United States Department of Labor
Employees' Compensation Appeals Board

C.M., Appellant	)	
and	)	**Docket No. 25-0196**
	)	**Issued: May 1, 2025**
U.S. POSTAL SERVICE, EDGEWOOD POST OFFICE, Columbia, SC, 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 December 18, 2024 appellant filed a timely appeal from a June 26, 2024 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 this case.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 37 percent permanent impairment of the right lower extremity, 21 percent of the left lower

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the June 26, 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*.

extremity, 15 percent of the right upper extremity, 3 percent of the left hand, and/or 7 percent of the left thumb, for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On June 13, 1996 appellant, then a 51-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on June 12, 1996 he twisted his right knee and lower back when dirt gave way, and he fell while in the performance of duty.[4] He was placed on modified duty. OWCP accepted appellant's claim for right knee sprain and lumbar sprain. On January 24, 2002 appellant stopped work. OWCP paid wage-loss compensation on the supplemental rolls effective that date, and on the periodic rolls effective October 6, 2002.

On July 16, 2002 appellant underwent OWCP-authorized right total knee replacement surgery.

By decision dated June 2, 2003, OWCP expanded the acceptance of appellant's claim to include right shoulder bicipital tenosynovitis and right shoulder strain.

On November 3, 2003 appellant underwent OWCP-authorized right shoulder arthroscopic surgery.

By decision dated May 18, 2004, OWCP granted appellant a schedule award for 37 percent permanent impairment of the right lower extremity and 15 percent permanent impairment of the right upper extremity based on the fifth edition of the American Medical Association, *Guides to the Evaluation of the Permanent Impairment*.[5] The period of the award ran for 153.36 weeks from May 16, 2004 through April 24, 2007.

On August 13, 2009 appellant underwent OWCP-authorized right shoulder arthroscopic debridement and decompression surgery.

Appellant subsequently filed a claim for compensation (Form CA-7) for an increased schedule award.

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[3] Docket No. 22-1260 (issued February 27, 2024); Docket No. 12-1259 (issued October 10, 2012).

[4] OWCP assigned the present claim OWCP File No. xxxxxx286. It subsequently accepted a May 1, 1991 occupational disease claim (Form CA-2) for left thumb flexor tendon synovitis due to factors of his federal employment. OWCP assigned that claim OWCP File No. xxxxxx345. By decision dated April 17, 2002, it granted appellant a schedule award for three percent permanent impairment of the left hand. By decision dated January 7, 2003, OWCP granted him a schedule award for seven percent permanent impairment of the left thumb. It has administratively combined OWCP File No. xxxxxx286 with OWCP File No. xxxxxx345, with the latter serving as the master file.

[5] A.M.A., *Guides* (5th ed. 2001).

By decision dated February 25, 2011, OWCP denied his claim for an increased schedule award.

On March 2, 2012, appellant requested reconsideration.

By decision dated March 12, 2012, OWCP denied appellant's reconsideration request, finding that it was untimely filed and failed to demonstrate clear evidence of error. Appellant appealed to the Board. By decision dated October 10, 2012, the Board affirmed the March 12, 2012 OWCP decision.

By decision dated October 31, 2012, OWCP expanded the acceptance of appellant's claim to include aggravation of lumbar radiculopathy.

An electromyogram and nerve conduction velocity (EMG/NCV) study dated March 29, 2019 showed evidence of sensory motor polyperipheral neuropathy of the lower extremities and evidence of right L5-S1 radiculopathy.

By decision dated October 20, 2020, OWCP expanded the acceptance of appellant's claim to include right knee arthritis and right knee medial meniscus tear.

On May 18, 2021 appellant filed a Form CA-7 for an increased schedule award.

OWCP subsequently referred appellant's claim, along with a statement of accepted facts (SOAF), the medical record, and a series of questions, to Dr. John B. Bieltz, an osteopathic physician Board-certified in orthopedic surgery, for a second opinion evaluation regarding permanent impairment of his bilateral upper and lower extremities due to his accepted June 12, 1996 employment injury in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] and *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). The October 22, 2020 SOAF provided to Dr. Bieltz did not mention the May 18, 2004 schedule award decision.

In a report dated August 11, 2021, Dr. Bieltz noted his review of the case record, including the SOAF, and recounted appellant's complaints of pain in his right knee, low back, right elbow, right shoulder, and left thumb. On examination of appellant's knees, he noted well-healed surgical scars and observed pain with direct palpation over the medial and lateral joint spaces. Active range of motion (ROM) was from 0 to 120 degrees. On examination of appellant's low back, Dr. Bieltz observed very limited forward flexion and very limited side-bending and rotation with pain. Straight leg raise testing was negative on sitting examination. Dr. Bieltz reported diminished sensation in both lower extremities. On examination of appellant's right shoulder, he observed very positive impingement sign. ROM testing of the right shoulder revealed forward flexion to 120 degrees with pain, passive ROM to 160 degrees with pain, and decreased internal and external rotation. On examination of appellant's left thumb, Dr. Bieltz noted decreased grip strength at both the right and left thumb and no obvious thenar atrophy or intrinsic wasting. He diagnosed status post right total knee replacement

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

surgery, status post left knee replacement surgery, chronic low back pain secondary to lumbar fusion, right shoulder impingement (status post three prior surgeries), and basilar joint arthritis status post ligament reconstruction and tendon interposition of the left thumb.

