United States Department of Labor
Employees' Compensation Appeals Board

P.H., Appellant	)	
and	)	**Docket No. 24-0897**
	)	**Issued: November 20, 2024**
U.S. POSTAL SERVICE, GOLDEN POST OFFICE, Denver, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On September 4, 2024 appellant filed a timely appeal from an April 26, 2024 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 met her burden of proof to establish greater than 100 percent permanent impairment of the right middle finger for which she has previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the April 26, 2024 decision, OWCP received additional evidence. 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*.

FACTUAL HISTORY

This case was previously before the Board.[3] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On December 24, 2011 appellant, then a 52-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 23, 2011 she slipped and fell on ice injuring her face and right hand while in the performance of duty. She stopped work on December 27, 2011 and returned on January 3, 2012. On February 10, 2012 OWCP accepted the claim for a closed fracture of the proximal phalanx of the right middle finger. On September 19, 2013 it expanded acceptance of the claim to include contracture of the right finger joint and right hand osteoarthritis.

On November 26, 2013 appellant underwent arthrodesis of the right long finger proximal interphalangeal (PIP) joint and synovial biopsy.

Appellant filed a claim for compensation (Form CA-7) for a schedule award on July 1, 2014. By decision dated October 3, 2014, OWCP granted her a schedule award for 89 percent permanent impairment of her right middle finger. Appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. By decision dated March 12, 2015, OWCP's hearing representative affirmed the October 3, 2014 schedule award decision.[4]

On June 5, 2015 appellant underwent surgical removal of the hardware in her right long finger.

In a report dated August 4, 2015, Dr. Edmund Rowland, a Board-certified orthopedic surgeon, noted that appellant continued to experience difficulties with her right hand including the inability to grasp or grip. Appellant reported that she was unable to curl the index, right, and small fingers tightly into her palm. Dr. Rowland diagnosed painful end-stage right long finger proximal interphalangeal (PIP) joint osteoarthritis with instability following fusion and hardware removal, an awkward stiff finger, and the inability to tightly curl the index, ring, and small fingers on the right. He was unable to provide a definitive explanation for appellant's inability to curl her fingers and suggested that this was due to adhesions tethering the flexor digitorum profundus (FDP) and limiting its excursion.

In a letter dated January 20, 2016, appellant requested an additional schedule award alleging that she had additional permanent impairment of her right hand due to her accepted employment injury.[5]

[3] Docket No. 21-0233 (issued May 10, 2023).

[4] On June 16, 2015 appellant appealed the March 12, 2015 decision to the Board. On October 7, 2015 she requested that the Board dismiss her appeal, which it did on January 20, 2016. *Order Dismissing Appeal*, Docket No. 15-1417 (issued January 20, 2016).

[5] On March 8, 2016 the Office of Personnel Management approved appellant's application for disability retirement.

Dr. Rowland completed a report and treatment notes on March 17, 2016 and indicated that he could not fully explain appellant's continued pain, tendon adhesions, and joint contractures of the right hand.

On May 12, 2016 the employing establishment noted that appellant had returned to regular duty on May 10, 2016.

Appellant filed a Form CA-7 requesting a schedule award on June 17, 2016. She provided a June 3, 2016 report from Dr. Gretchen Brunworth, a Board-certified physiatrist, who discussed appellant's December 23, 2011 employment incident and resulting medical treatment. Dr. Brunworth provided findings on physical examination and noted that following the 2015 surgery appellant developed deficits in range of motion (ROM) of the second through fifth fingers of the right hand and was unable to make a full grip. She opined that adhesions of the palmar fascia limited movement of the flexor tendons. Dr. Brunworth recommended physical therapy and found that appellant had not reached maximum medical improvement (MMI). However, she also provided an impairment rating.

On February 23, 2017 appellant filed a Form CA-7 requesting a schedule award. She submitted a report dated February 20, 2017 from Dr. Brunworth finding that she had reached MMI and addressing her permanent impairment. Dr. Brunworth noted appellant's history of injury and diagnosed fracture of the PIP joint of her right third digit with arthrodesis and severe end-stage osteoarthritis. She found ROM deficits in the second through fifth fingers on the right and noted that appellant was unable to make a full fist. Dr. Brunworth concluded that appellant had seven percent upper extremity impairment for the middle finger, eight percent upper extremity impairment for the index finger, eight percent impairment rating for fourth finger, and eight percent upper extremity impairment for the fifth finger. She combined appellant's impairment ratings to reach 27 percent permanent impairment of the right upper extremity.

