United States Department of Labor
Employees' Compensation Appeals Board

D.A., Appellant	)	
and	)	**Docket No. 07-1790**
	)	**Issued: February 6, 2008**
U.S. POSTAL SERVICE, POSTAL INSPECTION SERVICE, Newark, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 25, 2007 appellant filed a timely appeal from the January 22, 2007 decision of an Office of Workers' Compensation Programs' hearing representative, who affirmed the termination of her compensation benefits. Pursuant to 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 the Office properly terminated appellant's compensation benefits effective May 18, 2003 on the grounds that she had no disability or residuals causally related to her accepted injuries; and (2) whether appellant established continuing disability or residuals related to her accepted employment injury.

FACTUAL HISTORY

On May 3, 2002 appellant, then a 52-year-old operations technician, hurt her back and arm when she fell backwards onto the ground hitting her desk with her left arm. She stopped work on May 6, 2002. On June 5, 2002 Dr. David Mattingly, a Board-certified osteopathic

physician specializing in family practice, treated appellant for cervical and lumbar strains, trapezius myofascitis, left shoulder sprain and lumbar radiculopathy, all of which were related to her May 3, 2002 fall. On July 10, 2002 the Office accepted appellant's claim for aggravation of lumbar sprain and contusion of the left arm.

On August 21, 2002 Dr. Gary Atkinson, a Board-certified osteopathic physician specializing in anesthesiology, diagnosed cervical radiculopathy, lumbar radiculopathy, right rotator cuff tear and bilateral carpal tunnel syndrome. He stated that she fell on a mailing envelope at work on May 3, 2002 injuring her right arm and fell at work again in July 2002 which caused pain in her neck, low back, left arm and legs. On physical examination, Dr. Atkinson noted that appellant's neck motion was limited because of pain which extended over her right acromioclavicular (ACV) joint. He found pain with pressure over both median nerves, but no Tinel's sign. Appellant had pain on palpitation of the lower cervical spine and the lumbar spine, especially over L4-5.

On August 27, 2002 the Office referred appellant for a second opinion examination with Dr. Anthony Salem, a Board-certified orthopedic surgeon. The statement of accepted facts indicated that appellant was initially treated for her accepted injuries on May 6, 2002. She was medically restricted to sedentary duties on April 20, 2002 prior to her accepted injury. Appellant had a history of motor vehicle accidents in 1993, carpal tunnel syndrome and clinical depression with anxiety. She had not returned to work since her accident and there was no anticipated date of return to work. The statement of accepted facts indicated that appellant had a "history of work-related injuries established" under file numbers A03-0213734, A03-0224290 and A03-0225239.

On September 26, 2002 Dr. Salem examined appellant and reviewed her medical history. Appellant reported that she was unable to sit, stand or pull and that she had pain in her low back, hips, knees, feet, shoulders and hands. She indicated that she injured her right rotator cuff in 1995 when she slipped on a mail sack and was out of work for a period of time. Dr. Salem reviewed the films of several diagnostic tests. A magnetic resonance imaging (MRI) scan performed on May 22, 2002 showed degeneration and stenosis at L3-4 and L4-5. X-rays performed on April 1, 2002 showed sacralization of L5 with narrowing and degeneration at L4-5 and straightening of the thoracic spine. Radiographs conducted on June 12, 2002 showed significant degenerative changes from C3-4 though C6-7. X-rays of appellant's shoulders, legs, knee, wrist and hands conducted on April 1, 2002 were relatively normal.

On physical examination, Dr. Salem found that appellant's active and passive left shoulder abduction was to 80 degrees. Her cervical spine had 20 degrees of extension, 30 degrees of flexion and 60 degrees of rotation. The deep tendon reflexes were +3/-4 for the upper extremities and +2 for the lower extremities. Appellant reported pain everywhere Dr. Salem touched her. Dr. Salem noted a positive Tinel's sign over her wrists, but no sensory loss. Appellant had a negative hyperflexion test. She could flex her lumbosacral spine 30 degrees, extend it five degrees and laterally bend it 10 degrees. Dr. Salem noted no weakness, sensory loss or muscle atrophy in the lower extremities. The straight-leg raising test produced pain and discomfort in appellant's low back at 60 degrees.

Dr. Salem found that appellant had significant degenerative arthritis of the cervical and lumbosacral spine and rotator cuff disease in her left shoulder. He stated that her prognosis was guarded because she was not going to recover from all of her conditions. Dr. Salem stated that appellant's neck and back had no greater problems than they did at the time of her fall and that the diagnostic studies revealed only long-standing changes. Appellant could return to work in a light-duty position despite her significant preexisting and nonindustrial disability, which was due to "a long life of morbid obesity, poor conditioning and possibly hard work and bad luck." Dr. Salem suggested physical limitations based on appellant's preexisting conditions. He opined that the maximum period of disability from her accepted conditions was two months following her injury in May 2002. Dr. Salem opined that appellant did not have any residuals of her work-related injury.