In response to OWCP's questions, Dr. Bieltz opined that appellant's injuries to his shoulder, neck, and low back should be added as accepted conditions to his claim. Regarding the permanent impairment rating for appellant's bilateral knee conditions, he reported that appellant had 20 percent permanent impairment of each lower extremity due to good result for ROM. Dr. Bieltz also opined that appellant had 33 percent whole person impairment for his low back fusion. Regarding appellant's cervical spine, he determined that appellant had 30 percent permanent impairment due to prior cervical spine fusion. Dr. Bieltz completed a work capacity evaluation form (Form OWCP-5c), which indicated that appellant was unable to work.

By decision dated September 10, 2021, OWCP expanded the acceptance of appellant's claim to include left and right post-traumatic shoulder arthritis, cervical and lumbar spine degenerative disc disease, facet arthrosis, cervical and lumbar stenosis, and left knee osteoarthritis.

On September 16, 2021, OWCP referred Dr. Bieltz' August 11, 2021 report, along with an updated SOAF, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as the district medical adviser (DMA), for his review.

In a September 21, 2021 report, Dr. Harris reviewed appellant's history and discussed Dr. Bieltz' examination findings. He opined that the evidence of record supported the diagnoses of status post right total knee replacement, status post right shoulder arthroscopic debridement, status post right shoulder arthroscopic chondroplasty, biceps debridement, and subacromial decompression with partial acromioplasty, status post posterior lumbar interbody fusion at L3-4-5, status-post percutaneous implantation of neurostimulator electrode ray and electrode leads, and status post left total knee arthroplasty.

Dr. Harris applied the sixth edition of the A.M.A., *Guides* and Table 1 of *The Guides Newsletter* and determined that appellant had no bilateral upper extremity permanent impairment for his cervical condition. For appellant's lumbar radiculopathy condition, Dr. Harris referenced the sixth edition of the A.M.A., *Guides* and Table 2 of *The Guides Newsletter* to determine that appellant had a Class 0 impairment for no neurologic deficit in the lower extremities, which resulted in zero percent permanent impairment for each lower extremity due to radiculopathy. For appellant's right shoulder condition, Dr. Harris indicated that under the diagnosis-based impairment (DBI) rating method, the appropriate class of diagnosis (CDX) for rotator cuff tendinitis under Table 15-5 (Shoulder Regional Grid), page 401, was a class 1E impairment, which resulted in five percent permanent impairment of the right upper extremity. He explained that there was insufficient medical evidence to calculate impairment rating utilizing the ROM rating method. For appellant's left thumb condition, Dr. Harris utilized the DBI-rating method and determined that appellant had zero percent permanent impairment. He noted that there was insufficient medical evidence to calculate impairment rating utilizing the ROM rating method. For appellant's bilateral knee conditions, Dr. Harris indicated that under the DBI-rating method, the appropriate CDX for having a good result following knee replacement arthroplasty under

Table 16-3 (Knee Regional Grid), page 511, was 2A, which resulted in 21 percent permanent impairment of each lower extremity.

On November 17, 2021 OWCP requested that the DMA clarify whether appellant's current impairment rating included his prior impairment ratings, or whether it was in addition to his prior impairment rating of 37 percent of the right lower extremity, 15 percent of the right upper extremity, 3 percent of the left hand, and 7 percent of the left thumb.

In a report dated November 22, 2021, Dr. Harris explained that there has been no increase in appellant's right and left upper extremity permanent impairment and no increase in appellant's right lower extremity permanent impairment. He reported that appellant's left lower extremity permanent impairment had increased to a total of 21 percent.

By decision dated April 12, 2022, OWCP granted appellant a schedule award for 21 percent permanent impairment of the left lower extremity. The period of the award ran for 60.48 weeks from August 11, 2021 through October 8, 2022. The award was based on the August 11, 2021 report of Dr. Bieltz and the September 21 and November 22, 2021 reports of Dr. Harris, the DMA.