On March 3, 2017 OWCP referred Dr. Brunworth's February 20, 2017 report, a statement of accepted facts (SOAF), and a list of questions to Dr. David J. Slutsky, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review and a determination of her permanent impairment for schedule award purposes. In a March 29, 2017 report, Dr. Slutsky found that Dr. Brunworth[6] did not provide any physical findings or medical reasoning in support of her permanent impairment calculations. He requested additional medical evidence addressing application of appellant's physical findings to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7]

In an April 7, 2017 development letter, OWCP requested additional medical evidence from appellant in support of her schedule award claim and afforded her 30 days for a response.

Dr. Brunworth responded on May 2, 2017 and asserted that her June 3, 2016 report explained appellant's permanent impairment for schedule award purposes.

[6] The DMA improperly attributed the June 3, 2016 report to Dr. Rowland rather than to Dr. Brunworth.

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

On August 8, 2017 the DMA found that Dr. Brunworth's[8] reports were insufficient to establish appellant's permanent impairment for schedule award purposes as appellant had not reached MMI at the time of the June 3, 2016 report and as the February 20, 2017 report did not contain findings or rationale in support of the impairment rating.

On December 1, 2017 OWCP referred appellant, a SOAF, and a list of questions for a second opinion evaluation of her permanent impairment for schedule award purposes with Dr. Richard Blecha, a Board-certified orthopedic surgeon.

In a January 4, 2018 report, Dr. Blecha reviewed the SOAF and medical records. He performed a physical examination and found that appellant had slight swelling of the PIP joint of the middle finger of the right hand. Dr. Blecha also found that her finger distal to the PIP joint was rotated medially a few degrees, and that she had slight tenderness in all fingers. He measured ROM of the thumb and four fingers three times. Dr. Blecha noted that appellant had undergone additional finger surgery in 2015 and developed complications resulting in partial ankyloses of all fingers and to some degree of the thumb. He found that due to the consequential injuries resulting from the 2015 surgery, appellant's whole hand should be rated for schedule award purposes. Dr. Blecha also found that appellant had reached MMI on December 15, 2016. He diagnosed ankyloses and arthrodesis and applied Table 15-2, page 394, of the A.M.A., *Guides*, which noted that motion loss may be assessed by Section 15.7, page 459, Range of Motion Impairment. Dr. Blecha found that appellant had 23 percent permanent impairment of the thumb or 9 percent permanent impairment of the right hand. He further determined that she had 59 percent impairment of the index finger or 12 percent permanent impairment of the hand, 92 percent impairment of the middle finger or 18 percent impairment of the hand, 84 percent impairment of the ring finger or 8 percent impairment of the hand, and 74 percent impairment of the little finger or 7 percent impairment of the hand, for total right hand impairment of 54 percent or 41 percent impairment of the right upper extremity.

On February 19, 2018 the DMA reviewed Dr. Blecha's report and found that appellant had 80 percent impairment of the right middle finger which converted to 16 percent right hand impairment and 14 percent right upper extremity impairment. He opined that hardware removal from the PIP joint was a relatively minor procedure and would not be expected to result in multiple contractures involving the thumb and adjacent digits in the absence of a documented chronic regional pain syndrome and that therefore the impairment rating should be restricted to the middle finger.

OWCP, on May 17, 2018, found that there was a conflict of medical opinion evidence between Drs. Blecha and Slutsky requiring an impartial medical examination. It referred appellant, a SOAF, and a list of questions for examination by Dr. Michael Dunn, a Board-certified orthopedic surgeon.

On June 5, 2018 Dr. Dunn completed a report and diagnosed contracture of the right hand. He opined that appellant had reached MMI and found that she had 24 percent permanent impairment of the right upper extremity based on loss of ROM in accordance with Table 15-30, Table 15-31, and Table 15-12 of the A.M.A., *Guides*.

[8] The DMA continued to attribute the June 3, 2016 and February 20, 2017 reports to Dr. Rowland rather than to Dr. Brunworth.

