well as pinpoint tenderness at C4 through T3 and the right glenohumeral joint. He reviewed a magnetic resonance imaging (MRI) scan of the right shoulder obtained on May 13, 2021, which demonstrated 20 to 40 percent thickness surface and intrasubstance partial tearing of the distal supraspinatus tendon; mild subscapularis and infraspinatus tendinopathy with superimposed 10 percent thickness undersurface and intrasubstance partial tearing within the anterior two thirds of the infraspinatus; 15 percent thickness infrasubstance tearing within the distal subscapularis; glenohumeral joint effusion and osteoarthritis; subacromial and subdeltoid bursitis; sources for rotator cuff impingement including lateral acromion downsloping and acromioclavicular joint capsule hypertrophy; and sclerotic callus formation within the posterior glenoid. Dr. Rozier also reviewed an MRI scan of the cervical spine obtained on May 13, 2021, which demonstrated at C2-3 broad 1 millimeter (mm) disc protrusion/herniation with mild right neural foraminal narrowing; at C3-4 a 1 mm retrolisthesis and broad disc protrusion measuring 1.5 mm to the right, 2 mm centrally, moderate right neural foraminal narrowing, moderate-to-severe right neural foraminal narrowing and bilateral C5 nerve root impingement; at C5-6, broad disc protrusion/herniation measuring 1.5 mm to the right, 2.5 mm centrally, severe bilateral neural foraminal narrowing, and bilateral C6 nerve root impingement; at C6-7, broad disc protrusion/herniation measuring 4 mm to the right, 2 mm centrally, severe bilateral neural foraminal narrowing, and bilateral C7 nerve root impingement; and at C7-T1, a 1.5 mm disc protrusion/herniation. He diagnosed mid-cervical disc disorder with

myelopathy; sprain of the ligaments of the cervical spine; intervertebral disc stenosis of the neural canal of the cervical region; cervical spinal stenosis; strain of the muscles and tendons of the rotator cuff of the right shoulder; and cervical radiculopathy.

Dr. Rozier, utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] opined that appellant had reached maximum medical improvement (MMI) on February 27, 2023. With regard to appellant's right upper limb impairment due to spinal nerve conditions, he referred to *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Exhibit 4, Proposed Table 1 for spinal nerve impairment, noting a right C5 moderate sensory deficit. Dr. Rozier stated that under The *Guides* Newsletter, the rating began with determining the class of diagnosis (CDX) as a Class 1, Grade C impairment with a default of two percent permanent impairment. He applied a grade modifier for functional history (GMFH) adjustment of 2 for symptoms with normal activity, per Table 15-7, pg. 406 of the A.M.A., *Guides*. He applied a grade modifier for clinical studies (GMCS) of 3 due to severe pathology per Table 15-9, pg. 410 of the A.M.A., *Guides*. Using the net adjustment formula, he calculated a Class 1, Grade E impairment for the right C5 moderate sensory deficit of three percent upper extremity impairment. Using the same references and grade modifiers, he calculated a five percent upper extremity impairment for a right C6 moderate sensory deficit and a three percent upper extremity impairment for a right C7 moderate sensory deficit. Referencing the Combined Values Chart, he calculated that these upper extremity impairments based on cervical radiculopathy at C5, C6, and C7 equated to 11 percent right upper extremity impairment.

Using the diagnosis-based impairment (DBI) method for right shoulder impingement syndrome with residual loss, and referring to Chapter 15, Table 15-5, page 402 of the A.M.A., *Guides*, Dr. Rozier noted that this diagnosis began with a Class 1, Grade C default of three percent upper extremity impairment. He applied a GMFH of 1 due to symptoms with vigorous/strenuous usage per Table 15-7, page 406, a GMPE of 1 due to mild range of motion (ROM) deficits per Table 15-8, page 408, and a GMCS of 1 due to mild pathology per Table 15-8, page 410, he found a net adjustment of zero. Hence, he calculated a three percent permanent impairment of the right upper extremity for right shoulder impingement syndrome. Dr. Rozier noted that if motion loss was present, the impairment may alternately be assessed using the ROM method using Section 15.7 of the A.M.A., *Guides*. He noted flexion to 150 degrees, extension to 40 degrees, abduction to 150 degrees, adduction to 30 degrees, internal rotation to 60 degrees, and external rotation to 80 degrees. Referring to Table 15-34, page 475 of the A.M.A., *Guides*, Dr. Rozier found a net adjustment of zero and calculated a total of 10 percent upper extremity impairment using the ROM method. Referencing the Combined Values Chart, he combined the 11 percent upper extremity impairment for right cervical radiculopathy and the 10 percent upper extremity impairment using the ROM method for right shoulder impingement syndrome to arrive at a total right upper extremity impairment rating of 20 percent.