Appellant appealed the April 12, 2022 decision to the Board. By decision dated February 27, 2024,[7] the Board set aside the April 12, 2022 OWCP decision, finding that Dr. Bieltz' opinion was based on a deficient SOAF in that it failed to mention appellant's previous schedule awards for his accepted injuries. The Board further found that Dr. Bieltz failed to obtain triplicate ROM measurements of appellant's upper extremities in accordance with FECA Bulletin No. 17-06.[8] The case was remanded for OWCP to refer appellant, along with an updated SOAF, the case record, and a series of questions to a new second opinion physician for a rationalized medical opinion regarding permanent impairment. Following any further development, OWCP was to issue a *de novo* decision.

On February 5, 2024 appellant filed a Form CA-7 claim for an increased schedule award due to right shoulder total replacement surgery on January 24, 2024.

In a February 8, 2024 development letter, OWCP requested additional medical evidence from appellant in support of his increased schedule award claim and afforded him 30 days for a response.

On March 20, 2024 OWCP referred appellant's claim, along with a March 12, 2024 SOAF, the case record, and a series of questions, to Dr. Glenn L. Scott, a Board-certified orthopedic surgeon, for a second opinion evaluation regarding any increased permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*. The SOAF provided to Dr. Scott listed the accepted conditions of left thumb flexor tendon synovitis, lumbar strain, right knee strain, aggravation of lumbar radiculopathy, right bicipital tenosynovitis, right shoulder strain, post-traumatic right knee osteoarthritis, right medial

[7] *Supra* note 3.

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

meniscus tear, bilateral post-traumatic shoulder arthritis, cervical and lumbar degenerative disc disease, facet arthrosis, cervical and lumbar stenosis, and left knee osteoarthritis.

In an April 15, 2024 report, Dr. Scott noted his review of the case record and updated SOAF. He listed appellant's accepted conditions, but limited his evaluation to appellant's upper and lower extremity conditions as a result of his accepted cervical and lumbar spine injuries. On examination of appellant's cervical spine, Dr. Scott noted tenderness, with no sustained paravertebral spasms. ROM included active flexion of 30 degrees and extension limited to just less than the neutral position, with 20 degrees of lateral bending. Dr. Scott found functional motor strength in the biceps and triceps and symmetrical grip. On examination of appellant's low back, he observed satisfactory alignment with no spasm or list. Straight leg raise testing was negative for acute nerve root irritation bilaterally and functional motor strength was present in the quadriceps and hamstring with some asymmetry secondary to bilateral total knee arthroplasties. Dr. Scott reported no dermatomal sensory deficit, but sensory dysesthesia on the soles of his feet in a nondermatomal pattern, more prominent on the left. He diagnosed status postoperative cervical spine decompression and fusion with mechanical pain syndrome and status postoperative lumbar decompression and fusion with postoperative mechanical pain syndrome. Dr. Scott opined that appellant had reached MMI. He explained that appellant was not experiencing any demonstrable radiculopathy or isolated spinal nerve injury affecting either his upper or lower extremities. Dr. Scott related that appellant's sensory complaints were nondermatomal and not following any specific dermatomal pattern. He opined that these symptoms were more typical of diabetic polyneuropathy than a spinal nerve injury. Dr. Scott determined that there was no impairment to the right upper extremity, left upper extremity, right lower extremity, or left lower extremity in accordance with the A.M.A., *Guides* and *The Guides Newsletter*. He concluded that other impairments secondary to the accepted employment-injury had been enumerated by other examiners.

On May 16, 2024 Dr. James Loging, a Board-certified orthopedic surgeon, responded to the February 8, 2024 development letter and listed his findings on examination of appellant's right shoulder for schedule award purposes. He noted that appellant required a total shoulder replacement for post-traumatic arthritis of the right shoulder which he attributed to the accepted employment injury. Dr. Loging found that appellant had reached MMI. On physical examination, he reported that there was extreme weakness to the right shoulder with limitations on extremes of motion with internal and external rotation, abduction, and forward flexion. Dr. Loging utilized the A.M.A., *Guides,* Table 15-5, page 405, for shoulder arthroplasty and found a class 3, grade E impairment, which equaled 46 percent permanent impairment of the right upper extremity.

On June 7, 2024 OWCP referred Dr. Scott's May 10, 2024 report, along with the medical record and an updated SOAF, to Dr. Harris, the DMA, for his review. In his June 10, 2024 report, Dr. Harris reviewed Dr. Scott's report and opined that appellant did not have any neurologic deficit in the upper extremities consistent with cervical radiculopathy consistent with the A.M.A., *Guides* and *The Guides Newsletter*. He further noted that ROM impairment was not appropriate for a diagnosis of cervical radiculopathy. Dr. Harris also opined that appellant had no neurologic deficit in the lower extremities consistent with lumbar radiculopathy in keeping with the A.M.A., *Guides* and *The Guides Newsletter*. He further noted that ROM impairment

was not appropriate for a diagnosis of lumbar radiculopathy. Dr. Harris did not review Dr. Loging's May 16, 2024 permanent impairment rating.

