# United States Department of Labor
# Employees' Compensation Appeals Board

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| **A.K., Appellant** | ) | |
| **and** | ) | **Docket No. 23-1135** |
| | ) | **Issued: April 11, 2024** |
| **DEPARTMENT OF JUSTICE, U.S. MARSHALS SERVICE, Glynco, GA, Employer** | ) | |

*Appearances:*
*Lawrence Berger, Esq.*, for the appellant[1]
*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 September 1, 2023 appellant, through counsel, filed a timely appeal from a March 16, 2023 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.[3]

[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*.

[3] The Board notes that following the March 16, 2023 decision, appellant submitted additional evidence to OWCP. 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 new evidence for the first time on appeal. *Id*.

## ***ISSUE***

The issue is whether appellant has met his burden of proof to establish greater than 10 percent permanent impairment of each upper extremity (shoulders), for which he previously received a schedule award.

## ***FACTUAL HISTORY***

On August 31, 2018 appellant, then a 35-year-old senior inspector instructor, filed a traumatic injury claim (Form CA-1) alleging that on August 30, 2018 he injured his left shoulder in a marshal academy training class while in the performance of duty. He did not immediately stop work. By decision dated September 27, 2018, OWCP accepted appellant's claim for other sprain of the left shoulder joint and superior glenoid labrum lesion of the left shoulder. It assigned the present claim OWCP File No. xxxxxx778.[4]

A magnetic resonance imaging (MRI) scan of the left shoulder dated September 12, 2018 revealed a complex full-thickness tear of the anterior labrum extending from the inferior labrum to the biceps anchor, cystic degeneration along the posterior lateral humeral head, mild cortical irregularity of the anterior-inferior glenoid, and subscapular tendinosis.

Appellant came under the treatment of Dr. Carl R. Freeman, a Board-certified orthopedist, who on November 9, 2018 performed OWCP-authorized diagnostic arthroscopy of the left shoulder and arthroscopic labral repair of the left anterior labrum with capsulorrhaphy. On April 9, 2019 Dr. Freeman diagnosed left shoulder labral tear. He recorded left shoulder range of motion (ROM) of 155 degrees of abduction, 175 degrees of forward flexion, 45 degrees of internal rotation, and 60 degrees of external rotation. On June 18, 2019 Dr. Freeman returned appellant to full-duty work without restrictions and opined that appellant did not sustain permanent impairment.

On November 18, 2019 Dr. John W. Ellis, Board-certified in emergency and family medicine, noted that appellant sustained a work-related right shoulder injury on March 21, 2017 and left shoulder injury on August 30, 2018. He reported that an April 26, 2017 MRI scan of the right shoulder revealed a tear of the posterior inferior labrum and high-grade cartilaginous flap of the posterior inferior glenoid. An MRI scan of the left shoulder dated September 12, 2018 revealed a complex full-thickness tear of the anterior labrum and cystic degeneration around the posterior lateral humeral head. Dr. Ellis discussed appellant's shoulder surgeries and diagnosed other lesions of the right shoulder and loose body in the right shoulder. He determined that appellant reached maximum medical improvement (MMI) at the time of his examination. Dr. Ellis noted that in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[5] appellant had 16 percent permanent

[4] Appellant had previously filed a traumatic injury claim (Form CA-1), assigned OWCP File No. xxxxxx022, for an injury sustained to his right shoulder on March 21, 2017, when he was engaged in a combative tactics training session while in the performance of duty. OWCP accepted that claim for other lesions of the right shoulder and loose body in the right shoulder. On June 12, 2018 it granted appellant a schedule award for three percent permanent impairment of the right upper extremity (shoulder). The period of the award ran from April 10 through June 14, 2018. OWCP has administratively combined OWCP File Nos. xxxxxx778 and xxxxxx022, with the latter serving as the master file.

