United States Department of Labor
Employees' Compensation Appeals Board

C.B., Appellant	)	
	)	**Docket No. 22-0823**
and	)	**Issued: March 3, 2026**
	)	
U.S. POSTAL SERVICE, CHANDLER-OCOTILLO STATION, Chandler, AZ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 4, 2022 appellant, through counsel, filed a timely appeal from an April 27, 2022 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id*. An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id*.; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] On June 2, 2022 the Board dismissed appellant's May 4, 2022 appeal as untimely filed. *Order Dismissing Appeal*, Docket No. 22-0823 (issued June 5, 2022). Appellant, through counsel, filed a timely petition for reconsideration. On June 10, 2025 the Board granted appellant's petition for reconsideration and reinstated her appeal as the appeal was received within 180 days from the date of issuance of the decision appealed. *Order Granting Petition for Reconsideration and Reinstating Appeal,* Docket No. 22-0823 (issued June 10, 2025).

Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than five percent permanent impairment of her right upper extremity and/or greater than 10 percent permanent impairment of her left upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On January 25, 2016 appellant, then a 58-year-old rural carrier associate, filed a traumatic injury claim (Form CA-1) alleging that she was injured on January 23, 2016 when a parcel fell onto lower left wrist while in the performance of duty.[5] OWCP accepted the claim for left trigger thumb. It later expanded its acceptance of the claim to include traumatic arthropathy of the left wrist and temporary aggravations of right middle trigger finger and right trigger thumb.

On July 14, 2016 appellant underwent surgery to her left thumb by Dr. Marc Dinowitz, a Board-certified orthopedic hand surgeon, including trigger release, tenosynovectomy of the flexor pollicis brevis (FPB), and cyst removal.

An October 18, 2016 electromyography and nerve conduction velocity (EMG/NCV) study noted an impression of mild bilateral median neuropathy at the wrists.

On December 6, 2016 appellant underwent surgery to the right hand by Dr. George K. Myo, a Board-certified orthopedic hand surgeon, including right carpal tunnel, right middle finger, and right thumb releases.

On April 18, 2017 Dr. Myo performed a left carpal tunnel release.

[3] 5 U.S.C. § 8101 *et seq*.

[4] The Board notes that following the April 27, 2022 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

[5] OWCP assigned the present claim OWCP File No. xxxxxx258. On November 30, 2016, appellant filed an occupational disease claim (Form CA-2) alleging injury as of January 23, 2016 due to repetitive work duties. OWCP assigned that claim OWCP File No. xxxxxx466 and accepted it for left carpal tunnel syndrome (CTS) under OWCP File No. xxxxxx466. She subsequently filed a Form CA-2 for a repetitive use injury as of May 28, 2016. OWCP assigned that claim OWCP File No. cccccc993 and accepted it for right CTS, trigger finger of the right middle finger, and right trigger thumb under OWCP File No. xxxxxx993. Appellant also filed a Form CA-2 for injuries to her knees, shoulders, hands, thumbs, and wrists, as of November 14, 2019, which OWCP denied under OWCP File No. xxxxxx491. OWCP has administratively combined OWCP File Nos. xxxxxx258, xxxxxx466, xxxxxx491, and xxxxxx993, with the latter serving as the master file.

On March 11, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In support thereof, appellant submitted a July 10, 2019 permanent impairment rating report by Dr. Mesfin Seyoum, a family medicine specialist, who noted that appellant had residual symptoms of pain in the wrists, limited motion in the thumbs, and difficulty with fine and gross motor coordination in the hands. On physical examination of the right thumb, Dr. Seyoum provided his range of motion (ROM) examinations and noted that the highest values after three attempts were 60 degrees interphalangeal (IP) flexion, 0 degrees IP extension, 40 degrees metacarpophalangeal (MCP) flexion, -10 degrees MCP extension, 5 cm of carpometacarpal (CMC) adduction, 40 degrees radial abduction, and 6 cm CMC opposition. On physical examination of the right middle finger, he indicated that the highest values after three attempts were 50 degrees distal interphalangeal (DIP) flexion, -10 degrees DIP extension, 90 degrees proximal interphalangeal (PIP) flexion, -10 degrees PIP extension, 80 degrees MCP flexion, and -20 degrees MCP extension. On physical examination of the left wrist and hand, Dr. Seyoum observed mild left thenar atrophy, tenderness to palpation, and positive Tinel's sign and Phalen's test and that the highest ROM values after three attempts were 30 degrees flexion, 30 degrees extension, 10 degrees radial deviation, and 20 degrees ulnar deviation. On examination of the left thumb, he noted the highest values after three attempts were 40 degrees IP flexion, -20 degrees IP extension, 30 degrees MCP flexion, -20 degrees MCP extension, 5 cm adduction, 40 degrees radial abduction, and 6 cm opposition. Dr. Seyoum's neurological examination revealed decreased sensation in the distribution patterns of the median nerves in both hands and fingers and weakness with grip strength bilaterally. He also recorded a *Quick*DASH score of 78.