On September 14, 2018 OWCP requested a supplemental report from Dr. Dunn providing a diagnosis, a detailed description of permanent impairment, and a discussion of the rationale for the calculation of appellant's permanent impairment rating based on the sixth edition of the A.M.A., *Guides*. In response, Dr. Dunn submitted his June 5, 2018 treatment note.

On September 24, 2018 OWCP determined that Dr. Dunn was a second opinion physician, not an impartial medical examiner (IME) as there was no conflict of medical opinion between an OWCP physician and a physician for appellant at the time of his referral.

On February 6, 2019 OWCP referred appellant, a SOAF, and a list questions for a second opinion evaluation with Dr. Raymond Topp, a Board-certified orthopedic surgeon, to determine her permanent impairment for schedule award purposes.

In a report dated February 26, 2019, Dr. Topp examined appellant and found that she had pain out of proportion to his examination. He found that the only appreciable casually connected diagnosis was to the right middle finger and noted that she later had a PIP fusion and hardware removal. Dr. Topp also found some ankylosis of the distal interphalangeal (DIP) joint due to the accepted employment injury but no signs of carpal tunnel syndrome or any other injury. He recommended nerve conduction velocity (NCV) studies and a right-hand magnetic resonance imaging (MRI) scan. Dr. Topp found that appellant had reached MMI. He determined that the hardware removal surgery resulted in no further impairment to the middle finger. Dr. Topp found no reason to include the remaining aspects of the right hand and found no organic basis for the loss of ROM as appellant was resistant and had pain out of proportion. He concluded that she had no more than 89 percent permanent impairment of her right middle finger.

Appellant underwent a right-hand MRI scan on March 18, 2019 which demonstrated bone marrow edema of the ulnar aspect of the right index finger metacarpal base or fracture. In a June 28, 2019 addendum, Dr. Topp reviewed the diagnostic studies and found that they confirmed that there was no evidence of carpal tunnel syndrome. He noted that appellant had baseline ulnar abutment syndrome which was chronic and unrelated to her accepted employment injury or resulting surgery.

In a September 1, 2019 report, the DMA found that Dr. Topp did not perform valid ROM measurements but instead noted that it was difficult to evaluate appellant's motion due to "a lack of cooperation." He also did not provide the angle of ankyloses of the PIP or DIP joint. The DMA concluded that appellant had no more than 89 percent permanent impairment of her right middle finger for which she had previously received a schedule award.

By decision dated September 11, 2019, OWCP denied appellant's claim for an additional schedule award. On October 10, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing before an OWCP hearing representative was held on February 6, 2020.

In a June 16, 2020 report, Dr. Michael James Sullivan, Board-certified in emergency medicine, examined appellant's right hand and diagnosed right hand pain, trigger ring finger right hand, Dupuytren's disease, and limitation of joint motion of the right hand.

By decision dated October 9, 2020, OWCP's hearing representative set aside the September 11, 2019 decision and remanded the case for further development by OWCP, including additional review of the medical records by the DMA to determine whether carpal tunnel syndrome or ulnar abutment syndrome was causally related to the accepted work injury and whether the impairment should "be for the right middle finger, hand, or upper extremity."

On November 10, 2020 the DMA, Dr. Slutsky, asserted that he was unable to comment on Dr. Topp's June 28, 2019 addendum regarding carpal tunnel syndrome or ulnar abutment syndrome as was it was not provided to him.

By decision dated November 12, 2020, OWCP denied appellant's claim for an additional schedule award.

Appellant appealed to the Board. By decision dated May 10, 2023, the Board found an unresolved conflict in medical opinion evidence between Drs. Slutsky and Topp, OWCP physicians, and Drs. Rowland and Brunworth, appellant's physicians. It directed OWCP to refer appellant to an impartial medical examiner (IME) to resolve the conflict in the medical opinion evidence regarding her permanent impairment due to her accepted conditions and to provide a reasoned opinion regarding whether she had an impairment of the right hand as a consequence of her accepted employment injury and resulting surgeries, to be followed by a *de novo* schedule award decision.

On August 24, 2023 OWCP referred appellant, along with a SOAF, and the medical record, to Dr. Joseph Tobin, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict in the medical opinion regarding permanent impairment for her upper extremity. It requested that he provide rationalized opinion regarding whether appellant had a permanent impairment of the right hand due to her accepted employment injury and resulting surgeries.

