United States Department of Labor
Employees' Compensation Appeals Board

C.P., Appellant	)	
and	)	**Docket No. 15-0617**
	)	**Issued: August 4, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Estero, FL, Employer	)	

Appearances:
Ronald S. Webster, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 26, 2015 appellant, through counsel, filed a timely appeal from a November 19, 2014 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.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation and medical benefits effective September 23, 2012 as she no longer had any residuals or disability causally related to her accepted employment-related injury; and (2) whether appellant has met her burden of proof to establish that she had continuing employment-related disability after September 23, 2012.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 26, 2003 appellant, then a 51-year-old rural carrier associate, filed an occupational disease claim alleging that the repetitious activities of her job caused bilateral hand pain. Under claim number xxxxxx137, OWCP accepted the conditions of bilateral carpal tunnel syndrome and paid benefits. Bilateral carpal tunnel releases were authorized. Appellant returned to unrestricted work activities on June 12, 2004. The employing establishment terminated her employment April 7, 2006. On May 11, 2006 appellant filed a second claim for right hand and arm pain which she attributed to her employment activities in April 2006. That claim, assigned file number xxxxxx598, was accepted for right carpal tunnel syndrome and right ulnar nerve lesion. OWCP paid appropriate benefits including a right ulnar nerve transposition, which appellant underwent October 9, 2006. Appellant was retained on OWCP's periodic compensation rolls for total disability from October 9, 2006.

Appellant continued to seek medical attention for her hand conditions. In recent years, she sought treatment from Dr. Howard Sleight, a Board-certified anesthesiologist, who focused on subjective pain relief and narcotic abuse monitoring. Appellant also sought treatment from Dr. Stuart B. Krost, a Board-certified physiatrist, who opined, in an April 8, 2011 report, that she had cervicalgia with reactive myofascial spasm and distal nerve entrapment. An upper electromyogram (EMG) demonstrated borderline bilateral carpal tunnel syndrome.

In December 2011, OWCP referred appellant, along with a statement of accepted facts (SOAF), list of questions, and the medical record, to Dr. Jonathan Black, a Board-certified orthopedic surgeon. In a January 17, 2012 report, Dr. Black noted the history of injury and his review of the medical records, including the SOAF. His bilateral wrist examination found no evidence of any swelling, ecchymosis, atrophy, or deformity. Wrist palpation did not reveal any effusion, tenderness or crepitations. Wrist range of motion was normal, with all muscles tendon units functioning independently. Strength in both wrists was full in all muscle groups tested. Reflexes were normal and symmetric and Tinel's and Phalen's signs were negative bilaterally at the wrists. Examination of right elbow revealed no deformity, ecchymosis, swelling, or atrophy. Palpation revealed no crepitus or effusion; mild medial tenderness was recorded. Range of motion testing was full in flexion and extension, actively, and passively. Strength was full in all muscle groups with a positive Tinel's noted over the trans-post ulnar nerve. An EMG and nerve conduction study (NCS) of January 24, 2007 revealed evidence of mild left carpal tunnel syndrome with no evidence of radiculopathy. Dr. Black diagnosed mild bilateral carpal tunnel syndrome with dysesthesia of the right ulnar nerve.

Regarding appellant's current status, Dr. Black opined that there were no objective medical findings to indicate that the accepted work-related conditions were still active, other than appellant's subjective complaints of pain and a mild EMG result from five years ago. He noted that the ulnar symptoms reported were a subjective finding and she was neurologically intact from the standpoint of her ulnar nerve. Dr. Black opined that the work-related conditions had resolved. He opined that appellant had reached maximum medical improvement and, while she could not medically return to her date-of-injury position, she could return to full-time employment with restrictions. A work capacity evaluation noted that she had permanent restrictions on no repetitive movements of wrists and elbow and 20-pound lifting restriction.

