United States Department of Labor
Employees' Compensation Appeals Board

K.E., Appellant	)	
and	)	**Docket No. 16-1494**
	)	**Issued: September 19, 2017**
DEPARTMENT OF THE AIR FORCE, PETERSON AIR FORCE BASE, CO, Employer	)	

Appearances:
Michael Welsh, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 12, 2016 appellant, through her representative, filed a timely appeal from a June 14, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

ISSUE

The issue is whether OWCP properly determined that appellant had no more than six percent permanent impairment of the right lower extremity and six percent permanent impairment of the left lower extremity, for which she previously received schedule awards.

[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] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before December 17, 2010 appellant, then a 64-year-old information technology specialist, climbed up and down stairs and carried a heavy backpack of work materials to and from several duty stations, causing a lumbosacral sprain, displacement of a lumbar intervertebral disc without myelopathy, and spinal stenosis with neurogenic claudication.

In an April 26, 2011 report, Dr. Orderia Mitchell, an attending Board-certified orthopedic surgeon, diagnosed L4-5 instability, L4-5 spinal stenosis, and multi-level disc disease. He prescribed a course of lumbar epidural steroid injections.

Appellant retired from the employing establishment on July 31, 2011.

On October 24, 2011 Dr. Munni R. Selagamsetty, an attending Board-certified internist, diagnosed disc protrusions at L3-4 and L4-5 with an annular tear. Dr. Mitchell diagnosed bilateral lumbar radiculopathy, weakness in both lower extremities, L2-3 anterolisthesis, and S1-2 facet arthropathy on December 2, 2011.

Dr. Michael W. Brown, an attending Board-certified neurosurgeon, provided reports from January 20 to February 1, 2012 diagnosing significant lumbar degenerative disc disease with multiple disc bulges, and a near total disc space collapse at L4-5. On May 30, 2012 he performed an L4-5 and L5-S1 decompression and fusion with screw and cage fixation. OWCP authorized the procedure.

In a June 21, 2013 report, Dr. Timothy O. Hall, an attending Board-certified physiatrist, opined that appellant had attained maximum medical improvement (MMI). He assessed seven percent permanent impairment of the spine.

On July 8, 2013 appellant claimed a schedule award (Form CA-7). In support of her claim, she submitted an October 31, 2013 impairment rating by Dr. John W. Ellis, an attending Board-certified family practitioner. Dr. Ellis reviewed appellant's history of injury, treatment, and surgery, noting that she had undergone left knee arthroscopy in the 1990s. Appellant completed a *Quick*DASH questionnaire, with a score of 89. On examination, Dr. Ellis observed weakness on flexion and extension of both knees, dorsiflexion of the toes, plantar flexion of the feet bilaterally, and heel and toe walking. He also noted bilaterally positive straight leg raising tests, greater on the left. Dr. Ellis diagnosed a lumbosacral strain, displacement of lumbar intervertebral disc without myelopathy, spondylolisthesis, lumbar spinal stenosis with neurogenic claudication, and aggravation of traumatic arthritis, tendinitis, and chondromalacia of both knees. He opined that all diagnosed conditions were work related. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (hereinafter, A.M.A., *Guides*) to assess appellant's right lower extremity, Dr. Ellis assigned a grade 2 modifier for Functional History (GMFH) due to pain with normal activity, and a grade 2 modifier for findings on Physical Examination (GMPE) due to moderate but consistent palpatory findings. For the right leg, Dr. Ellis found three percent impairment of the L4 spinal nerve, 11 percent impairment of the L5 spinal nerve, and 12 percent impairment of the S1 spinal nerve due to weakness. Using the Combined Values Chart, he found 24 percent permanent impairment of the right leg according to Table 16-12[3] and the July/August 2009 *The*

[3] Table 16-12, page 534 of the sixth edition of the A.M.A., *Guides* is entitled "Peripheral Nerve Impairment."

Guides Newsletter criteria rating spinal nerves to an extremity. For the left leg, Dr. Ellis found 3 percent impairment of the L4 spinal nerve, 18 percent impairment of the L5 spinal nerve, and 12 percent impairment of the S1 spinal nerve due to weakness. He combined these impairments to equal 30 percent permanent impairment of the left leg according to Table 16-12 and the July/August 2009 *The Guides Newsletter*.