On June 1, 2023, appellant filed a claim for compensation (Form CA-7) for a schedule award.

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

On June 20, 2023, OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and the medical record, to Dr. Morley Slutsky, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review and a determination of appellant's permanent impairment for schedule award purposes.

In a July 14, 2023 report, Dr. Slutsky reviewed appellant's history of injury, the SOAF, and the medical record, including the March 20, 2023 report of Dr. Rozier. He noted that the report had found very significant bilateral cervical radiculopathy at C5, C6, and C7, but that he had not been provided with records from other providers to support that the findings were consistent. Dr. Slutsky requested that OWCP provide him with all prior medical notes to determine if the cervical radiculopathy findings were consistent between providers. He indicated that appellant's date of MMI was February 27, 2023, the date of the examination by Dr. Rozier. Referencing the A.M.A., *Guides* and *The Guides Newsletter*, Dr. Slutsky advised that the most impairing diagnosis was a partial thickness rotator cuff tear of the right shoulder with residual dysfunction and used this diagnosis in DBI calculations. Referring to Table 15-5, page 401-405 of the A.M.A., *Guides*, he calculated an upper extremity impairment of three percent.

On October 13, 2023, OWCP responded to Dr. Slutsky's request that he be provided with further medical notes from other providers to support consistent findings of significant bilateral cervical radiculopathy at C5, C6, and C7. It requested an addendum report from Dr. Slutsky to clarify his permanent impairment rating.

In a report dated October 17, 2023, Dr. Herbert White, Jr., Board-certified in occupational medicine, responded to OWCP's October 13, 2023 clarification request, noting that Dr. Slutsky was no longer available to clarify his July 14, 2023 report. He reviewed appellant's history of injury, the SOAF, and the medical record, including the March 20, 2023 report of Dr. Rozier. Dr. White noted that review of the medical record indicated inconsistencies between the physical evaluations of Dr. Willis and Dr. Rozier in that the evaluation of Dr. Willis found no motor impairment at C7 on the left, while the evaluation of Dr. Rozier found a mild motor impairment at C7 on the left. He recommended that appellant be referred for a second opinion evaluation to determine the reproducibility of Dr. Rozier's physical evaluation.

On January 9, 2024, OWCP referred appellant, along with the medical record, a SOAF, and a series of questions to Dr. George Cole, a Board-certified orthopedic surgeon, for a second opinion examination and permanent impairment ratings of the bilateral upper extremities.

In a report dated March 4, 2024, Dr. Cole reviewed the SOAF and appellant's medical record. On physical examination of the right shoulder, he noted tenderness to palpation and ROM deficits of 150 degrees of flexion compared to a normal 180 degrees, 40 degrees of extension compared to a normal 50 degrees, 110 degrees of abduction compared to a normal 170 degrees, and 40 degrees of internal rotation compared to a normal 80 degrees, as well as 70 degrees of external rotation compared to a normal 60 degrees. Dr. Cole utilized the ROM impairment rating method at Table 15-34, pg. 475, noting limitation of ROM of the right shoulder on flexion, extension, adduction, internal rotation, and external rotation constituted an 11 percent permanent impairment. In reaching this impairment rating under the ROM method, he referred to Table 15-35, page 477, noting that no grade modifiers were applied as the obtained impairment was consistent with Grade Modifier 1 and similar to the GMFH. Regarding the right shoulder, Dr. Cole

applied the DBI rating method for impingement syndrome. Referencing Table 15-5, page 401-405 of the A.M.A., *Guides*, he found that the CDX was a Class 1, Grade C impairment with a default value of one percent. Referring to Table 15-7, page 406, Dr. Cole assigned a GMFH of 1 for acute injury with residual symptoms. Referring to Table 15-8, pg. 408, he assigned a GMPE of 1 for tenderness of the right shoulder. The GMCS was not applicable as Dr. Cole had not obtained diagnostic studies at that time. Using the net adjustment formula, he calculated that appellant's percentage of permanent impairment for the right shoulder was one percent. Utilizing the standards of *The Guides Newsletter,* Dr. Cole found zero percent permanent impairment of the upper extremities as a result of cervical spinal nerve impairments, as appellant had near-normal ROM and no sensory or motor deficits of the upper extremities. He stated that appellant had reached MMI as of March 4, 2024, the date of his examination.