OWCP requested that Dr. Black provide an addendum report clarifying his contradiction regarding the diagnosis of mild carpal tunnel syndrome and the positive Tinel's sign at the right elbow. In a March 6, 2012 report, Dr. Black stated that appellant had carpal tunnel release in 2002 and a subsequent revision carpal tunnel release. The fact that appellant had residual "mild left carpal tunnel syndrome" by EMG did not necessarily translate into a continued residual of her work-related condition. The median nerve could show continued signs of mild compression event following release as this was the nature of nerves in general. Dr. Black explained that, on physical examination, appellant did not have any ongoing signs of carpal tunnel syndrome as there was negative Phalen's maneuver and Tinel's signs bilaterally and she demonstrated full range of motion. He explained that she did not have any continued disability from her work-related condition, but she should not perform her date-of-injury job as she was at high risk for reinjury. Dr. Black opined that the accepted conditions had resolved.

On August 17, 2012 OWCP notified appellant of the proposed termination of her medical and wage-loss compensation benefits based on Dr. Black's reports of January 17 and March 6, 2012, which substantiated that she was not experiencing any residuals or disability caused by the accepted work-related conditions. Appellant was provided 30 days to submit additional information.

Appellant's counsel responded in a letter dated September 7, 2012. He argued that Dr. Black was inconsistent in his reports by citing a positive Tinel's sign and then opining that the carpal tunnel condition had resolved. Counsel argued that Dr. Black was biased against injured workers. No additional medical evidence was received.

By decision dated September 21, 2012, OWCP terminated appellant's medical benefits and compensation for wage loss effective September 23, 2012 finding that the weight of the medical evidence rested with Dr. Black.

On September 28, 2012 OWCP received appellant's request for a telephonic hearing before an OWCP hearing representative. Both appellant and her counsel testified at the telephonic hearing held on January 8, 2013.

Medical evidence was received subsequent to the September 21, 2012 decision. A March 11, 2011 EMG and NCS noted borderline delayed median nerve distal latency bilaterally. An interpretation of borderline bilateral carpal tunnel syndrome with no evidence of neuropathy or radiculopathy was provided.

In a July 1, 2011 report, Dr. Nasir Khalidi, an internist, saw appellant for severe headaches. His examination found no motor weakness in the arms. Sensory testing revealed minimal loss to pinprick and mild subjective loss to pinprick in the hands. With regards to the work-related diagnosis, Dr. Khalidi provided an impression of carpal tunnel release status post and ulnar entrapment neuropathy, right cubital tunnel transposition status post.

In a February 29, 2012 report, Dr. Leonard Benton, a Board-certified anesthesiologist, reviewed Dr. Black's report and appellant's chart. He agreed that she had permanent limitations secondary to wrist and elbow pain and neuropathy and that maximum medical improvement had

been reached. Dr. Benton indicated that appellant could not work in a job requiring lifting, pushing, or pulling and recommended functional capacity testing.

In a September 26, 2012 letter, Dr. Sleight reported that appellant presented to the office with hyperesthesia in the upper extremities, pain in bilateral wrist and right elbow, and a decrease in muscle strength in the upper extremities. He related that she had stated that she was unable to carry a bag of groceries, vacuum, or do many of her daily functions due to her inability to carry anything of significant weight or do repetitive motions of the wrist and right elbow due to severe pain. Dr. Sleight suggested that a functional capacity test be performed to determine appellant's work capabilities.

In a November 6, 2012 report, Dr. Lian Jen, a Board-certified physiatrist, noted that this was appellant's initial visit. He noted her history of injury and subjective complaints. Dr. Jen reported examination findings, which included right hand motor strength of 4/5, with 3+/5 to 4-/5 in the bilateral upper extremities. He noted weak grip and wrist strength and presented the recorded left and right measurements. Deep tendon reflexes were 1/4 with intact sensory to light touch, but decreased in both hands. Dr. Jen found right hand weakness and stiffness in the finger range of motion. An assessment of bilateral carpal tunnel syndrome and right ulnar neuropathy were provided. Dr. Jen opined that appellant continued to exhibit residual pain and weakness in both hands, despite surgeries, finding that her work injuries were still present, and disabling. He found her work aggravation to be permanent and that she was currently disabled for all work.

