United States Department of Labor
Employees' Compensation Appeals Board

L.A., Appellant	)	
	)	**Docket No. 25-0744**
and	)	**Issued: November 19, 2025**
	)	
U.S. POSTAL SERVICE, LAMAR STATION, Memphis, TN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 30, 2025 appellant filed an appeal from a March 28, 2025 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] The Board notes that, while OWCP's March 28, 2025 letter was not accompanied by appeal rights, it constitutes a final adverse decision issued by OWCP. *K.K.*, Docket No. 19-0652 (issued September 19, 2019); *see Henry F. Dyer*, Docket No. 05-452 (issued May 13, 2005).

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that following the March 28, 2025 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 established greater than 17 percent permanent impairment of the left upper extremity, 23 percent permanent impairment of the right upper extremity, 17 percent permanent impairment of the left lower extremity, and/or 17 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On July 26, 1995 appellant, then a 44-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on July 26, 1995 he broke three ribs and suffered two collapsed lungs when he was struck by a car in the performance of duty. He stopped work on July 26, 1995. OWCP accepted the claim for three broken ribs and pulmonary collapse.[4]

By decision dated June 9, 1997, OWCP granted appellant a schedule award for 23 percent permanent impairment of the right upper extremity. This award was based on findings related to appellant's right shoulder which resulted in 17 percent permanent impairment, and right arm weakness due to C6 nerve impairment, which resulted in 6 percent permanent impairment.[5]

It subsequently expanded its acceptance of the claim to include contusions of multiple sites not otherwise classified; closed fracture of the ribs, closed fracture of the clavicle; bilateral knee sprain; old bucket handle tear of the medial meniscus, bilateral; trigger finger of the right thumb; and traumatic arthropathy of the left pelvic region and thigh.

On August 9, 2023 OWCP received a June 29, 2020 claim for compensation (Form CA-7) for a schedule award.

On September 6, 2023 OWCP prepared a statement of accepted facts (SOAF). The SOAF properly noted appellant's three work-related injuries and the conditions accepted under each claim. It also noted the authorized surgical procedures appellant had undergone.[6]

[4] OWCP assigned the present claim OWCP File No. xxxxxx557. Appellant has prior claims before OWCP. Under OWCP File No. xxxxxx935, OWCP accepted a traumatic injury claim for lumbar and neck sprains/strains. Under OWCP File No. xxxxxx231, OWCP accepted a traumatic injury claim for lumbar, neck, and right shoulder sprains/strains and multiple contusions. OWCP has administratively combined appellant's claims under OWCP File Nos. xxxxxx935, xxxxxx231, and xxxxxx557, with the later serving as the master file.

[5] By decision dated June 10, 2022, OWCP granted appellant a schedule award for eight percent permanent impairment of the lungs. By decision dated May 22, 2023, the Board affirmed OWCP's finding that appellant had no more than an eight percent permanent impairment of the lungs. Docket No. 23-0212 (issued May 22, 2023).

[6] On April 6, 2011 appellant underwent arthroscopy with debridement and removal of medial meniscus from mid to posterior horn; debridement of lateral meniscus inner perimeter tear and fraying; debridement of articular cartilage of medial and lateral compartment; and ablation and debridement of hypertrophic synovial tissue. On February 20, 2013 he underwent arthroscopy with debridement of torn medial meniscus complex tear; debridement of parrot break tear of lateral meniscus; debridement of articular cartilage and medial compartment tibial and femora articular surface; debridement of hyperemic/hypertrophic synovial tissue, medial and lateral compartments. On July 6, 2014 appellant underwent left trigger thumb release with release of the flexor tendon sheath, and tenolysis of flexor tendons.

On September 12, 2023 OWCP referred appellant, together with the case file and the SOAF, to Dr. Samuel Meredith, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation assessment of appellant's work-related conditions and any resulting permanent impairment for schedule award purposes.