On December 2, 2013 OWCP referred appellant, the medical record, and a statement of accepted facts (SOAF) to Dr. William V. Watson, a Board-certified orthopedic surgeon, for a second opinion regarding the percentage of permanent impairment to the legs caused by the accepted lumbar conditions. Dr. Watson reviewed the medical record and the SOAF. He found that appellant had reached MMI as of Dr. Hall's June 21, 2013 examination. Dr. Watson examined appellant on December 17, 2013, finding full strength in both legs, and sensory loss throughout the left leg in a nonanatomic pattern. He recommended additional testing. On January 8, 2014 a lumbar magnetic resonance imaging (MRI) scan showed a transitional, rudimentary disc at L5-S1 with partial sacralization of the L5 vertebral body, anterior and posterior surgical fusion from L3 to L5, no definite interosseous fusion at L3-4 and L4-5, multilevel lumbar degenerative disc disease with facet arthropathy, with new, mild foraminal narrowing at T12-L1, stable moderate-to-severe neural foraminal narrowing at L1-2, stable mild-to-moderate foraminal narrowing at L2-3, and mild-to-moderate neural foraminal narrowing at L4-5. Dr. Watson also obtained January 23, 2014 electromyography (EMG) and nerve conduction velocity (NCV) studies of the lower extremities showing "no electrodiagnostic evidence of lumbosacral radiculopathy or sciatic/femoral neuropathy." In a January 29, 2014 report, he opined that appellant had no impairment of either lower extremity as the new electrodiagnostic and imaging studies showed no radicular or other neurologic impairment.

On February 7, 2014 an OWCP medical adviser reviewed Dr. Watson's reports and the medical record. He found that appellant attained MMI as of the date of Dr. Watson's December 17, 2013 examination. The medical adviser opined that appellant had no ratable impairment of either lower extremity according to the July/August 2009 *The Guides Newsletter*, as electrodiagnostic and imaging studies demonstrated no lumbar spinal root involvement.

By decision dated February 12, 2014, OWCP denied appellant's schedule award claim, finding that the medical evidence did not establish a lumbar spinal nerve root impairment affecting either lower extremity.

In a February 5, 2015 letter, appellant, through her representative at that time, requested reconsideration. She submitted additional medical evidence. Dr. Brown provided April 28, 2014 and January 12, 2015 reports, diagnosing L3-4 stenosis above the L4-S1 fusion, consistent with a transitional syndrome, and bilateral lower extremity radiculopathy. He opined that the L3-4 stenosis was competent to cause appellant's symptoms of bilateral lower extremity pain, greater on the right.

On May 2, 2014 Dr. Mark J. Hinrichs, an attending Board-certified internist and physiatrist, noted appellant's complaints of bilateral lower extremity pain, greater on the right. He diagnosed L3-4 spinal stenosis with transitional syndrome, status post fusion.

Dr. Ellis provided a July 17, 2014 supplemental report explaining that negative electrodiagnostic studies did "not rule out spinal nerve impairment." He opined that appellant

had reached maximum medical improvement. Dr. Ellis noted appellant's complaints of greater weakness in both knees, and newly diminished sensation on the inner aspect of both thighs. Referring to Table 16-12 and the July/August 2009 *The Guides Newsletter*, for the right leg, he found four percent impairment of the L3 spinal nerve, three percent impairment of the L4 spinal nerve, six percent impairment of the L5 spinal nerve, and seven percent impairment of the S1 spinal nerve due to weakness. Using the Combined Values Chart, Dr. Ellis found 19 percent permanent impairment of the right leg. For the left leg, he found 4 percent impairment of the L3 spinal nerve, 3 percent impairment of the L4 spinal nerve, 18 percent impairment of the L5 spinal nerve, and 12 percent impairment of the S1 spinal nerve due to weakness. Dr. Ellis combined these impairments to equal 19 percent permanent impairment of the left leg according to Table 16-12 and the July/August 2009 *The Guides Newsletter*.

On April 9, 2015 an OWCP medical adviser reviewed the medical evidence submitted on reconsideration, and opined that appellant did not have a ratable impairment of either leg as there was no objective spinal nerve root impingement affecting either leg.

By decision dated April 10, 2015, OWCP denied modification of the February 12, 2014 decision, finding that the medical evidence did not establish a ratable impairment of either lower extremity.