Dr. Seyoum applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] to his examination findings. Using the diagnosis-based impairment (DBI) rating methodology, he found six percent digit impairment for left trigger thumb, which corresponded with two percent left upper extremity impairment. Using the ROM rating methodology, Dr. Seyoum found 20 percent digit impairment for left trigger thumb, which corresponded with 7 percent left upper extremity impairment. He explained that as the ROM rating methodology yielded the higher rating over the DBI methodology, appellant had seven percent permanent impairment of the left upper extremity for trigger thumb. Using the DBI methodology, Dr. Seyoum found 6 percent of the left upper extremity for CTS, for a total of 13 percent permanent impairment of the left upper extremity due to left CTS and trigger thumb.

Regarding the right upper extremity, Dr. Seyoum applied the DBI rating methodology and found six percent digit impairment for right trigger thumb, which corresponded with two percent right upper extremity impairment. Using the ROM methodology, he found 15 percent digit impairment, which corresponded with 5 percent right upper extremity impairment. Regarding the right middle trigger finger, Dr. Seyoum found one percent upper extremity impairment using the DBI methodology and six percent upper extremity impairment using the ROM methodology. Using the DBI rating methodology, he found five percent of the right upper extremity for CTS. Dr. Seyoum explained that as the ROM rating methodology yielded the higher rating over the DBI methodology for the middle finger and thumb, appellant was entitled to a schedule award for 16

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

percent permanent impairment of the right upper extremity for CTS, middle trigger finger, and trigger thumb.

Under OWCP File No. xxxxxx466, OWCP referred Dr. Seyoum's July 10, 2019 report and a statement of accepted facts (SOAF) to Dr. David I. Krohn, a Board-certified internist serving as a district medical adviser (DMA), for review and an opinion regarding appellant's permanent impairment.

In reports dated February 17 and May 5, 2020, Dr. Krohn evaluated the permanent impairment of appellant's right and left upper extremities, respectively, by applying the DBI and ROM rating methods to Dr. Seyoum's July 10, 2019 physical examination findings. He noted that he had reviewed the October 18, 2016 EMG/NCV data and indicated that the results did not meet the standard of the A.M.A., *Guides* for ratable impairment for CTS. Under the ROM rating method, Dr. Krohn found a total of 12 percent permanent impairment of right hand due to trigger thumb and middle trigger finger, which corresponded to 11 percent permanent impairment of the right upper extremity. Regarding left trigger thumb, he found eight percent permanent impairment of the left upper extremity under the ROM rating method. Dr. Krohn opined that appellant reached MMI on July 10, 2019, the date of Dr. Seyoum's examination.

Under OWCP File No. xxxxxx993, on December 31, 2020, OWCP referred appellant, a SOAF, and the medical record to Dr. Michael A. Steingart, a Board-certified osteopathic orthopedic surgeon, for a second opinion examination and impairment rating evaluation of the bilateral upper extremities.

In a report dated January 18, 2021, Dr. Steingart reviewed the SOAF, medical record, and appellant's history of injuries on January 23, 2016. He performed a physical examination of the left wrist and observed that the highest values after three attempts were 60 degrees flexion, 50 degrees extension, 20 degrees radial deviation, and 30 degrees ulnar deviation. On physical examination of the right middle finger, Dr. Steingart observed that the highest values after three attempts were 70 degrees DIP flexion, 0 degrees DIP extension, 90 degrees PIP flexion, 0 degrees PIP extension, 90 degrees MCP flexion, and 20 degrees MCP extension. He also indicated that appellant related that she was having no problems whatsoever with the right middle finger. On physical examination of the right thumb, Dr. Steingart observed the highest values after three attempts were 60 degrees IP flexion, 10 degrees IP extension, 60 degrees MCP flexion, 0 degrees MCP extension, 5 cm CMC abduction, 40 degrees radial abduction, and 6 degrees CMC opposition. On physical examination of the left thumb, he observed the highest values after three attempts were 80 degrees IP flexion, 10 degrees IP extension, 60 degrees MCP flexion, 0 degrees MCP extension, 2 cm CMC abduction, 50 degrees radial abduction, and 7 degrees CMC opposition.