In his October 27, 2023 report, Dr. Tobin described appellant's 2011 employment injury and resulting surgery. He reviewed the SOAF and the medical records. Dr. Tobin performed a physical examination and initially found that she exhibited 90 degrees of flexion of the metacarpophalangeal (MP) joint of her fifth digit but as the examination progressed to her hand, she became rigid such that any attempt to flex her joints was met with rigidity and complete extension of her wrist and hand. Appellant's long digit demonstrated that her PIP joint was rigidly flexed at 20 degrees and that the DIP joint had little to no motion. He found that her middle finger MP joint ROM was extremely difficult or impossible to measure "because of the extreme muscle rigidity that she is voluntarily enacting in both her wrists and all digits of her hand. The hand does not show extreme warmth, erythema, or vascular changes."

Dr. Tobin opined that appellant's work-related injury was related to the fracture of her PIP joint of her middle finger. He asserted that the additional conditions of carpal tunnel syndrome and ulnar abutment syndrome were unrelated to her original injury. Dr. Tobin determined that appellant's ROM measurements were difficult to assess due to lack of cooperation and could not be relied upon in determining an impairment rating as she made it clear to him that she felt that her impairment rating was directly related to her ROM measurements. He further explained that the ROM measurements of her other digits, hands, and wrist were impacted by appellant's voluntary muscular rigidity and unwillingness to cooperation with an adequate ROM assessment of her hand.

Using the DBI method of the A.M.A., *Guides*, Dr. Tobin noted that appellant had undergone arthrodesis of the right long finger PIP joint on November 15, 2013 and hardware removal on June 5, 2015. He advised that arthrodesis was best rated using the ROM method. Under the ROM methodology of the A.M.A., *Guides*, Dr. Tobin found complete ankylosis of the DIP and PIP joints, which yielded a combined 30 and 50 percent permanent impairment rating or 80 percent of the digit. He further determined that 100 percent fusion, ankylosis, and zero motion of the MP joint yielded 45 percent impairment of the digit. Dr. Tobin determined that appellant had lost 100 percent use of her right-hand middle finger due to loss of ROM. He found 100 percent impairment of that digit due to loss of ROM corresponding to 12 percent impairment of the "hand" in accordance with Table 15-11.

On February 23, 2024 OWCP requested a supplemental report from Dr. Tobin addressing the date of MMI. In an April 23, 2024 addendum, Dr. Tobin found that appellant had reached MMI on October 28, 2015 as determined by Dr. Roland.

By decision dated April 26, 2024, OWCP granted appellant a schedule award for an additional 11 percent permanent impairment of her right middle finger, for a total impairment of 100 percent. The award ran for 3.1 weeks from October 27 through November 19, 2023, and was based on Dr. Tobin's October 27, 2023 and April 23, 2004 reports.

LEGAL PRECEDENT

The schedule award provisions of FECA,[9] and its implementing federal regulations,[10] 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. FECA, however, does not specify the way the percentage of loss 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.[11] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[12]

In addressing impairment of the upper extremities, the sixth edition of the A.M.A., *Guides* request identify the impairment for the CDX condition, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[14] Evaluators are directed to provide reasons for their impairment rating

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id.* at § 10.404(a).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[13] A.M.A., *Guides* (6th ed. 2009) at 3, section 1.3, *The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.

[14] *Id.* at 411.

choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[15]

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.[16] 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.[17] 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.[18]

Regarding the application of ROM or DBI 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).
>
> "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 impairment rating for the diagnosis in question, the method producing the higher rating should be used*." (Emphasis in the original.)[19]
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> The Bulletin further advises:
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> "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."[20]

Section 8123(a) of FECA provides that, 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 IME) who shall make an

[15] *R.A.*, Docket No. 19-1798 (issued November 4, 2020); *S.J.*, Docket No. 18-0966 (issued September 20, 2019); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[16] A.M.A., *Guides* 461.

[17] *Id.* at 473.

[18] *Id.* at 474.