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

impairment of the right upper extremity due to restricted ROM. He noted a *Quick*DASH score of 32 for the right and left upper extremities. Dr. Ellis recorded appellant's active ROM measurements on three successive trials for the right shoulder which included: 120 degrees of forward flexion equaling three percent impairment, 20 degrees of extension equaling two percent impairment, 160 degrees of abduction equaling three percent impairment, 20 degrees of adduction equaling one percent impairment, 40 degrees of internal rotation equaling four percent impairment, and 50 degrees of external rotation equaling two percent impairment. Using the Combined Values Chart he calculated 16 percent permanent impairment of the right shoulder in accordance with the A.M.A., *Guides*. With regard to the right shoulder, Dr. Ellis utilized the diagnosis-based impairment (DBI) rating method to find that, under Table 15-5 (Shoulder Regional Grid), beginning on page 401, appellant's superior labrum anterior to posterior (SLAP) surgery and sprain of the right shoulder warranted five percent permanent impairment of the right upper extremity.

With regard to the left shoulder, Dr. Ellis diagnosed other sprain of the left shoulder joint and superior glenoid labrum tear of the left shoulder. He determined that appellant reached MMI at the time of his examination. Dr. Ellis noted that in accordance with the A.M.A., *Guides* appellant had 19 percent permanent impairment of the left upper extremity due to restricted ROM. He recorded appellant's active ROM measurements on three successive trials for the left shoulder which included: 80 degrees of forward flexion equaling nine percent impairment, 10 degrees of extension equaling two percent impairment, 170 degrees of abduction equaling zero percent impairment, 20 degrees of adduction equaling one percent impairment, 30 degrees of internal rotation equaling four percent impairment, and 50 degrees of external rotation equaling two percent impairment. Using the Combined Values Chart, he calculated 19 percent impairment of the right shoulder in accordance with the A.M.A., *Guides*. Dr. Ellis utilized the DBI rating method to find that under Table 15-5, for the SLAP surgery and sprain of the left shoulder, appellant had five percent impairment of the left upper extremity.

On November 26, 2019 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

In a development letter dated December 9, 2019, OWCP requested that appellant submit an impairment evaluation from his attending physician that addressed whether he had obtained MMI and to provide a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides*. It afforded him 30 days to submit the necessary evidence. No response was received.

By decision dated January 16, 2020, OWCP denied appellant's increased schedule award claim.

On October 17, 2020 appellant requested reconsideration.

On October 20, 2020 OWCP routed Dr. Ellis' November 18, 2019 report and the case record to Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination of appellant's date of MMI and the permanent impairment of his bilateral upper extremities under the sixth edition of A.M.A., *Guides*.

In an October 21, 2020 report, Dr. Katz discussed the findings in Dr. Ellis' November 18, 2019 report. He indicated that upon review of the records, appellant's treating physician

Dr. Freeman on April 9, 2019 provided measurements for ROM for the left shoulder that varied markedly from those ROM findings of Dr. Ellis on November 18, 2019. Dr. Katz determined that there was a significant conflict of information between these two examiners and recommended a second opinion impairment evaluation for both upper extremities be obtained.

On October 26, 2020 OWCP requested Dr. Ellis address Dr. Katz' October 21, 2020 report and provide a permanent impairment rating in accordance with the A.M.A., *Guides*. It afforded him 30 days to respond.

In a report dated November 12, 2020, Dr. Ellis reviewed Dr. Katz' report and disagreed with his findings. He noted that the April 9, 2019 office visit with Dr. Freeman was not an adequate examination for a schedule award rating and did not follow the A.M.A., *Guides*. Dr. Ellis addressed the disparity in his ROM measurements and those of Dr. Freeman as referenced by Dr. Katz and indicated that the A.M.A., *Guides* provides that the latest examination be utilized for an impairment rating. He therefore advised that his November 28, 2019 impairment rating was the appropriate report for a schedule award calculation. Dr. Ellis further advised that it was not uncommon for patients to develop worsening ROM over time with the types of injuries and surgeries appellant experienced. He affirmed the findings in his November 18, 2019 report.

