United States Department of Labor
Employees' Compensation Appeals Board

L.F., Appellant	)	
and	)	**Docket No. 26-0173**
	)	**Issued: June 4, 2026**
DEPARTMENT OF VETERANS AFFAIRS, BILOXI VA MEDICAL CENTER, Biloxi, MS, 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 December 11, 2025, appellant filed a timely appeal from a December 11, 2025 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 established greater than 0 percent permanent impairment of the left upper extremity, 13 percent permanent impairment of the right upper extremity, 2

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the December 11, 2025 decision, appellant submitted additional evidence to OWCP. 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.*

percent permanent impairment of the left lower extremity, and/or 2 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[3] The facts and circumstances of the case as set forth in the Board's prior decision and prior order are incorporated herein by reference. The relevant facts are as follows.

On November 11, 2020, appellant, then a 39-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on August 6, 2020 he injured his right shoulder when he fell to the floor while performing cardiopulmonary resuscitation (CPR) in the performance of duty. On February 10, 2022, he underwent nonauthorized right shoulder arthroscopy with rotator cuff SLAP (superior labrum anterior and posterior) tear repair, implant augmentation, open biceps tenodesis, subacromial decompression, and distal clavicle resection. By decision dated June 20, 2023, OWCP accepted the claim for contusion of right knee, contusion of left knee, thoracic strain, contusion of chest wall, contusion of right wrist, and contusion of left wrist. It subsequently expanded the acceptance of the claim to include strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, strain of muscle and tendon of back wall of thorax, and contusion of right front wall of thorax.

On March 14, 2024, OWCP referred appellant, along with a statement of accepted facts (SOAF), the medical record, and a series of questions, to Dr. Simon Finger, a Board-certified orthopedic surgeon, for a second opinion examination to assess the status of his accepted conditions and work capacity.

In an April 9, 2024 medical report, Dr. Finger noted his review of the SOAF, appellant's history of injury and medical treatment. He recounted appellant's complaints of right shoulder pain, with achiness in his bilateral knees and wrists. On examination, Dr. Finger observed bilateral knee motion with a range of 0 to 130 degrees, full range of motion of the bilateral wrists and all fingers, loss of 15 degrees forward flexion and 15 degrees abduction in the right shoulder, and tenderness to resistance testing in the right rotator cuff. He opined that the accepted right shoulder conditions remained active, and that the remainder of the accepted conditions had resolved without residuals. Dr. Finger indicated that appellant had attained maximum medical improvement (MMI). He returned appellant to limited-duty work with restrictions.

On April 17, 2024, appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated July 17, 2024, OWCP denied appellant's schedule award claim as the medical evidence of record did not demonstrate a ratable permanent impairment of a scheduled member or function of the body.

[3] Docket No. 24-0272 (issued May 2, 2024).

On July 17, 2024, appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

By decision dated September 24, 2024, OWCP's hearing representative set aside the July 17, 2024 decision and remanded the case for preparation of an updated SOAF and referral to a second opinion physician for an impairment rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*), to be followed by a *de novo* decision.

On October 16, 2024, OWCP referred appellant, an updated SOAF, and the medical record to Dr. Finger for a permanent impairment evaluation according to the sixth edition of the A.M.A., *Guides*.[4]

In a December 19, 2024 report, Dr. Finger noted his review of the updated SOAF and medical record. He also noted appellant's symptoms of bilateral shoulder and knee pain with restricted motion, pain around his chest, thorax, and right wrist. On examination, Dr. Finger found full bilateral knee extension, bilateral knee flexion at 120 degrees. He observed very mild impingement of the right shoulder. Dr. Finger obtained three trials of range of motion measurements for the bilateral shoulders of 140 degrees flexion, 40 degrees extension, 150 degrees abduction, and 40 degrees adduction, 30 degrees internal rotation of the right shoulder, and 50 degrees on the left; right shoulder external rotation at 40 degrees, and left shoulder external rotation at 60 degrees. He also obtained three trials of range of motion of the bilateral wrists, with flexion and extension at 70 degrees, and radial and ulnar deviation at 30 degrees. Dr. Finger opined that all accepted employment conditions had reached MMI as of that date.