On June 8, 2024, Dr. White reviewed the medical record and SOAF, including the March 4, 2024 report of Dr. Cole. He applied the examination findings of Dr. Cole with reference to the A.M.A., *Guides* and *The Guides Newsletter* in his calculation of appellant's permanent impairment and concurred with Dr. Cole's calculation of permanent impairment ratings, for a right upper extremity of 11 percent for shoulder impingement using the ROM method and zero percent for cervical spine impairment. Dr. White further concurred with the March 4, 2024 date of MMI.

By decision dated June 25, 2024, OWCP granted appellant a schedule award of 11 percent permanent impairment of the right upper extremity. The award ran for 34.32 weeks from March 4 through October 30, 2024.

On July 10, 2024, appellant requested reconsideration and submitted additional evidence.

In reports dated June 11 through July 9, 2024, Drs. Amanda Jackson, Stephen Brown, and Quan Pham, chiropractors, noted diagnoses of sprain of the ligaments of the cervical spine, sprain of the right shoulder girdle, cervical radiculopathy, right shoulder rotator cuff strain, right shoulder impingement syndrome, right shoulder primary osteoarthritis, right shoulder bursitis, cervical disc displacement, and cervical root disorders.

In a follow-up report dated June 14, 2024, Dr. Robert Lowry, a physical medicine and rehabilitation specialist, examined appellant for complaints of lower back, neck, and bilateral shoulder pain. Significant changes since his previous examination were noted as mild cervical paraspinal tenderness with poor ROM. Dr. Lowry diagnosed cervical spine sprain, right shoulder sprain, cervical radiculopathy, right rotator cuff strain, right shoulder impingement, right shoulder osteoarthritis, right shoulder bursitis, cervical disc displacement, and cervical root disorder. He recommended cervical epidural steroid injection at C5-6 and continued physical therapy.

By decision dated July 17, 2024, OWCP denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[4] and its implementing regulations[5] 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[6] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[7]

It is the claimant's burden of proof to establish permanent impairment of the scheduled member or function of the body as a result of an employment injury.[8] OWCP's procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides*.[9]

In addressing 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 to be rated.[10] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by a GMFH, a GMPE, and/or a GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators

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[4] *Supra* note 1.

[5] 20 C.F.R. § 10.404.

[6] *Id*.; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] *E.D.*, Docket No. 19-1562 (issued March 3, 2020); *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[9] *Supra* note 7 at Chapter 2.808.5 (March 2017).

[10] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[11] A.M.A., *Guides* 383-492; *see also M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[12] *Id*. at 405-12. Table 15-4 and Table 15-5 also provide that, if motion loss is present for a claimant with certain diagnosed elbow and shoulder conditions, permanent impairment may alternatively be assessed using Section 15.7 (ROM impairment). Such a ROM rating stands alone and is not combined with a DBI rating. *Id*. at 398-405, 475-478.

are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology versus the ROM methodology for rating of upper extremity impairments.[14] Regarding the application of ROM or DBI 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)."[15]

The FECA Bulletin further advises:

> "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*."[16] (Emphasis in the original.)

Neither FECA, nor its implementing regulations, provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[17] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was designed for situations in which a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in OWCP's procedures.[19]

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

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

[15] *Id*.; *see also V.L*., Docket No. 18-0760 (issued November 13, 2018).

[16] *Id.*; *see also E.A.*, Docket No. 25-0036 (issued November 13, 2024).

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see S.J*., Docket No. 22-0714 (issued March 31, 2023); *C.S*., Docket No. 19-0851 (issued November 18, 2019).

[18] *Supra* note 7 at Chapter 2.808.5c(3) (March 2017).