Under OWCP File No. xxxxxx466, OWCP again routed appellant's claim to Dr. Krohn serving as the DMA for "calculation of impairment to the bilateral upper extremities based on any and all of the three injuries listed in the SOAF."

In an April 21, 2021 report, Dr. Krohn reiterated his opinion that the October 18, 2016 EMG/NCV data did not meet the standard for the diagnosis of right or left CTS in accordance with the A.M.A., *Guides* and, therefore, appellant had no ratable impairment for right or left CTS. He applied the DBI methodology to Dr. Steingart's January 18, 2021 physical examination findings

and found that under Table 15-3, Wrist Regional Grid, page 397, the CDX for traumatic arthropathy of the left wrist was a Class 1 impairment with a default impairment rating of five percent of the left upper extremity. He indicated that a GMFH could not be applied because appellant's *Quick*DASH score of 78 exceeded GMPE and GMCS by two or more grades. Dr. Krohn assigned a GMPE of 1 for mild decreased ROM and a GMCS of 0 due to no available clinical studies. He applied the net adjustment formula, which resulted in a final DBI rating of three percent permanent impairment of the left upper extremity for left wrist arthropathy. Regarding the right middle trigger finger, Dr. Krohn found no ratable impairment under the DBI rating method, noting that appellant related no problems with the right middle finger during her evaluation with Dr. Steingart. Regarding the right trigger thumb, he found five percent digit impairment for right trigger thumb, or two percent permanent impairment of the right upper extremity.

Dr. Krohn also applied the ROM rating methodology to Dr. Steingart's January 18, 2021 physical examination findings. Regarding the left wrist, he found that: flexion to 60 degrees resulted in no impairment; extension to 50 degrees equaled three percent impairment; radial deviation to 20 degrees resulted in no impairment; and ulnar deviation to 30 degrees resulted in no impairment, for a total of three percent left upper extremity impairment. Dr. Krohn noted that as the impairment by the ROM methodology was greater than that by the DBI methodology, appellant had six percent left upper extremity impairment for six percent for left wrist arthropathy. Regarding the right wrist, he found that: 50 degrees flexion equaled three percent permanent impairment; 50 degrees extension equaled three percent permanent impairment; 20 degrees radial deviation resulted in no permanent impairment; and 30 degrees ulnar deviation resulted in no permanent impairment, for a total of six percent permanent impairment of the right upper extremity for the right wrist. Regarding the right middle finger, Dr. Krohn found the only ratable impairment was for 90 degrees of PIP flexion, which equaled six percent digit impairment under the ROM rating methodology. Regarding the right thumb, he found that 60 degrees IP flexion equaled one percent permanent impairment, CMC abduction to 5 cm equaled four percent permanent impairment, 6 cm opposition equaled four percent permanent impairment, and the remaining ROM measurements yielded no ratable impairment, for a total of nine percent permanent digit impairment for right trigger thumb. Dr. Krohn combined the ratings for the right middle finger, thumb, and wrist under the ROM methodology, which yielded a final rating of 10 percent permanent impairment of the right upper extremity.

In an August 4, 2021 supplemental report, Dr. Krohn explained that the actual measurements of direct conduction of the median nerves bilaterally in the October 18, 2016 EMG/NCV study did not meet the standard of the A.M.A., *Guides* for the diagnosis of CTS. Therefore, he continued to opine that appellant did not have ratable impairment in either upper extremity for CTS.

By decision dated April 27, 2022, OWCP granted appellant a schedule award for 5 percent permanent impairment of the left upper extremity and 10 percent permanent impairment of the right upper extremity. It accorded the weight of the medical opinion evidence to the April 21, 2021 report of Dr. Krohn as DMA. The award ran for 46.8 weeks from July 10, 2019 through June 1, 2020.

LEGAL PRECEDENT

The schedule award provisions of FECA[7] and its implementing regulations[8] 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 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., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, is used to calculate schedule awards.[10]

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.[11] OWCP 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*.[12]

In determining 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. With respect to the fingers and hand, the relevant portions of the arm for the present case, reference is made to Table 15-2 (Digital Regional Grid) beginning on page 391. After the class of diagnosis (CDX) is determined from the appropriate regional grid (including identification of a default grade value), the net adjustment formula is applied using a GMFH, GMPE, and/or GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

The A.M.A., *Guides* also provide that the ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no

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[7] *Supra* note 1

[8] 20 C.F.R. § 10.404.

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

[10] 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).

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

[12] *Supra* note 10 at Chapter 2.808.5 (March 2017).

[13] *See* A.M.A., *Guides* (6th ed. 2009) at 405-12. Table 15-2 also provides that, if motion loss is present for a claimant with certain diagnosed digit 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 394, 468-469.