In a report dated October 5, 2023, Dr. Meredith reviewed appellant's history of work-related injuries, and appellant's medical records. He noted appellant's physical examination findings. Dr. Meredith related an impression of history of multiple rib fractures and chest wall injury, resolved; cervical strain without evidence of chronic radiculopathy; right distal clavicle fracture with resultant restricted range of motion (ROM) and fracture deformity; lumbar strain without clear evidence of measurable radiculopathy; left shoulder pain and crepitus with restricted ROM; and left trigger thumb surgical release with no residual impairment. He concluded that he would provide a permanent impairment rating after receiving x-rays of appellant's hips and knees.

In an addendum dated November 21, 2023, Dr. Meredith reviewed x-ray interpretations of appellant's hips and knees, finding osteoarthritis with three-millimeter (mm) cartilage interval in all four joints. He provided a permanent impairment rating regarding appellant's hips using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] Utilizing the diagnosis-based impairment (DBI) rating, he referenced Table 16-4, Hip Regional Grid: Lower Extremity Impairments, page 514, and found that the class of diagnosis (CDX) of primary arthritis with three millimeter cartilage was a Class 1 impairment with a default value of seven percent of each hip. Dr. Meredith assigned a grade modifier for functional history (GMFH) of 1, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 1. He applied the net adjustment formula and found that appellant had 7 percent permanent impairment of each hip, utilizing the DBI methodology. Dr. Meredith also rated appellant's bilateral hips using the ROM method. He found that using the ROM method appellant had a 10 percent left hip permanent impairment and a 10 percent right hip permanent impairment.

Next, Dr. Meredith found that appellant had seven percent permanent impairment of the left lower extremity and a seven percent permanent impairment of the right lower extremity for knee arthritis. Using the DBI rating methodology, he identified the CDX as Class 1 knee arthritis with a three mm cartilage interval, which yielded a default value of seven percent impairment of each lower extremity pursuant to Table 16-3 on page 511 of the A.M.A., *Guides*. Dr. Meredith found a GMFH of 1, a GMPE of 1, and a GMCS of 1. He again applied the net adjustment formula to calculate seven percent permanent impairment of each knee. Dr. Meredith combined the 7 percent permanent impairment for each knee with the 10 percent permanent impairment of each hip to find 17 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity.

Regarding appellant's upper extremity impairment, Dr. Meredith concluded that the DBI methodology was not applicable for the diagnosis of right shoulder clavicle fracture diagnosis and obscure left shoulder diagnosis of either soft tissue or muscle and tendon. Therefore, Dr. Meredith rated appellant's bilateral shoulder impairment using the ROM method. Using Table 15-34, page 475, for the right shoulder he found that 110 degrees of abduction yielded three percent

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

impairment, 80 degrees flexion yielded three percent impairment, 20 degrees extension yielded no impairment, 60 degrees external rotation yielded no impairment, 60 degrees internal rotation yielded four percent impairment, and 20 degrees adduction yielded two percent impairment. Dr. Meredith added these findings to conclude that appellant had 12 percent permanent impairment of the right upper extremity due to loss of ROM of the right shoulder.

For the left upper extremity, Dr. Meredith found that 110 degrees of abduction yielded three percent impairment, 80 degrees of flexion yielded nine percent impairment, 20 degrees of extension yielded two percent impairment, 60 degrees of external rotation yielded no impairment, 60 degrees of internal rotation yielded two percent impairment, and 20 degrees adduction yielded one percent impairment. He totaled these findings to conclude that appellant had 17 percent permanent impairment due to loss of ROM of the left shoulder.

On December 19, 2023 OWCP forwarded the medical record, including Dr. Meredith's report and SOAF, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA).

In a December 29, 2023 report, Dr. Harris utilized the findings in Dr. Meredith's October 5, 2023 report and November 21, 2023 addendum. He summarized appellant's accepted conditions and surgical procedures. Dr. Harris applied the DBI methodology to Dr. Meredith's findings and found that appellant had five permanent impairment of his right upper extremity using Table 15-5, page 405 for a diagnosis of clavicle fracture. Utilizing the ROM methodology and Dr. Meredith's findings, he found that appellant had 17 percent permanent impairment of the right upper extremity due to loss of ROM of the right shoulder.