On March 4, 2021, OWCP informed appellant that a conflict in medical opinion evidence existed between Dr. Ellis, appellant's treating physician, and Dr. Katz, the DMA, regarding the extent of his permanent impairment for schedule award purposes. It referred him, together with a statement of accepted facts (SOAF), the medical record, and a series of questions, to Dr. Joseph Tobin, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a report dated April 6, 2021, Dr. Tobin reviewed the SOAF and the medical record, and performed a physical examination. For the right shoulder, he noted 145 degrees of forward elevation, 90 degrees of abduction, and 30 degrees of external rotation, and indicated that internal rotation was to appellant's "belt line" for both shoulders. Dr. Tobin noted that appellant reached MMI in August 2019. He referred to the sixth edition of the A.M.A., *Guides*, and utilized the DBI rating method to find that, under Table 15-5 (Shoulder Regional Grid), page 402, the class of diagnosis (CDX) for appellant's SLAP lesion of the bilateral shoulders resulted in a Class 1 impairment. Dr. Tobin noted appellant had a severe problem with pain, other symptoms, and less than normal activity, but he did not require assistance to perform self-care. Pursuant to Table 15-9, page 410, he assigned a grade modifier of 4 for a SLAP lesion, severe problem. Dr. Tobin utilized the adjustment grid and based upon functional history, clinical studies, and diagnoses opined that appellant sustained 10 percent permanent impairment of each upper extremity. He found that the A.M.A., *Guides* did not provide for the ROM method to be utilized in determining an impairment rating when a diagnosis is available and is stated on the diagnostic shoulder regional grid.

On May 18 and July 20, 2021 OWCP requested clarification from Dr. Tobin with regard to the date of MMI and the impairment rating provided on April 6, 2021. No response was received.

On April 12, 2022 OWCP routed Dr. Tobin's April 6, 2021 report and the case record to Dr. Katz, serving as DMA, for review and a determination of appellant's date of MMI and the permanent impairment of his upper extremities under the sixth edition of the A.M.A., *Guides*. It

requested that Dr. Katz review Dr. Tobin's April 6, 2021 report and provide an opinion discussing whether he agreed with its findings.

In a report dated April 19, 2022, Dr. Katz indicated that Dr. Tobin's report could not be considered probative. He noted that Dr. Tobin incorrectly stated that ROM impairment was not provided for by the A.M.A., *Guides*. Dr. Katz advised that pursuant to Table 15-5 an alternative ROM impairment should be submitted if higher than a DBI rating. He further noted that Dr. Tobin failed to reference specific tables or provide worksheets to explain the method by which he arrived at his determination of 10 percent permanent impairment in each upper extremity. Dr. Katz also noted that Dr. Tobin did not provide complete ROM measurements for all planes of motion for the bilateral shoulders. He recommended that Dr. Tobin be offered that opportunity to submit a corrective supplemental report and if he is unable to comply then another impartial medical examination should be performed.

On June 23, 2022 OWCP requested clarification from Dr. Tobin with regard to the date of MMI and the impairment rating provided on April 6, 2021.

OWCP received a May 6, 2022 supplemental report, wherein Dr. Tobin opined that appellant had 10 percent permanent impairment of each upper extremity. He advised that this was the total and complete impairment sustained. Dr. Tobin indicated that this was not in addition to any prior schedule award.

In a memorandum dated July 31, 2022, OWCP noted that it made several attempts to obtain a supplemental report from Dr. Tobin without response.

By decision dated September 1, 2022, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left upper extremity (shoulder) and an additional 7 percent permanent impairment of the right upper extremity (shoulder), for a total of 10 percent. The period of the award ran for 53.04 weeks from April 6, 2021 through April 12, 2022.

OWCP continued to receive additional evidence. On September 14, 2022 Dr. Ellis evaluated appellant for an updated impairment rating for his left shoulder injury. He diagnosed other sprain of the left shoulder joint and superior glenoid labral lesion. Dr. Ellis noted that appellant reached MMI on September 14, 2022. He indicated a *Quick*DASH score of 39 for the left upper extremity and 16 for the right upper extremity. Dr. Ellis recorded appellant's active ROM measurements and opined that he had 21 percent permanent impairment of the left upper extremity and 15 percent permanent impairment of the right upper extremity in accordance with the ROM rating method of the A.M.A., *Guides*. He referred the A.M.A., *Guides* and utilized the DBI rating method to find that, under Table 15-5, page 402, the CDX for appellant's multidirectional shoulder instability resulted in 25 percent impairment of the left upper extremity and 13 percent permanent impairment of the right upper extremity.