By decision dated March 26, 2013, an OWCP hearing representative affirmed the September 21, 2012 decision finding that Dr. Black's opinion continued to carry the weight of the medical evidence and established that appellant no longer had any residuals of carpal tunnel syndrome in either arm or any residuals of her right ulnar neuropathy.

On September 20, 2013 OWCP received appellant's September 16, 2013 request for reconsideration. Additional evidence was received, which included medication summary reports and basic information regarding clinical drug testing.

A September 11, 2013 NCS showed bilateral median motor neuropathies at the wrist with no evidence of ulnar neuropathy, cervical radiculopathy, or plexopathy.

In a March 11, 2013 report, Dr. Sleight noted examination findings of hypotonicity and abnormal motor strength; atrophy of the thenar eminences, weakness of all fingers, numbness of all fingers and thumbs, and a negative Tinel's sign bilaterally. He diagnosed several conditions including carpal tunnel syndrome.

In a May 6, 2013 report, Dr. Jen noted appellant's complaints of neck pain, hand weakness, and numbness, despite bilateral carpal tunnel release and right ulnar transposition. Examination findings were provided and arthritic changes in right hand noted. An assessment of bilateral carpal tunnel syndrome and right ulnar neuropathy was provided. Dr. Jen noted reviewing records which diagnosed appellant with bilateral carpal tunnel syndrome with right ulnar neuropathy and that a March 11, 2011 EMG/nerve conduction velocity (NCV) showed borderline bilateral carpal tunnel syndrome. He stated that current examination showed residual

weakness in both hands, right worse than left, with ongoing numbness despite surgeries. Dr. Jen opined that appellant's surgical correction had failed.

By decision dated December 9, 2013, OWCP denied modification of the March 26, 2013 decision.

Appellant again requested reconsideration by letter dated January 13, 2014, received by OWCP on January 21, 2014.

In a January 6, 2014 report, Dr. Jen stated that his examinations and review of appellant's condition showed that she continued to suffer from the disabling residuals of the originally accepted work-related conditions. He indicated that he knew of no subsequent injury she sustained to her wrists or hands and that the objective testing done on September 11, 2013 clearly indicated objective findings consistent with bilateral motor neuropathy at the wrist level. Dr. Jen noted that the second opinion physician who examined appellant also found a positive Tinel's sign, which was consistent with the continued residuals of the accepted injuries. He opined that the type of injury that was accepted and sustained by her in 2006 did not normally just disappear and she continued to have this condition. Dr. Jen explained that he had considered the history of the original accident, the intervening treatments, as well as his own examination/evaluations of appellant, and concluded that the previously accepted conditions were still symptomatic and related to the underlying accident.

An unreadable report dated January 31, 2014 report from Dr. Anjan K. Ghosh, a Board-certified anesthesiologist, was also received.

By decision dated April 21, 2014, OWCP denied modification of the December 9, 2013 decision.

Appellant again requested reconsideration by letter dated October 2, 2014, received by OWCP on October 6, 2014.

In a January 31, 2014 report, Dr. Ghosh noted that he took over appellant's care approximately two months ago. He stated that he had reviewed her medical records and noted that his clinical evaluation of her was basically unchanged. Dr. Ghosh found that appellant continued to manifest physical signs of peripheral neuropathic pain, numbness, and weakness affecting both her left and right hands, clinical signs compatible with diagnosis of mononeuritis of upper limb and mononeuritis multiplex, and carpal tunnel syndrome. His physical examination found motor weakness of both hands with left hand grip motor strength rated as 2+/5 and right hand grip 4+/5. Dr. Ghosh's examination confirmed continued weakness in in all fingers of both hands, persistent numbness of all fingers except the thumbs, and muscle atrophy of the thenar eminence of both hands. He related that Tinel's sign was negative bilaterally in his examination, as well as in the examinations previous to his.