On September 15, 2015 appellant, through her representative at that time, requested reconsideration. She submitted additional medical evidence. Dr. Brown provided a July 20, 2015 report that diagnosed transitional syndrome related to the May 30, 2012 decompression and fusion authorized by OWCP. He explained that negative EMG and NCV studies did not preclude a diagnosis of lower extremity radiculopathy, as the diagnoses was based primarily on the patient's symptoms and clearly fit appellant's objective, severe L3-4 stenosis. Dr. Brown concurred with Dr. Ellis' finding of 19 percent permanent impairment of each lower extremity.

In an August 20, 2015 letter, Dr. Ellis affirmed his prior findings, reiterating that the negative electrodiagnostic studies did not rule out lumbar radiculopathy.

On November 5, 2015 OWCP noted a conflict of medical opinion between Drs. Brown and Ellis, for appellant, and OWCP's medical adviser and Dr. Watson, for the government, regarding the appropriate percentage of permanent lower extremity impairment attributable to the accepted lumbar conditions and surgery. To resolve the conflict, it selected Dr. Hendrick J. Arnold, a Board-certified orthopedic surgeon.

Dr. Arnold provided a January 14, 2016 report reviewing the medical record and SOAF. On examination, he observed restricted lumbar motion, increased lumbar lordosis, inability to toe raise on the right, inability to step up onto a 12-inch stool, equal reflexes throughout both legs, full motion of the hips, knees, and ankles bilaterally, full 5/5 strength of the anteriortibial, peroneal, gastrocnemius, hip flexor, hip adductor, and hip abductor muscles bilaterally, diminished light touch sensation in both lower extremities, and a mild Trendelenburg gait. Dr. Arnold administered a *Quick*DASH questionnaire with a score of 94, indicating a moderate functional history. Appellant scored 24 on the American Academy of Orthopedic Surgeons (AAOS) Lower Extremity questionnaire, also indicating a moderate functional history impairment according to Table 16-6. Dr. Arnold diagnosed L3, L4, L5, and S1 bilateral radiculopathy based on appellant's symptoms, L3-4 and L4-5 instability, a collapsed disc space

at L4-5, severe lumbar degenerative disc disease, spinal stenosis at L4-5 and L5-S1, and facet arthropathy at all levels. He found a grade modifier of 1 for Clinical Studies (GMCS), and a GMFH of 2. Dr. Arnold therefore moved the default grade C diagnosis-based impairment Class of Diagnosis (CDX) one space to the right, to grade D. Referring to Table 2 of the July/August 2009 *The Guides Newsletter*, he found nine percent motor and one percent sensory deficit of the L3 spinal nerves, two percent sensory and seven percent motor impairment of the L4 and L5 spinal nerves due to mild sensory and mild motor impairments, and one percent sensory and four percent motor impairments of the S1 spinal nerves due to mild sensory and motor impairments. Dr. Arnold combined these values to equal 29 percent permanent impairment of each lower extremity.

A different OWCP medical adviser reviewed Dr. Arnold's report on March 1, 2016, asserting that Dr. Arnold did not understand the significance of his clinical observations of appellant's motor strength. He disagreed with Dr. Arnold's assessment of a motor impairment based on appellant's inability to step up onto a 12-inch stool, as this could be voluntary limiting due to pain. The medical adviser argued that this was insufficient evidence for an objective motor impairment in the absence of weakness on muscle testing. He concluded that, as appellant did not have any motor loss, Dr. Arnold "incorrectly" applied the A.M.A., *Guides* when he based the schedule awards on motor loss. The medical adviser concurred with Dr. Arnold's finding of sensory impairments, one percent for L3, two percent for L4, two percent for L5, and one percent for S1 bilaterally. He noted that the impairment values for the right and left lower extremities could be added instead of combined as they were derived from the same tables. The medical adviser concluded that the sensory loss for both lower extremities, as derived from the application of *The Guides Newsletter*, resulted in 6 percent permanent impairment each, for a total 12 percent permanent impairment.