Regarding the right upper extremity, Dr. Finger diagnosed a SLAP tear of the right shoulder, partial thickness rotator cuff tear, and acromioclavicular arthrosis. He noted that according to the diagnosis-based impairment (DBI) rating methodology of the A.M.A., *Guides*, it was appropriate to evaluate the acromioclavicular joint as it would yield the highest percentage of impairment. Dr. Finger referred to Table 15-5 (Shoulder Regional Grid: Upper Extremity Impairments), page 503 of the A.M.A., *Guides* to find a class of diagnosis (CDX) of 1 due to distal clavicle excision which he found yielded a 10 percent impairment of the right upper extremity. He assigned a grade modifier for functional history (GMFH) of 2 for pain with normal activities, a grade modifier for physical examination (GMPE) of 2 for palpatory findings with moderate restriction of range of motion, and no grade modifier for clinical studies (GMCS) as they were used to make the diagnosis. Dr. Finger totaled and averaged the grade modifiers to find a net modifier of two, to equal 12 percent permanent impairment of the right upper extremity. Additionally, he diagnosed a right wrist contusion. Dr. Finger referred to Table 15-3 (Wrist Regional Grid: Upper Extremity Impairments), page 395 of the A.M.A., *Guides*, and assigned a Class 1, Grade C impairment, with a default 1 percent upper extremity impairment. He assigned a GMFH of 1 for pain and symptoms with strenuous activity, and a GMPE of 1 for minimal palpatory findings, which resulted in an additional 1 percent impairment of the right upper extremity, for a total 13 percent permanent impairment of the right upper extremity.

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

Regarding the left upper extremity, Dr. Finger diagnosed left shoulder impingement syndrome, and acromioclavicular disease. He noted that the acromioclavicular joint impairment should be used to determine the impairment class as it was the most disabling condition affecting the left upper extremity. Dr. Finger referred to Table 15-5 to find a Class 1 CDX with a default of three percent impairment of the left upper extremity for a history of painful residual symptoms. He found a GMFH of 1 for pain with strenuous activity, and a GMPE of 1 for mild loss of range of motion, which resulted in three percent permanent impairment of the left upper extremity.

Regarding the bilateral lower extremities, Dr. Finger referred to Table 16-3 (Knee Regional Grid – Lower Extremity Impairments), page 509 of the A.M.A., *Guides* to find a Class 1, Grade C CDX for bilateral knee contusions, with a default two percent impairment of each lower extremity. He found a GMFH of 1 for mild problem, and a GMPE of 1 for minimal palpatory findings, which resulted in two percent impairment of each lower extremity.

Dr. Finger referred to Table 15-34 (shoulder Range of Motion), page 475 of the A.M.A., *Guides* to apply the range of motion (ROM) rating methodology to appellant's right shoulder condition. He found that 140 degrees of flexion yielded three percent impairment, 40 degrees extension yielded one percent impairment, 150 degrees abduction yielded three percent impairment, 40 degrees adduction yielded zero percent impairment, 30 degrees internal rotation yielded four percent impairment, and 40 degrees external rotation yielded four percent impairment. Dr. Finger added the 3, 1, 3, 0, 4, and 4 percent impairment to equal 15 percent permanent impairment of the right upper extremity due to restricted shoulder motion. He also found 11 percent permanent impairment of the left upper extremity due to restricted left shoulder motion. Dr. Finger noted that there was no applicable impairment for the accepted thoracic contusion, as there was no evidence of motor or sensory injury to any extremity originating in the spine.

On January 29, 2025, OWCP referred appellant's claim to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as OWCP's district medical adviser (DMA). In a February 3, 2025 report, Dr. Katz indicated that OWCP should obtain a supplemental report from Dr. Finger with an impairment rating for the accepted left wrist injury. He noted that there was no applicable impairment rating for the left shoulder as OWCP had not accepted an employment-related left shoulder condition.

On February 11, 2025, OWCP requested a supplemental report from Dr. Finger.

In a March 10, 2025 supplemental report, Dr. Finger opined that there was no ratable impairment of the left wrist under either the DBI or ROM rating methodology.

On April 9, 2025, OWCP referred appellant's claim to Dr. Katz for review of Dr. Finger's supplemental report and an impairment rating.

In a report received on April 21, 2025, Dr. Katz utilized the findings in Dr. Finger's December 19, 2024 report and March 10, 2025 supplemental report. He summarized appellant's accepted conditions and surgical procedure. Dr. Katz found that appellant had reached MMI as of December 19, 2024, the date of Dr. Finger's second opinion examination. He concurred with Dr. Finger's DBI impairment rating of 12 percent permanent impairment of the right upper extremity for acromioclavicular joint disease, and 1 percent permanent impairment of the right upper extremity for right wrist contusion. Dr. Katz referred to Table 15-34 to apply the ROM