On October 18, 2022 appellant requested reconsideration.

On October 19, 2022 OWCP routed Dr. Ellis' September 14, 2022 report, a SOAF, and the case file to Dr. Katz serving as a DMA, for review and a determination of permanent impairment of appellant's upper extremity under the A.M.A., *Guides*, and his date of MMI.

In a report dated October 25, 2022, Dr. Katz disagreed with Dr. Ellis's impairment rating for multidirectional instability, noting that neither the MRI scan findings nor Dr. Ellis' own

examination findings supported this diagnosis. Dr. Katz further noted the discrepancy between the ROM findings of Dr. Freeman and those of Dr. Ellis. He recommended appellant be referred for a second opinion examination.

On November 17, 2022 OWCP referred appellant, the medical record, a SOAF, and a series of questions to Dr. Curt L. Freudenberger, a Board-certified orthopedist, for a second opinion evaluation of his permanent impairment for schedule award purposes.

In a December 14, 2022 report, Dr. Freudenberger noted appellant's history of injury and medical treatment. He noted that active ROM measurements were obtained on three successive trials for each shoulder. With regard to the right shoulder, Dr. Freudenberger calculated 14 percent permanent impairment under the ROM method. With regard to the left shoulder, he calculated 16 percent permanent impairment under the ROM method.

Dr. Freudenberger referred to the sixth edition of the A.M.A., *Guides*, and utilized the DBI rating method to find that, under Table 15-5, page 402, the CDX for appellant's right and left labral lesions, including SLAP tearing with no instability, resulted in a Class 1 impairment with a default value of 12 percent.[6] He found that the ROM method resulted in 14 percent permanent impairment for the right upper extremity, which was the higher result of the two methodologies. Dr. Freudenberger advised that appellant reached MMI on December 14, 2021. Regarding the ROM method for the left shoulder, he found that the ROM method resulted in 16 percent permanent impairment for the left upper extremity, which was the higher of the two methodologies.

On January 4, 2023 OWCP routed Dr. Freudenberger's December 14, 2022 report, a SOAF, and the case file to Dr. Katz serving as an OWCP DMA, for review and a determination of permanent impairment of appellant's upper extremity under the A.M.A., *Guides*, and his date of MMI. It noted that claimant was previously awarded compensation for "10 percent and 7 percent permanent partial impairment of the left upper extremity and 7 percent right upper extremity." OWCP instructed Dr. Katz to stipulate whether the percentage provided includes the prior percentage awarded or if it should be considered in addition to the prior percentage awarded.

In a report dated January 5, 2023, Dr. Katz advised that, in order to complete the review and determine the net additional award now due, he had requested the prior DMA reports authorizing previous awards for each upper extremity so that overlapping impairments could be identified.

On January 10, 2023 OWCP indicated that it enclosed copies of the DMA reports from 2018 and 2020 and requested Dr. Katz calculate the additional net award due.

On January 11, 2023 Dr. Katz indicated that although the OWCP memorandum dated January 10, 2023 stated that prior DMA reports from 2018 and 2020 were submitted, he was only able to locate one definitive recommendation from April 25, 2018 in which three percent impairment was recommended for the right shoulder impairment. He noted that the memorandum states that prior awards in the amount of "'10 percent and 7 percent of the LUE' and 7 percent RUE were made." Dr. Katz advised that he was unable to account for the additional awards and

[6] Dr. Freudenberger provided a DBI rating for the CDX of multidirectional instability. He calculated 12 percent permanent impairment of each upper extremity for multidirectional instability.

additional clarification was necessary to determine a recommendation regarding any additional awards.

By decision dated March 16, 2023, OWCP denied modification of the September 1, 2022 decision.