Dr. Ghosh concluded that his examination, as well as the record, supported findings of sensory and motor deficits in both hands, mononeuritis of the upper limb and mononeuritis multiplex, as well as carpal tunnel syndrome. Furthermore, EMG and NCV studies on September 11, 2013 were consistent with bilateral median motor neuropathies at the wrist. Dr. Ghosh indicated that he was unable to make a determination as to the causal relationship of

appellant's carpal tunnel syndrome. He noted that he was medically treating her pain arising in her hands and her neck pain, which was associated with cervical degenerative disc disorder.

In an August 14, 2014 report, Dr. Jen indicated that his examinations and review of appellant's condition showed that she continued to suffer from the disabling residuals of the accepted work-related conditions. He reiterated that he knew of no subsequent injury she had sustained to her wrists or hands, and the objective testing of September 11, 2013 supported that her condition had worsened. Dr. Jen opined that the type of injury that was accepted and sustained by appellant in 2006 did not normally disappear and that the objective testing confirmed that she continued to have this condition. He again concluded that her previously accepted conditions were still symptomatic, and had worsened as denoted by an EMG/NCV test performed in 2013.

By decision dated November 19, 2014, OWCP denied modification of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to her employment, OWCP may not terminate compensation without establishing that the disability had ceased or that it is no longer related to the employment.[2]

OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on an adequate factual and medical background.[3] Furthermore, the right to medical benefits for treatment of an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals from an employment-related condition that require further medical treatment.[4]

ANALYSIS -- ISSUE 1

OWCP accepted that the conditions of bilateral carpal tunnel syndrome and a right lesion of the ulnar nerve were causally related to her federal employment and paid appropriate benefits, including a right ulnar nerve transposition, which appellant underwent on October 9, 2006. It terminated her wage-loss compensation and medical benefits effective September 23, 2012 finding that the weight of the medical opinion evidence rested with Dr. Black, a Board-certified orthopedic surgeon, serving as the second opinion physician. The Board finds that OWCP properly terminated appellant's wage-loss compensation and medical benefits.

In his January 17, 2012 report, Dr. Black noted the history of injury, the SOAF, and his review of the medical records. These included objective testing of January 24, 2007 which showed evidence of mild left carpal tunnel syndrome and no evidence of radiculopathy.

[2] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[3] *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

[4] *Mary A. Lowe*, 52 ECAB 223 (2001); *Wiley Richey*, 49 ECAB 166 (1997).

Dr. Black presented examination findings of the bilateral wrists and the right elbow, which were essentially negative except for a positive Tinel's over the trans-post ulnar nerve. He diagnosed mild bilateral carpal tunnel syndrome with dysesthesia of the right ulnar nerve. Dr. Black opined that there were no objective medical findings to indicate that the accepted work-related conditions were still active other than appellant's subjective complaints of pain and a mild EMG result from five years ago. He stated that she was neurologically intact from the standpoint of her ulnar nerve. Dr. Black opined that the work-related conditions had resolved, appellant had reached maximum medical improvement, and she could return to full-time employment with restrictions. In his March 6, 2012 supplemental report, he clarified that, while he had noted that she had residual "mild left carpal tunnel syndrome" by EMG study, this did not necessarily translate into a continued residual of her work-related condition. The fact that the median nerve showed continued signs of mild compression following release, was the intrinsic nature of nerves. Dr. Black explained that appellant did not have any signs of active carpal tunnel syndrome on physical examination as there was negative Phalen's maneuver and Tinel's signs bilaterally and she demonstrated full range of motion. He opined that the accepted conditions had resolved and she did not have any continued disability from her work-related condition. Dr. Black explained the work restrictions were preventive in nature.