Addressing the left upper extremity, Dr. Harris applied the DBI methodology, he found two percent permanent impairment for a diagnosis of shoulder strain using Table 15-5, page 401. Applying ROM methodology, he again found that appellant had 17 percent permanent impairment of the left upper extremity using Table 15-34, page 475.

Next, Dr. Harris found seven percent permanent impairment of the right hip and seven percent impairment of the left hip applying the DBI for documented 3mm joint space narrowing, pursuant to Table 16-4, page 514. He found that an ROM rating was not appropriate as appellant's diagnosed right and left hip conditions did not meet any of the criteria discussed in section 16.7, page 543 for a stand-alone rating.

With respect to appellant's bilateral knee impairment, Dr. Harris applied the DBI methodology and pursuant to Table 16-3, page 509 found 10 percent permanent impairment of the right lower extremity and 10 percent permanent impairment for the left lower extremity based on a diagnosis of partial medial and lateral meniscectomy. He advised that an ROM rating was not appropriate as appellant's diagnosed knee conditions did not meet any of the criteria discussed in section 16.7, page 543 for a stand-alone rating. Utilizing the combined values table, Dr. Harris found 17 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity. Dr. Harris concluded that appellant had 17 percent right upper extremity permanent impairment, 17 percent left upper extremity permanent impairment, 17 percent right lower extremity permanent impairment, and 17 percent left lower extremity permanent impairment. He found that the date of MMI was October 5, 2023, the date of Dr. Meredith's examination.

On February 13, 2024 OWCP requested clarification from Dr. Harris. It noted that under FECA a permanent impairment rating could not be granted for impairment of the spine; however, an award could be granted for impairment of the upper or lower extremities caused by spinal nerve impairment. He was asked to provide an impairment rating pursuant to *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*). In an addendum dated February 22, 2024, Dr. Harris noted that appellant had previously been awarded 23 percent right upper extremity permanent impairment. As there was no increase in appellant's right upper extremity impairment, Dr. Harris found that appellant was not entitled to an additional schedule award for right upper extremity permanent impairment.

By decision dated September 5, 2024, OWCP granted appellant a schedule award for 17 percent permanent impairment of the left upper extremity, 17 percent permanent impairment of the left lower extremity, and 17 percent permanent impairment of the right lower extremity. It found that appellant was not entitled to an additional schedule award for his right upper extremity as he had previously been granted a schedule award for 23 percent permanent impairment for the right upper extremity. The period of the award ran for 150.96 weeks from October 5, 2023 to August 26, 2025.

On February 26, 2025 appellant alleged that the schedule award failed to address all his impacted body parts. He related that the overlapping of his right and left rib cages was very noticeable on x-rays and were problematic. Appellant asked if his rib cage was considered in his schedule award. Additionally, he explained that he sustained left shoulder and left hip injuries which are very painful.

By decision dated March 28, 2025, OWCP denied his request for modification of the September 5, 2024 schedule award decision. It informed appellant the September 5, 2024 schedule award determination had been based on all the conditions accepted in the current claim as well as the combined subsidiary claims.

LEGAL PRECEDENT

The schedule award provisions of FECA[8] and its implementing federal regulations[9] 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. Through its implementing regulations, OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11] The Board has approved the use by OWCP of the A.M.A.,

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id. See also F.S.*, Docket No. 23-1014 (issued April 10, 2024); *V.J.,* Docket No. 1789 (issued April 8, 2020); *Jacqueline S. Harris,* 54 ECAB 139 (2002); *Ronald R. Kraynak,* 53 ECAB 130 (2001).

[11] *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 2.808.5a (March 2017).

Guides for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[12]

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.[13] After the CDX is determined (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and/or GMCS.[14] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[15]

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.[16] After the CDX is determined (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and/or GMCS.[17] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[18]

Regarding the application of ROM or DBI impairment 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)."[19]

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*

[12] *F.S., supra* note 10; *M.D.,* Docket No. 20-0007 (issued May 13, 2020); *P.R.,* Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera,* 12 ECAB 348 (1961).