In a March 21, 2016 supplemental report, Dr. Arnold acknowledged that it was "defensible" to only use sensory impairments as appellant's muscle manual motor testing and electrodiagnostic studies had been repeatedly normal, and that she had no atrophy in either lower extremity. He also acknowledged that appellant's inability to step up onto a 12-inch stool could be due to pain symptoms, as OWCP's medical adviser suggested, and not organic weakness. However, Dr. Arnold further opined that appellant had motor findings that were both objective and abnormal. In this regard, he noted that appellant had muscle weakness against gravity due to her inability to perform toe rises and raising her body upon a 12-inch stool on the right and only one time on the left. Additionally, there were imaging findings "implying listhesis, cervical and foraminal stenosis." Dr. Arnold therefore concluded that the inclusion of motor impairment was "defensible." He added:

> "If you conclude that this is not justified, I think that is a decision that you make and as I said is defensible based on my statements … though I do not agree that this is the course of action that should be taken. It is your *privilege* to make this choice; if you choose sensory only, it is also your *responsibility* as I recommend motor *and* sensory rating." (Emphasis in the original.)

The second OWCP medical adviser reviewed Dr. Arnold's supplement report on May 11, 2016, and recommended that OWCP utilize Dr. Arnold's sensory impairment ratings only, which equaled six percent permanent impairment of each lower extremity. He explained that diagnostic tests were normal and that the "only abnormality was a subjective finding of [appellant's]

inability to raise [the] body weight up on a 12-inch stool." The medical adviser concluded that this was subjective and under the control of appellant and was "not in any way related to motor loss."

By decision dated June 14, 2016, OWCP vacated its April 10, 2015 decision, and issued schedule awards for six percent permanent impairment of each lower extremity. It found that the weight of the medical opinion rested with the second OWCP medical adviser.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulation[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[6] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[7]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[8] A schedule award is not payable for the loss, or loss of use, of a part of the body that is not specifically enumerated under FECA.[9] Moreover, neither FECA nor its implementing regulations provides for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is specifically excluded from the definition of organ under FECA.[10]

In 1960 amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[11] The sixth edition of the A.M.A., *Guides* does not

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. *See also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (January 2010).

[7] Federal (FECA) Procedure Manual, *id*. at Chapter 2.808.5a (February 2013).

[8] *Pamela J. Darling*, 49 ECAB 286 (1998).

[9] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[10] *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

[11] *Supra* note 9.

provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009) is to be applied.[12]

Section 8123(a) of FECA provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[13] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[14] If the impartial specialist is unwilling or unable to clarify or elaborate on his opinion as requested, the case should be referred to another appropriate impartial medical specialist.[15] Unless this procedure is carried out by OWCP, the intent of section 8123(a) of FECA[16] will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[17]

OWCP procedures provide that, while an OWCP medical adviser may create a conflict in medical opinion, he or she may not resolve it.[18] If a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the medical adviser to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*. However, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. OWCP's medical adviser cannot resolve a conflict in medical opinion.[19]

ANALYSIS

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

OWCP accepted that appellant sustained a lumbosacral sprain, displacement of a lumbar intervertebral disc without myelopathy, and spinal stenosis with neurogenic claudication. Appellant underwent L4-5 and L5-S1 decompression and fusion on May 30, 2012, authorized by OWCP.

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[12] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[13] 5 U.S.C. § 8123(a); *Robert W. Blaine*, 42 ECAB 474 (1991).

[14] *Delphia Y. Jackson*, 55 ECAB 373 (2004).

[15] *Guiseppe Aversa*, 55 ECAB 164 (2003).

[16] 5 U.S.C. § 8123(a).

[17] *Harold Travis*, 30 ECAB 1071 (1979).

[18] Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.810.8(g) (September 2010).

[19] *Id*. at 2.810.8(k) (September 2010). *See V.G.*, 59 ECAB 635, 641 (2008); *Richard R. Lemay*, 56 ECAB 341, 348 (2005) (an OWCP medical adviser may review the opinion of an impartial specialist but the resolution of the conflict is the responsibility of the impartial medical specialist).

Appellant claimed a schedule award and submitted impairment ratings from Dr. Ellis who, on July 17, 2014 found 19 percent impairment of each leg based on *The Guides Newsletter*. On July 20, 2015 Dr. Brown concurred with Dr. Ellis' rating. OWCP obtained a second opinion from Dr. Watson, a Board-certified orthopedic surgeon, who on January 29, 2014 found no permanent impairment of either leg as electrodiagnostic studies demonstrated no spinal nerve root impairment. An OWCP medical adviser agreed with Dr. Watson's finding.