## ***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 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[10] 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.[11]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's *International Classification of Functioning Disability and Health (ICF): A Contemporary Model of Disablement*.[12] Under the sixth edition, the evaluator identifies the impairment CDX, which is then adjusted by a grade modifier for functional history (GMFH), a grade modifier for physical examination (GMPE), and a grade modifier for clinical studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[15]

FECA Bulletin No. 17-06 provides guidance in applying ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities.[16] Regarding the

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id*. at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[11] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[12] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

[13] *Id*. at 494-531.

[14] *Id*. at 411.

[15] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

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

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

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
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> "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*."[17] (Emphasis in the original.)
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> The Bulletin further provides:
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> "If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[18]
>
> "Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians' evaluation, the CE should route that report to the DMA for a final determination."[19]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical examiner (IME)) who shall make an examination.[20] 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

[17] *Id*.

[18] *Id*.; *R.L.*, Docket No. 19-1793 (issued August 7, 2020).

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

[20] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

with the case.[21] When a 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.[22]

## ***ANALYSIS***

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

OWCP properly determined that there was a conflict in the medical opinion evidence between Dr. Ellis, appellant's treating physician, and Dr. Katz, an OWCP district medical examiner, regarding the extent of permanent impairment of his bilateral upper extremities due to his accepted left shoulder joint sprain, left shoulder superior glenoid labrum lesion, right shoulder lesions, and loose body in the right shoulder. In order to resolve the conflict, it properly referred him, pursuant to 5 U.S.C. § 8123(a), to Dr. Tobin for an impartial medical examination.[23]

The Board finds, however, that Dr. Tobin's reports are not well rationalized regarding the extent of appellant's permanent impairment due to his accepted right and left upper extremity injuries as he did not properly apply the standards of the A.M.A., *Guides*.

In his April 6, 2021, and May 6, 2022 reports, Dr. Tobin reviewed the SOAF and the medical history and performed a physical examination. He opined that the A.M.A., *Guides* did not provide for the ROM method to be utilized in determining an impairment rating when a diagnosis is available and is stated on the diagnostic shoulder regional grid. However, Table 15-5 provides for an alternative ROM impairment that should be submitted if higher than a DBI impairment. As he did not provide an impairment rating in accordance with the A.M.A., *Guides*, his opinion is insufficient to carry the special weight of the medical evidence regarding the nature and extent of appellant's permanent impairment due to his accepted bilateral shoulder injuries.[24]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[25] However, when the impartial medical specialist is unable to clarify or elaborate on the original report or if a supplemental report is also vague, speculative or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a second impartial specialist

[21] 20 C.F.R. § 10.321.

[22] *K.D.*, Docket No. 19-0281 (issued June 30, 2020); *J.W.*, Docket No. 19-1271 (issued February 14, 2020); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts*, 31 ECAB 1010 (1980).

[23] *L.Y.*, Docket No. 20-0398 (issued February 9, 2021); *B.S.*, Docket No. 19-1717 (issued August 11, 2020) *Darlene R. Kennedy*, *id*.

[24] *See K.W.*, Docket No. 22-0320 (issued July 28, 2022); *see also id*.

[25] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

for the purpose of obtaining a rationalized medical opinion on the issue.[26] In this case, the Board finds that Dr. Tobin, serving as the IME, failed to provide an opinion that conforms to the A.M.A., *Guides*, and, is therefore insufficient to carry the special weight of the medical evidence regarding the nature and extent of appellant's permanent impairment.[27] On remand, OWCP shall refer appellant to a new IME in the appropriate field of medicine. After this and other such further development as deemed necessary, it shall issue a *de novo* decision.

## ***CONCLUSION***

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

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the March 16, 2023 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: April 11, 2024
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

[26] *M.C.*, Docket No. 22-1160 (issued May 9. 2023); *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

[27] *See also L.Y.*, Docket No. 20-0398 (issued February 9, 2021); *Paul R. Evans, Jr.*, 44 ECAB 646, 651 (1993).