rating methodology to appellant's right shoulder condition. He found that 140 degrees of flexion yielded three percent impairment, 40 degrees extension yielded one percent impairment, 150 degrees abduction yielded three percent impairment, 40 degrees adduction yielded zero percent impairment, 30 degrees internal rotation yielded four percent impairment, and 40 degrees external rotation yielded two percent impairment. Dr. Katz added the three, 1, 3, 0, 4, and 2 percent impairments to equal 13 percent permanent impairment of the right upper extremity. He found that as Dr. Finger observed normal range of motion of the bilateral wrists, there was no applicable ROM impairment rating for either wrist. Dr. Katz explained that the ROM rating methodology should be utilized as it provided a greater percentage of permanent impairment than the DBI rating methodology. He concurred with Dr. Finger's calculation of two percent permanent impairment of the right lower extremity, and two percent permanent impairment of the left lower extremity. Dr. Katz found no applicable impairment of the left upper extremity.

By *de novo* decision[5] dated June 12, 2025, OWCP granted appellant a schedule award for 13 percent permanent impairment of the right upper extremity, 0 percent permanent impairment of the left upper extremity, 2 percent permanent impairment of the right lower extremity, and 2 percent permanent impairment of the left lower extremity. The period of the award ran 52.08 weeks, for the period May 13, 2025 through May 12, 2026. OWCP found that Dr. Katz, the DMA, noted "normal range of motion for [the] right upper extremity and the impairment rating is determined based on the diagnosis impairment table."

On June 12, 2025, appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. OWCP subsequently received an August 6, 2020 hospital emergency department report by Dr. Christopher L. Smelley, an osteopath Board-certified in emergency medicine, wherein he opined that the August 6, 2020 employment injury caused contusions of the chest wall, bilateral knees, and bilateral wrists, and a thoracic strain. It also received medical literature.

By decision dated December 11, 2025, the OWCP hearing representative affirmed OWCP's June 12, 2025 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing federal regulations[7] 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.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is

[5] On its face, OWCP's June 12, 2025 decision is captioned as a "remand decision."

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *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).

used to calculate schedule awards.[9] 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.[10]

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.[11] 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.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13]

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.[14] 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.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

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)."[17]

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[9] *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).

[10] *F.S., supra* note 8; *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).

[11] *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).

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

[13] *Id.*

[14] *F.S., supra* note 8; *A.H*., Docket No. 23-0335 (issued July 28, 2023); *B.B*., Docket No. 20-1187 (issued November 18, 2021); *M.D., supra* note 10; *T.T*., Docket No. 18-1622 (issued May 14, 2019).

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

[16] *Id.*

[17] FECA Bulletin No. 17-06 (issued May 8, 2017); *B.B., supra* note 14; *V.L*., Docket No. 18-0760 (issued November 13, 2018).

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.*" (Emphasis in the original.)[18]

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."[19]

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.[20]

ANALYSIS

The Board finds that appellant has not established greater than zero percent permanent impairment of the left upper extremity, two percent permanent impairment of the left lower extremity, and/or two percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation. However, the Board further finds that the case is not in posture for decision with regard to whether appellant has established greater than 13 percent permanent impairment of the right upper extremity.

On October 16, 2024, OWCP referred appellant, along with the medical record, an updated SOAF, and a series of questions to Dr. Finger, a second opinion physician, for a permanent impairment evaluation according to the standards of the sixth edition of the A.M.A., *Guides*. Regarding the left upper extremity, Dr. Finger diagnosed left shoulder impingement syndrome, and acromioclavicular disease. He noted that the acromioclavicular joint impairment should be used to determine the impairment class as it was the most disabling condition affecting the left upper extremity. Dr. Finger referred to Table 15-5 to find a Class 1 CDX with a default of three percent impairment of the left upper extremity for a history of painful residual symptoms. He found a GMFH of 1 for pain with strenuous activity, and a GMPE of 1 for mild loss of range of

[18] *Id.*

[19] *Id.*

[20] *See supra* note 9 at Chapter 2.808.6f (March 2017). *See also L.A.*, Docket No. 25-0744 (issued November 19, 2025); *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).

motion, which resulted in a three percent permanent impairment of the left upper extremity. Regarding the bilateral lower extremities, Dr. Finger referred to Table 16-3 (Knee Regional Grid -- Lower Extremity Impairments), page 509 of the A.M.A., *Guides* to find a Class 1, Grade C CDX for bilateral knee contusions, with a default two percent impairment of each lower extremity. He found a GMFH of 1 for mild problem, and a GMPE of 1 for minimal palpatory findings, which resulted in two percent impairment of each lower extremity. In a March 10, 2025 supplemental report, Dr. Finger opined that there was no ratable impairment of the left wrist under either the DBI or ROM rating methodology.