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

[20] *Id.*

examination.[21] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22]

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.[23]

ANALYSIS

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

Preliminarily, the Board notes that it is unnecessary to consider the evidence appellant submitted prior to the issuance of OWCP's November 12, 2020 decision because the Board considered that evidence in its May 10, 2023 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[24]

In his October 27, 2023 report, Dr. Tobin, the IME, opined that appellant's ROM was difficult to assess due to lack of cooperation and could not be relied upon in determining an impairment rating as she made it clear to him that she felt that her impairment rating was directly related to her ROM measurements. He further explained that the ROM measurements of her middle finger MP joint and her other digits, hands, and wrist were impacted by her voluntary muscular rigidity and unwillingness to cooperation with an adequate ROM assessment of her hand. Dr. Tobin then applied the ROM methodology to find an 80 percent impairment of the digit due to complete ankylosis of the DIP and PIP joints and 45 percent impairment of the digit due to 100 percent fusion, ankylosis, and zero motion of the MP joint, which he found yielded 100 percent loss of use of the right middle finger. He opined that appellant had 12 percent permanent impairment of the right hand. The Board finds, however, that Dr. Tobin's report is not well rationalized regarding the extent of appellant's permanent impairment due to her right middle finger, as he does not properly provide findings or apply the standards of the A.M.A., *Guides*.[25] He provided conflicting findings about whether there was a ratable additional impairment of the right middle finger due to loss of ROM of the MP joint of the right middle finger due to appellant's voluntary rigidity.

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[21] 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).

[22] 20 C.F.R. § 10.321; *P.H.*, Docket No. 21-0233 (issued May 10, 2023); *R.C.*, 58 ECAB 238 (2006).

[23] *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).

[24] *J.D.*, Docket No. 21-0425 (issued January 24, 2022); *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

[25] Section 15.7 of the sixth edition of the A.M.A., *Guides* provides that ROM should be measured after a warmup, in which the individual moves the joint through its maximum ROM at least three times. The ROM examination is then performed by recording the active measurements from three separate ROM efforts and all measurements should fall within 10 degrees of the mean of these three measurements. The maximum observed measurement is used to determine the ROM impairment. A.M.A., *Guides* 464; *see also C.H.*, Docket No. 20-0529 (issued June 16, 2021); *P.H.*, Docket No. 18-0987 (issued March 30, 2020).

Additionally, the Board notes that Dr. Tobin opined that appellant's work-related injury was solely related to the fracture of her PIP joint of her middle finger. He also found, without explanation, that the additional conditions of carpal tunnel syndrome and ulnar abutment syndrome were unrelated to her original injury. As Dr. Tobin did not provide medical reasoning for his opinions, his reports are of diminished probative value regarding the extent of appellant's work-related conditions and the degree of her permanent impairment due to her accepted employment injury.[26] Accordingly, his opinion does not conform to the A.M.A., *Guides*, and is of diminished probative value regarding the degree of permanent impairment due to appellant's accepted upper extremity conditions.[27] Therefore, it is insufficient to carry the special weight of the medical opinion evidence regarding the nature and extent of appellant's permanent impairment.[28]

Proceedings under FECA are not adversarial in nature, and OWCP is not a disinterested arbiter. The claimant has the burden of proof to establish entitlement to compensation.[29] However, OWCP shares responsibility in the development of the evidence to see that justice is done.[30] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[31]

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, it has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[32] However, when the original report of the IME is vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a new IME for the purpose of obtaining a rationalized medical opinion on the issue.[33]

The case shall be remanded to OWCP for referral of appellant to a new IME for the purpose of resolving the conflict in the medical opinion evidence on the issue of the present case.[34] The IME shall provide an impairment rating and explain whether appellant's impairment extends from

[26] *See R.W.*, Docket No. 24-0746 (issued September 30, 2024); *H.C.*, Docket No. 21-0761 (issued May 5, 2022).

[27] *Id*.

[28] *See R.W., supra* note 26; *V.G.*, Docket No. 20-0455 (issued June 17, 2021).

[29] *See L.B.*, Docket No. 19-0432 (issued July 23, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[30] *Id*.; *see also R.W., supra* note 26; *C.F.*, Docket No. 21-0003 (issued January 21, 2022); *S.A.*, Docket No. 18-1024 (issued March 12, 2020).

[31] *Id*.

[32] *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

[33] *See R.W., supra* note 26; *A.K.*, Docket No. 23-1135 (issued April 11, 2024); *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, id*.

[34] *See R.W., supra* note 26; *D.D.*, Docket No. 24-0203 (issued May 2, 2024); *R.O.*, Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996).

her finger into her hand and/or upper extremity. After this and other such further development as deemed necessary, it shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 26, 2024 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further development consistent with this decision of the Board.

Issued: November 20, 2024
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board