OWCP found a conflict of opinion between appellant's physicians, Drs. Ellis and Brown, and Dr. Watson and OWCP's first medical adviser, for the government, and selected Dr. Arnold, a Board-certified orthopedic surgeon, to resolve it. Dr. Arnold provided a January 14, 2016 report, finding 29 percent permanent impairment of each leg due to a combination of sensory and motor impairments, based in part on appellant's inability to step up onto a 12-inch stool. On February 8, 2016 a second OWCP medical adviser disagreed, contending that Dr. Arnold should not have assessed impairment for motor loss based only on appellant's ability to raise herself onto a 12-inch stool. He characterized the assessment as a misapplication of the A.M.A., *Guides*. The medical adviser calculated six percent permanent impairment of each lower extremity, one percent for the L3 enervation, two percent for L4, two percent for L5, and one percent for S1. These percentages were based on Table 16-12 and the July/August 2009 *The Guides Newsletter* criteria rating spinal nerves to an extremity. In his March 21, 2106 supplemental report, Dr. Arnold acknowledged that it was "defensible" to rate appellant for any sensory impairments only. However, he pointed out that appellant's inability to raise herself onto a 12-inch stool was a reliable sign of organic motor weakness that warranted an additional percentage of permanent impairment. Dr. Arnold also noted that there was objective evidence of motor impairment. He reiterated his opinion that both sensory and motor impairments should be considered in assessing appellant's permanent impairment, noted his disagreement to only applying sensory impairments, and added that it was OWCP's "privilege" and "responsibility" to only utilize sensory impairments. Following the submission of Dr. Arnold's supplemental report, the second OWCP medical adviser reiterated his finding of six percent permanent impairment of each lower extremity. OWCP found that the second OWCP medical represented the weight of the medical evidence in issuing the June 14, 2016 schedule awards for six percent permanent impairment of each lower extremity. The Board finds, however, that this was improper.

In order to properly resolve the conflict created, it is the impartial medical specialist, Dr. Arnold, who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A., *Guides*. An OWCP medical adviser may review an opinion for compliance with the A.M.A., *Guides*, but the resolution of the conflict is the responsibility of the impartial medical specialist.[20] In this case, Dr. Arnold explained that appellant had an objective, ratable motor deficit due to the accepted spinal conditions because she was unable to raise herself onto the stool. While OWCP's second medical adviser characterized the disagreement as pertaining only to a misapplication of the A.M.A., *Guides* on Dr. Arnold's part, the dispute actually concerned the interpretation of Dr. Arnold's clinical observations. OWCP's medical adviser exceeded his role as reviewer by substituting his clinical judgment for that of Dr. Arnold.[21]

[20] *See id*.; Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.808.6(g)(1) (February 2013).

[21] *Supra* note 19; Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.810.8(g) (September 2010).

OWCP procedures note:

> "*If the referee specialist submits an opinion* which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, the CE [claims examiner] should seek clarification or further rationale from that physician. When OWCP undertakes to develop the evidence by referring the case to an [OWCP]-selected physician, it has an obligation to seek clarification from that physician upon receiving a report that did not adequately address the issues that [OWCP] sought to develop….
>
> "Only if the referee physician does not respond, or does not provide a sufficient response after being asked, should the CE request a new referee examination."[22]

In this case, Dr. Arnold was equivocal as to whether to use both motor and sensory impairments when calculating the amount of permanent impairment. His report was not well rationalized and, although given an opportunity to clarify his opinion, the Board finds his report insufficient to resolve the conflict of medical opinion. Therefore, the case will be remanded to OWCP for selection of a new impartial medical examiner to resolve the outstanding conflict of medical evidence. Following such further development as is deemed necessary, OWCP shall issue a *de novo* decision on the schedule award issue.

On appeal appellant's representative contends that OWCP's reliance on OWCP's medical adviser's review of Dr. Arnold's opinion violated its procedures and Board precedent. As set forth above, the case will be remanded to OWCP for appointment of a new impartial medical examiner and attendant evaluation.

CONCLUSION

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

[22] Federal (FECA) Procedure Manual, *supra* note 6 at Chapter 2.810.11(e) (September 2010); *K.C.*, Docket No. 15-1086 (August 24, 2015).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 14, 2016 is set aside. The case is remanded for further action consistent with this decision of the Board.

Issued: September 19, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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