The Board has carefully reviewed the opinion of Dr. Black and finds that it is of probative value with respect to its conclusions regarding the relevant issue in the present case.[5] Dr. Black's opinion is based on a proper factual and medical history and he thoroughly reviewed the SOAF and medical records.[6] He provided medical rationale for his opinion that the work-related conditions had resolved by explaining that there were no objective medical findings to indicate that the accepted work-related conditions were still active and appellant was neurologically intact from the standpoint of her ulnar nerve. Dr. Black further explained that the median nerve can show continued signs of mild compression following release due to the nature of nerves in general. He also explained that the work restrictions were preventive in nature. Thus, Dr. Black's opinion establishes that appellant was no longer experiencing residuals or disability related to the accepted work-related conditions.

In support of her claim, appellant submitted a September 26, 2012 letter from Dr. Sleight. Dr. Sleight reported that she presented with hyperesthesia in the arms and pain in the bilateral wrists and right elbow. While he reported decreased strength in the upper extremities, he did not provide any objective data or comparative study to demonstrate the reported decrease in strength. Dr. Sleight noted appellant's subjective complaints, but provided no objective documentation of ongoing work-related injuries and offered no specific examination findings to support continuation of the work injuries. Thus, his report is insufficient to cause a conflict with Dr. Black's opinion that the work-related injuries had resolved with no disability.

In his November 6, 2012 report, Dr. Jen noted appellant's history of injury, her subjective complaints, and reported examination findings with testing which included decreased strength in the bilateral upper extremities, weak grip and wrist strength, and decreased sensation in both hands. He noted right hand weakness and stiffness in range of motion of fingers. Dr. Jen

[5] *See R.W.*, Docket No. 12-375 (issued October 28, 2013).

[6] *See Melvina Jackson*, 38 ECAB 443 (1987).

diagnosed bilateral carpal tunnel syndrome and right ulnar neuropathy. He opined that appellant's work injuries were still present and disabling as she continued to exhibit residual pain and weakness in both hands, despite surgeries. However, Dr. Jen did not explain her residual pain and weakness in both hands after operative intervention and removal from the work environment since 2006. Thus, his report is of limited probative value regarding the current issue and does not create a conflict in medical evidence.[7]

The remainder of the medical evidence, including the March 11, 2011 EMG and NCS showing borderline bilateral carpal tunnel syndrome, failed to offer any opinion regarding the cause of appellant's condition and is of limited probative value on the issue of causal relationship.[8] Dr. Khalidi did not diagnosis active carpal tunnel syndrome or ulnar neuropathy, but instead identified her as postoperative. While Dr. Benton agreed that appellant had permanent limitations from her wrist and elbow pain and her neuropathy and offered work restrictions, his opinion is of limited probative value as it was based on a review of Dr. Black's report, not his own examination, and he offered no opinion on causal relationship.[9] Thus, this evidence is insufficient to cause a conflict with Dr. Black's opinion.

The Board finds that Dr. Black's opinion constitutes the weight of the medical evidence and is sufficient to justify OWCP's termination of benefits for the accepted conditions. OWCP properly terminated entitlement to compensation and medical benefits effective September 23, 2012. Accordingly, its decision to terminate appellant's compensation and medical benefits is affirmed.[10]

LEGAL PRECEDENT -- ISSUE 2

Once OWCP properly terminates appellant's compensation benefits, the burden shifts to appellant to establish that she has continuing disability after that date related to her accepted injury.[11] To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background, supporting such a causal relationship.[12] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[13]

[7] Medical reports without adequate rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof. *Ceferino L. Gonzales*, 32 ECAB 1591 (1981).

[8] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[9] *Id.*

[10] *L.C.*, Docket No. 12-1177 (issued August 19, 2013).

[11] *See Manuel Gill*, 52 ECAB 282 (2001).

[12] *Id.*

[13] *Paul Foster*, 56 ECAB 208 (2004); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

ANALYSIS -- ISSUE 2

OWCP met its burden of proof to terminate appellant's compensation benefits as of September 23, 2012. Appellant, therefore, bears the burden of proof to establish by the weight of the evidence that she had continuing disability on or after September 23, 2012 due to the accepted employment injury.[14] The Board finds that she submitted insufficient medical evidence to establish disability due to residuals of her accepted conditions after September 23, 2012.