[13] *F.S., id.*; *N.B.,* Docket No. 22-1295 (issued May 25, 2023); *B.G.,* Docket No. 21-1052 (issue April 11, 2023); *S.L.,* Docket No. 22-0613 (issued April 4, 2023); *J.B.,* Docket No. 21-0141 (issued January 27, 2023); *M.D.,* Docket No. 16-0207 (issued June 3, 2016); *D.F.,* Docket No. 15-0664 (issued January 8, 2016).

[14] A.M.A., *Guides* 493- 553; *see id.*

[15] *Id.*

[16] *F.S., supra* note 10; *A.H.,* Docket No. 23-0335 (issued July 28, 2023); *B.B.,* Docket No. 20-1187 (issued November 18, 2021); *M.D., supra* note 13; *T.T.,* Docket No. 18-1622 (issued May 14, 2019).

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

[18] *Id.*

[19] FECA Bulletin No. 17-06 (issued May 8, 2017); *B.B., supra* note 16; *V.L.,* Docket No. 18-0760 (issued November 13, 2018).

impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[20]

The Bulletin also advises:

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[21]

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.[22]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 17 percent permanent impairment of the left upper extremity, 23 percent permanent impairment of the right upper extremity, 17 percent permanent impairment of the left lower extremity, or 17 percent permanent impairment of the right lower extremity, for which he received schedule award compensation.

In his report dated October 5, 2023, Dr. Meredith noted all of appellant's diagnosed conditions and then explained that appellant's cervical and lumbar strains did not show evidence of chronic radiculopathy, and that appellant's left trigger thumb surgical release had no residual impairment. In a supplemental report dated November 21, 2023 he rated appellant's upper and lower extremity permanent impairment. Regarding appellant's right upper extremity, Dr. Meredith found that the DBI methodology was not applicable for the diagnosis shoulder clavicle fracture. Applying the ROM methodology, he found that appellant had 110 degrees abduction, 80 degrees flexion, 20 degrees extension, 60 degrees external rotation, 60 degrees internal rotation, and 20 degrees adduction, which he concluded yielded a total right upper extremity permanent impairment rating of 12 percent.

For appellant's left upper extremity, Dr. Meredith found that the DBI methodology was not applicable for soft tissue or tendon. Applying the ROM methodology, he again found that appellant had 110 degrees abduction, 80 degrees flexion, 20 degrees extension, 60 degrees external rotation, 60 degrees internal rotation, and 20 degrees adduction, which he concluded yielded a total left upper extremity impairment of 17 percent.

[20] *Id.*

[21] *Id.*

[22] *See supra* note 10 at Chapter 2.808.6f (March 2017). *See also M.R.*, Docket No. 25-0020 (issued March 13, 2025); *D.S.,* Docket No. 20-0670 (issued November 2, 2021); *P.W.,* Docket No. 19-1493 (issued August 12, 2020); *J.T.,* Docket No. 17-1465 (issued September 25, 2019); *C.K.,* Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan,* 57 ECAB 349 (2006).

Regarding appellant's bilateral knee impairments, Dr. Meredith identified the CDX as a Class 1 impairment for primary arthritis with a three mm cartilage interval, which he found yielded a default value of seven percent using Table 16-3 on page 511. He applied a GMFH of 1, a GMPE of 1, and a GMCS of 1, which yielded seven percent impairment for each knee. Dr. Meredith found that knee ROM showed some flexion restriction, but did not pass the threshold for ROM impairment.

Regarding appellant's bilateral hip impairments, Dr. Meredith identified the CDX as a Class 1 impairment for primary arthritis with a three mm cartilage interval, which he found yielded a default value of seven percent using Table 16-4 on page 514. He thereafter calculated that appellant had 10 percent permanent impairment of each hip for loss of ROM. As the ROM methodology was greater than the DBI methodology, he found that appellant had 10 percent permanent impairment of each hip. Dr. Meredith combined the 7 percent permanent impairment for each knee with the 10 percent permanent impairment of each hip to find 17 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity.