OWCP referred the case to Dr. Katz, an OWCP DMA, for an impairment rating. In his February 3, 2025 report, the DMA properly found that there was no applicable impairment rating for the left shoulder as OWCP had not accepted an employment-related left shoulder condition. The DMA concurred with Dr. Finger's finding that there was no ratable impairment of the left wrist under either the DBI or ROM rating methodology. He further concurred with Dr. Finger's calculation of two percent permanent impairment of the right lower extremity, and two percent permanent impairment of the left lower extremity.

Dr. Finger and Dr. Katz accurately summarized the relevant medical evidence, provided a summary of findings on examination, and reached conclusions regarding appellant's impairment, which comported with the findings and with the appropriate provisions of the A.M.A., *Guides*. The reports of Dr. Finger and Dr. Katz and the DMA, therefore, represent the weight of the medical evidence.[21] As the medical evidence of record is insufficient to establish permanent impairment of his left upper and bilateral lower extremities, the Board finds that appellant has not met his burden of proof in this regard.

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

However, in regard to the right upper extremity, in reports dated December 19, 2024 and March 10, 2025, Dr. Finger calculated 13 percent permanent impairment of the right upper extremity utilizing the DBI rating methodology for acromioclavicular arthrosis with partial thickness rotator cuff tear and distal clavicle excision. He also referred to Table 15-34 to calculate 13 percent permanent impairment of the right upper extremity utilizing the ROM rating methodology for limited motion of the shoulder. Dr. Finger found that 140 degrees of flexion yielded three percent impairment, 40 degrees extension yielded one percent impairment, 150 degrees abduction yielded three percent impairment, 40 degrees adduction yielded zero percent impairment, 30 degrees internal rotation yielded four percent impairment, and 40 degrees external rotation yielded four percent impairment. Dr. Finger added the three, one, three, zero, four, and four percent impairments to equal 15 percent permanent impairment of the right upper extremity due to restricted shoulder motion.

In a report received on April 21, 2025, Dr. Katz opined that the ROM rating methodology should be utilized to assess appellant's right upper extremity impairment as it provided a greater

[21] *See K.S.*, 21-0238 (issued June 7, 2022); *M.J.*, Docket No. 20-1264 (issued February 16, 2021); *J.D.*, Docket No. 19-0414 (issued August 19, 2019); *P.L.*, Docket No. 17-0355 (issued June 27, 2018); *Ronald J. Pavlik*, 33 ECAB 1596 (1982).

percentage of impairment that the DBI rating methodology. He concurred with Dr. Katz' assignment of three percent impairment for right shoulder flexion at 140 degrees, one percent impairment for right shoulder extension at 40 degrees, three percent impairment for right shoulder abduction at 150 degrees, zero percent impairment for right shoulder adduction at 40 degrees, and four percent for internal rotation of the right shoulder at 30 degrees. Dr. Katz, however, correctly found that according to Table 15-34, external rotation of the right shoulder at 40 degrees constituted two percent impairment of the right upper extremity, and not four percent as found by Dr. Finger. He added the 3, 1, 3, 0, 4, and 2 percent impairments to equal 13 percent impairment of the right upper extremity due to loss of right shoulder motion. However, Dr. Katz did not indicate if the 1 percent right upper extremity impairment for right wrist contusion utilizing the DBI rating methodology at Table 15-3 as found by Dr. Finger should be added to the 13 percent permanent impairment of the right upper extremity previously awarded.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[22] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[23] As OWCP undertook development of the evidence, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[24]

The case must therefore be remanded for further development of the medical evidence. On remand, OWCP shall request a supplemental report from Dr. Katz, the DMA, regarding whether the one percent right upper extremity impairment for the accepted right wrist contusion should be added to the 13 percent permanent impairment previously awarded. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that appellant has not established greater than zero percent permanent impairment of the left upper extremity, two percent permanent impairment of the left lower extremity, and/or two percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation. However, the Board further finds that the case is not in posture for decision with regard to whether appellant has established greater than 13 percent permanent impairment of the right upper extremity.

[22] *N.L.,* Docket No. 19-1592 (issued March 12, 2020); *M.T.,* Docket No. 19-0373 (issued August 22, 2019); *B.A.,* Docket No. 17-1360 (issued January 10, 2018).

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

[24] *R.P.*, Docket No. 25-0701 (issued September 11, 2025); *G.M.,* Docket No. 19-1931 (issued May 28, 2020); *W.W.,* Docket No. 18-0093 (issued October 9, 2018).

ORDER

IT IS HEREBY ORDERED THAT the December 11, 2025 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 4, 2026
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