By decision dated June 26, 2024, OWCP denied appellant's claim for an increased schedule award.

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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guide*s as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[11] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[12]

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*.[13] Under the sixth edition, for lower extremity impairments, the evaluator identifies the impairment CDX, which is then adjusted by a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and/or a grade modifier for clinical studies (GMCS).[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15] The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory deficit, and loss of strength.[16]

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

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id*. at § 10.404(a).

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

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

[14] *Id*. at 383-492.

[15] *Id*. at 411.

[16] *J.C.*, Docket No. 21-0288 (issued July 1, 2021); *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *E.B.*, Docket No. 10-0670 (issued October 5, 2010); *Robert V. Disalvatore*, 54 ECAB 351 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see J.C., id*.; *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

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*. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities.[19]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[20] Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "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).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[21]
>
> The Bulletin further provides:
>
> "If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[22]
>
> "Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received

[18] *See* 5 U.S.C. § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[19] *Supra* note 12 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

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

[21] *Id*.

[22] *Id*.; *S.B.*, Docket No. 24-0153 (issued March 28, 2024); *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

> within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians' evaluation, the CE should route that report to the DMA for a final determination."[23]

It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment.[24]

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.[25]

ANALYSIS

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

OWCP referred appellant to Dr. Scott for a second opinion evaluation regarding permanent impairment of his bilateral upper and lower extremities due to his accepted May 30, 1997 and June 12, 1996 employment injuries in accordance with the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*. In a May 10, 2024 report, Dr. Scott noted his review of the March 12, 2024 SOAF, the case record, and appellant's accepted conditions, but limited his evaluation to the upper and lower extremity conditions as a result of his accepted cervical and lumbar spine injuries. He did not evaluate appellant's extremity ROM or other deficits due to his accepted left thumb flexor tendon synovitis, right knee strain, right bicipital tenosynovitis, right shoulder strain, post-traumatic right knee osteoarthritis, right medial meniscus tear, bilateral post-traumatic shoulder arthritis, and left knee osteoarthritis.

It is well established that a physician's opinion must be based on a complete and accurate factual and medical background. When OWCP has accepted an employment condition as occurring in the performance of duty, the physician must base his opinion on these accepted conditions.[26] Further, OWCP's procedures dictate that, when an OWCP medical adviser, second opinion specialist, or referee physician renders a medical opinion based on a SOAF, which is

[23] *Id*. *See also W.H.*, Docket No. 19-0102 (issued June 21, 2019).

[24] *R.P.*, Docket No. 25-0025 (issued December 4, 2024); *T.S.*, Docket No. 16-1406 (issued August 9, 2017); *T.S.*, Docket No. 09-1308 (issued December 22, 2009).

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

[26] *K.S.*, Docket No. 22-1011 (issued January 5, 2023); *D.T.*, Docket No. 21-1168 (issued April 6, 2022); *G.B.*, Docket No. 20-0750 (issued October 27, 2020); *T.P.*, 58 ECAB 524 (2007).

incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[27]

In the present case, OWCP erred in according the weight of the evidence to Dr. Scott's May 10, 2024 report, as he did not rely on the March 12, 2024 SOAF,[28] which noted all of appellant's accepted conditions, including the left thumb flexor tendon synovitis, right knee strain, right bicipital tenosynovitis, right shoulder strain, post-traumatic right knee osteoarthritis, right medial meniscus tear, bilateral post-traumatic shoulder arthritis, and left knee osteoarthritis in developing his impairment rating for schedule award purposes.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[29] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[30]

The case shall therefore be remanded for further development. On remand, OWCP shall refer appellant along with the medical record, an updated SOAF, and a series of questions to a new second opinion physician in the appropriate field of medicine, for an evaluation and a rationalized medical opinion regarding the extent of any increased permanent impairment, warranting a schedule award.[31] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[27] *J.Z.*, Docket No. 22-0829 (issued December 9, 2022); *M.H.*, Docket No. 21-1014 (issued July 8, 2022); *N.W.*, Docket No. 16-1890 (issued June 5, 2017); *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[28] *P.W. (J.W.)*; Docket No. 24-0713 (issued September 20, 2024); *T.J.*, Docket No. 24-0705 (issued August 28, 2024); *A.P.*, Docket No. 22-0183 (issued January 9, 2024).

[29] *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *D.G.*, Docket No. 15-0702 (issued August 27, 2015); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[30] *S.S.*, *id.*; *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[31] *See G.R.*, Docket No. 24-0791 (issued October 28, 2024); *E.L.*, Docket No. 23-0515 (issued May 8, 2024).

ORDER

IT IS HEREBY ORDERED THAT the June 26, 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.

Issued: May 1, 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