Dr. Harris, on December 29, 2023, utilized Dr. Meredith's findings. Using the DBI method, he identified the CDX for right shoulder as Class 1 for right clavicle fracture using Table 15-5, page 405 of the A.M.A., *Guides*, which yielded a default value of five percent. Applying the ROM methodology, Dr. Harris found that appellant had 17 percent permanent impairment of the right upper extremity using Table 15-34, page 475. While Dr. Meredith had found that appellant had a 12 percent permanent impairment for loss of ROM of the right shoulder, Dr. Harris correctly found that 110 degrees of abduction yielded 3 percent impairment, 80 degrees of flexion yielded 9 percent impairment, 20 degrees of extension yielded 2 percent impairment, 60 degrees of external rotation yielded no impairment, 60 degrees of internal rotation yielded 2 percent impairment, and 20 degrees adduction yielded 1 percent impairment. He totaled these findings to conclude that appellant had 17 percent permanent impairment due to loss of ROM of the right shoulder.

Addressing the left upper extremity, Dr. Harris applied the DBI methodology, he found two percent permanent impairment for a diagnosis of shoulder strain using Table 15-5, page 401. Applying the ROM methodology, he found that appellant had 17 percent permanent impairment of the left upper extremity using Table 15-34, page 475. Dr. Harris correctly again found that 110 degrees of abduction yielded 3 percent impairment, 80 degrees of flexion yielded 9 percent impairment, 20 degrees of extension yielded 2 percent impairment, 60 degrees of external rotation yielded no impairment, 60 degrees of internal rotation yielded 2 percent impairment, and 20 degrees adduction yielded 1 percent impairment. He concluded that appellant had 17 percent permanent impairment due to loss of ROM of the left shoulder.

For the right and left hips, Dr. Harris found seven percent permanent impairment in each hip by applying the DBI methodology and using Table 16-4, page 514 for three mm arthritis. He found that ROM was not appropriate as appellant's diagnosed bilateral hip conditions did not meet any of the criteria discussed in section 16.7, page 543. Next, Dr. Harris, using the DBI methodology and using Table 16-3, page 509 found 10 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity for the diagnosis of partial medial and lateral meniscectomy in each knee. He advised that ROM was not appropriate as appellant's diagnosed knee condition did not meet any of the criteria discussed in section 16.7,

page 543. Utilizing the Combined Values Chart, Dr. Harris found 17 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity.

In an addendum dated February 22, 2024, Dr. Harris noted that since appellant had previously been awarded 23 percent right upper extremity permanent impairment, there was no increase in appellant's right upper extremity impairment. Thus, he found that appellant was not entitled to an additional schedule award for right upper extremity permanent impairment.

The Board finds that Dr. Harris properly utilized Dr. Meredith's findings to rate appellant's permanent impairment pursuant to the A.M.A., *Guides*. OWCP properly determined that appellant had not established greater than 17 percent permanent impairment of the left upper extremity, 23 percent permanent impairment of the right upper extremity, 17 percent permanent impairment of the left lower extremity, and 17 percent permanent impairment of the right lower extremity, for which he received a schedule award, based on the findings of the DMA.[23] There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.[24]

On appeal, appellant contends that he is entitled to an additional schedule award for his accepted rib condition. However, the ribs are not a scheduled member or function of the body for purposes of a schedule award under 5 U.S.C. § 8107.

Appellant may request a schedule award or increased schedule award based at any time on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased permanent impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish a greater than 17 percent permanent impairment of the left upper extremity, 23 percent permanent impairment of the right upper extremity, 17 percent permanent impairment of the left lower extremity, and 17 percent permanent impairment of the right lower extremity, for which he received schedule award compensation.

[23] *See S.W.*, Docket No. 23-0804 (issued January 2, 2024); *B.L.,* Docket No. 22-0068 (issued October 12, 2022); *J.S.,* Docket No. 19-1567 (issued April 1, 2020); *J.M.,* Docket No. 18-1334 (issued March 7, 2019).

[24] *See S.W.*, *id.*; *D.S.,* Docket No. 20-0670 (issued November 2, 2021); *D.F.,* Docket No. 17-1474 (issued January 26, 2018); *A.T.,* Docket No. 16-0738 (issued May 19, 2016).

ORDER

IT IS HEREBY ORDERED THAT the March 28, 2025 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 19, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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