OWCP received a September 11, 2013 NCS, a March 11, 2013 report from Dr. Sleight and a January 31, 2014 report from Dr. Ghosh. However, this medical evidence fails to offer any opinion regarding the cause of appellant's condition and is of limited probative value on the issue of causal relationship.[15] The NCS, which showed bilateral median motor neuropathies at the wrist, provided no opinion as to whether the diagnosed condition was causally related to the accepted conditions. Dr. Sleight diagnosed several conditions including carpal tunnel syndrome, but failed to offer an opinion on causation and is of limited probative value.[16] While Dr. Ghosh diagnosed carpal tunnel syndrome, he specifically stated that he was unable to make a determination as to the causal relationship of the condition. Thus, this medical evidence is insufficient to meet appellant's burden of proof to establish continuing disability due to the accepted conditions.

Several reports were received from Dr. Jen. In his May 6, 2013 report, Dr. Jen provided an assessment of bilateral carpal tunnel syndrome and right ulnar neuropathy based on his examination findings of residual weakness in both hands, right worse than left, with ongoing numbness despite surgeries, his review of medical records, and a March 11, 2011 EMG/NCV, which showed borderline bilateral carpal tunnel syndrome. He opined that appellant's surgical correction failed. However, Dr. Jen failed to provide any medical rationale explaining how she remained disabled or had residuals from the accepted conditions. A mere conclusion without the necessary medical rationale to explain how and why the physician believes that appellant's surgical correction of the accepted conditions failed is not sufficient to meet her burden of proof. The medical evidence must also include rationale explaining how the physician reached the conclusion he or she is supporting, which Dr. Jen failed to do.[17]

In his January 6 and August 14, 2014 reports, Dr. Jen stated that he considered the history of the original accident, the intervening treatments and his own examination/evaluations of appellant. His opinion continued to be that the previously accepted conditions were still symptomatic and related to the underlying accident. Dr. Jen stated that he knew of no subsequent injury appellant sustained to her wrists or hands and that the September 11, 2013 objective testing was consistent with bilateral motor neuropathy at the wrist level. He also noted

[14] *See Amelia S. Jefferson*, 57 ECAB 183 (2005).

[15] *Supra* note 8.

[16] *Id.*

[17] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

that the second opinion physician had found a positive Tinel's sign, which was consistent with the continued residuals of the accepted injuries. In his August 14, 2014 report, Dr. Jen indicated that the objective testing of September 11, 2013 supported that appellant's condition has worsened. However, he offered no medical rationale to support continued residuals or disability of the accepted condition. Dr. Jen's explanation that the type of injury that was accepted and sustained by appellant in 2006 did not normally just disappear is a generalization. As such, his reports are insufficient to meet her burden of proof.

There is no other medical evidence of record from a physician which gives reasoned support that appellant had any employment-related residuals or disability after September 23, 2012.

On appeal, counsel argues that the medical opinions from Dr. Jen, Dr. Ghosh, and Dr. Sleight indicate that appellant's accepted conditions still exist, are disabling, and have worsened. However, as indicated above, none of those physicians provided a well-rationalized medical opinion to support that she continues with residuals or disability from her accepted conditions. Counsel also argues that Dr. Black's opinion on which OWCP relied to terminate compensation benefits is not rationalized. As indicated above, Dr. Black's opinion constitutes the weight of the medical opinion evidence at the time compensation benefits were terminated.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective September 23, 2012 on the grounds that she no longer had any residuals or disability causally related to her accepted conditions. The Board further finds that she did not meet her burden of proof to establish that she had any employment-related residuals or disability after September 23, 2012.

ORDER

IT IS HEREBY ORDERED THAT the November 19, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 4, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board