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

other diagnosis-based sections are applicable.[15] If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[16] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss, and functional reports are determined to be reliable.[17]

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.[18] FECA Bulletin No. 17-06 provides:

> "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.*"[19] (Emphasis in the original.)

Impairment due to CTS is evaluated under Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[20] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities.[21]

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.[22]

Section 8123(a) of FECA provides, in pertinent 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 (known as a referee physician or an impartial medical

[15] *Id.* at 461.

[16] *Id.* at 473.

[17] *Id.* at 474.

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

[19] *Supra* note 13 at 474.

[20] *Id*. at 449.

[21] *Id*. at 448-49.

[22] *See supra* note 13 at Chapter 2.808.6(f) (March 2017); *see also 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).

examiner (IME)) who shall make an examination."[23] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case. When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[24]

ANALYSIS

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

In his July 10, 2019 report, Dr. Seyoum, appellant's attending physician, applied the DBI and ROM rating methodologies to his examination findings for the left thumb and concluded that appellant had 20 percent digit impairment for left trigger thumb, which corresponded with 7 percent left upper extremity impairment, under the ROM rating methodology. Regarding the left wrist, he referenced Table 15-23 to find 6 percent left upper extremity due to CTS, noting that the October 18, 2016 EMG/NCV study revealed mild bilateral median neuropathy at the wrists, for a total of 13 percent left upper extremity impairment due to CTS and trigger thumb. Regarding the right upper extremity, Dr. Seyoum found five percent right upper extremity impairment for right trigger thumb and six percent upper extremity impairment for the right middle trigger finger using the ROM rating methodology. Using the DBI rating methodology, he found five percent of the right upper extremity for CTS. Dr. Seyoum opined that appellant was entitled to a schedule award for 16 percent permanent impairment of the right upper extremity for CTS, middle trigger finger, and trigger thumb.

On April 21 and August 4, 2021 Dr. Krohn, the DMA, rated appellant's right and left upper extremity impairment by applying the DBI and ROM methodologies to the January 18, 2021 physical examination findings of Dr. Steingart. He found that the October 18, 2016 EMG/NCV data did not meet the standard for the diagnosis of right or left CTS in accordance with the A.M.A., *Guides* and, therefore, appellant had no ratable impairment for right or left CTS. Dr. Krohn ultimately determined that the ROM rating methodology provided the higher ratings of six percent of the left upper extremity for left wrist arthropathy, two percent permanent impairment of the right upper extremity for right trigger thumb, and six percent permanent impairment of the right upper extremity for the right wrist. Regarding the right middle trigger finger, he found no ratable impairment under the DBI rating methodology, as appellant related no problems with the right middle finger during her evaluation with Dr. Steingart but indicated that the ROM rating method yielded six percent digit impairment of the right middle finger due to 90 degrees of PIP flexion. Dr. Krohn combined the ratings for the right middle finger, thumb, and wrist, and found a combined value of 10 percent permanent impairment of the right upper extremity.

[23] 5 U.S.C. § 8123(a). *See R.C.*, Docket No. 18-0463 (issued February 7, 2020); *see also G.B.*, Docket No. 16-0996 (issued September 14, 2016).

[24] 20 C.F.R. § 10.321. *See also J.H.*, Docket No. 22-0981 (issued October 30, 2023); *N.D.*, Docket No. 21-1134 (issued July 13, 2022); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

As noted above, if there is a disagreement between an employee's physician and an OWCP referral physician, OWCP will appoint an IME who shall make an examination.[25] The Board finds that a conflict in medical opinion exists between Dr. Seyoum and the DMA, Dr. Krohn, regarding the extent of the permanent impairment of appellant's right and left upper extremities and application of the sixth edition of the A.M.A., *Guides* to the diagnoses of right and left CTS.

The Board, therefore, will remand the case for OWCP to refer appellant to an IME for resolution of the conflict in medical opinion evidence. On remand OWCP shall refer the case record, a SOAF setting forth the accepted injuries and combined claims under OWCP File Nos. xxxxxx258, xxxxxx993, xxxxxx466, and xxxxxx491, and appellant to a specialist in the appropriate field of medicine, to serve as an IME, for a reasoned medical opinion regarding the extent of permanent impairment of appellant's upper extremities.[26] 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.

[25] *See E.B.*, Docket No. 23-0169 (issued August 24, 2023); *S.S.*, Docket No. 19-1658 (issued November 12, 2020); *C.S.*, Docket No. 19-0731 (issued August 22, 2019); *see also supra* note 22.

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

ORDER

IT IS HEREBY ORDERED THAT the April 27, 2022 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: March 3, 2026
Washington, DC

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

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

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