[19] *Supra* note 7 at Chapter 3.700, Exhibit 4 (January 2010); *see also M.W*., Docket No. 20-2052 (issued May 24, 2021); *C.K*., Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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.[20]

Section 8123(a) of FECA provides in part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[21] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22]

ANALYSIS -- ISSUE 1

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

In a March 20, 2023 report, Dr. Rozier reviewed appellant's history of injury and conducted a physical examination of appellant's bilateral upper extremities. Referencing the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*, he applied grade modifiers and the net adjustment formula to find three percent upper extremity impairment for right C5 moderate sensory deficit; five percent upper extremity impairment for right C6 moderate sensory deficit; and three percent upper extremity impairment for right C7 moderate sensory deficit. Referencing the Combined Values Chart, Dr. Rozier calculated that these upper extremity impairments based on cervical radiculopathy at C5, C6, and C7 equated to 11 percent upper extremity impairment. Using the ROM method for right shoulder impingement syndrome with residual loss, and referencing the A.M.A., *Guides*, he applied grade modifiers and the net adjustment formula, calculating a total of 10 percent upper extremity impairment. Dr. Rozier then combined the 11 percent upper extremity impairment for right cervical radiculopathy and the 10 percent upper extremity impairment using the ROM method for right shoulder impingement syndrome to arrive at a total right upper extremity impairment of 20 percent.

OWCP referred appellant to Dr. Cole for a second opinion evaluation. In a report dated March 4, 2024, Dr. Cole reviewed the SOAF and appellant's medical record. Dr. Cole conducted a physical examination and obtained ROM measurements. Utilizing the standards of *The Guides Newsletter,* he found a zero percent permanent impairment of the upper extremities as a result of cervical spinal nerve impairment, as appellant had no sensory or motor deficits of the upper extremities. With reference to the sixth edition of the A.M.A., *Guides* regarding right shoulder impingement syndrome, Dr. Cole utilized the ROM impairment rating method, noting limitation of ROM of the right shoulder constituted an 11 percent permanent impairment. On June 8, 2024, Dr. White reviewed the medical record and SOAF, including the March 4, 2024 report of Dr. Cole.

[20] *Supra* note 7 at Chapter 2.808.6(f) (March 2017); *see also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, *id.*; *Frantz Ghassan*, *id.*

[21] 5 U.S.C. § 8123(a).

[22] 20 C.F.R. § 10.321; *see A.T.*, Docket No. 23-0309 (issued August 13, 2024); *R.J.*, Docket No. 23-0580 (issued April 15, 2024); *V.B.*, Docket No. 19-1745 (issued February 25, 2021); *K.C.*, Docket No. 19-1251 (issued January 24, 2020).

Dr. White applied the findings of Dr. Cole with reference to the A.M.A., *Guides* and *The Guides Newsletter* in his calculation of appellant's permanent impairment and concurred with Dr. Cole's calculation of appellant's permanent impairment rating for right upper extremity. The Board has previously explained that in evaluating permanent impairment under the A.M.A., *Guides*, and *The Guides Newsletter*, if a conflict exists in the medical opinion between appellant's treating physician and OWCP's second opinion physician, regarding appellant's physical examination findings, a conflict is created as to the degree of appellant's permanent impairment.[23]

The Board thus finds that a conflict in medical opinion exists between Dr. Rozier, appellant's treating physician, and Dr. Cole, OWCP's second opinion physician, with regard to the severity of appellant's permanent impairment of the right upper extremity, necessitating referral to an impartial medical examiner (IME) for resolution of the conflict in accordance with 5 U.S.C. § 8123(a).[24]

On remand, OWCP shall refer appellant, along with an updated SOAF and the medical record, to a specialist in the appropriate field of medicine for a reasoned opinion resolving the conflict regarding the extent of appellant's permanent impairment, in accordance with 5 U.S.C. § 8123(a).[25] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.[26]

CONCLUSION

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

[23] *J.P.*, Docket No. 23-0442 (issued August 29, 2023); *see A.D.*, Docket No. 20-0553 (issued April 19, 2021).

[24] 5 U.S.C. § 8123(a); *see also S.L.*, Docket No. 24-0522 (issued June 17, 2024); *S.G.*, Docket No. 24-0529 (issued June 12, 2024).

[25] *See S.W.*, Docket No. 22-0917 (issued October 26, 2022); *K.D.*, Docket No. 19-0281 (issued June 30, 2020).

[26] In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2024 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board. The July 17, 2024 nonmerit decision is set aside as moot.

Issued: March 19, 2025
Washington, DC

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

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board