The Office provided Dr. Salem's report to Dr. Atkinson and Dr. Joseph Thoder, a Board-certified orthopedic surgeon, who was treating appellant's upper extremity conditions and Dr. Joseph Torg, a Board-certified orthopedic surgeon, who was treating her lower extremity and back conditions. Dr. Torg agreed with Dr. Salem's findings; however, Dr. Atkinson disagreed, based on the findings of his August 21, 2002 report. Dr. Thoder did not respond.

On November 4, 2002 the Office found that there was a conflict on the issue of whether appellant had any remaining residuals from her accepted employment injury. Appellant was referred to Dr. Joseph Jelen, a Board-certified orthopedic surgeon, to resolve the conflict.

On January 14, 2003 Dr. Jelen conducted a physical examination of appellant and reviewed the medical evidence. He stated that she injured her lumbar spine in 1995 which left her capable of working in a sedentary position. Dr. Jelen noted that appellant's job description did not mention heavy lifting, but that she stated that she was required to lift up to 75 pounds. He reported that appellant complained of pain in the neck, shoulders, arms, thoracic spine, lumbar spine, sacroiliac joint, buttocks, legs and knees. Appellant stated that she had pain radiating down both legs into the ankles and feet, primarily on the left side. On review of the diagnostic imaging films appellant brought with her, Dr. Jelen concurred with the findings of the diagnostic reports in the record. He noted that a May 23, 2002 MRI scan showed degenerative disc disease throughout appellant's lumbar spine, with chronic bulging at the L2-3, L3-4 and L4-5 discs associated with spurring. At L5-S1 there was a central bulge or chronic protrusion impinging on the epidural structure. Radiographic studies from April 1, 2002, prior to her May 3, 2002 injury, showed degenerative joint disease and bone spur formation with disc narrowing at L3-4 and all lower levels of the lumbosacral spine. Dr. Jelen compared the April 2002 x-rays to those made on June 12, 2002 and found no significant change. A June 12, 2002 x-ray of appellant's cervical spine showed large osteophyte formation at C4-5 through C6-7. A November 14, 2002 MRI scan of the left shoulder showed minimal joint fluid, degenerative changes and supraspinatus tendinopathy with the possibility of a tear in the scar or fibrous tissue.

Dr. Jelen noted that appellant walked into his office without difficulty, carried a heavy x-ray folder in her arms and moved her arms in a relatively painless fashion while sitting on the examination room table. Appellant's cervical spine had 45 degrees of flexion, 30 degrees of extension and 45 degrees of rotation to the right and left. Dr. Jelen noted that she stopped her movements because of pain. Reflexes, strength and sensation in appellant's upper extremities

were equal and normal. When the Tinel's signs were performed over her wrists she reported tingling in her right middle finger and left middle and index fingers. Appellant's left shoulder had active adduction to 110 degrees and passive adduction to 140 degrees where she voluntarily stopped movement. Dr. Jelen noted a subtle click in both shoulders with rotation to the level of the sacroiliac joint, but found no weakness. Appellant flexed her lumbar spine 30 degrees before stopping because of pain and tenderness. She had no observed weakness in toe and heel standing. Dr. Jelen found tenderness over all areas examined. Rotation of both hips did not produce groin or leg pain and the sitting leg raising test did not produce back or leg pain.

Dr. Jelen found that the accepted conditions of aggravation of lumbar sprain and left arm contusion were consistent with appellant's presentation and that no other conditions could be linked to her accepted employment injury. He found that her prognosis was poor because of her many chronic symptoms from previous injuries and preexisting degenerative changes in the spine and soft tissues of the shoulder. Dr. Jelen stated that appellant's disability related to her accepted injury had ceased and that she was able to work in a sedentary fashion. He indicated that appellant had no obvious residuals from the accepted injuries and that all of her current symptoms and findings were explained by her chronic degenerative changes and age-related wear. Dr. Jelen stated that the low back and left arm aggravation caused by appellant's May 3, 2002 employment injury had resolved. He noted that the pain appellant experienced in most areas of her body was real, but that this was consistent with her preinjury condition. Dr. Jelen provided physical limitations for any future employment based on her preexisting conditions.

By notice dated February 13, 2003, the Office proposed termination of appellant's compensation on the grounds that the weight of the medical evidence established that she had no continuing disability related to her accepted injury.

On March 6, 2003 appellant, through counsel, objected to the proposed termination. She contended that Dr. Jelen's report was not adequately rationalized and was self-contradictory. Appellant stated that Dr. Jelen did not review the electromyogram (EMG) that she underwent on January 10, 2003 prior to providing his opinion. She also contended that Dr. Jelen's understanding of the history of the case was flawed. Appellant submitted additional medical evidence.

On August 29, 2002 Dr. Thoder stated that appellant had overuse injuries that were causing distal hand complaints and carpal tunnel syndrome in her right hand. He noted that her history of injury went back several years and that the right side has typically been worse than the left. Dr. Thoder found that appellant had discomfort in both arms, with a positive Tinel's sign, Phalen's sign and median nerve compression test bilaterally at the wrists. The right was worse than the left, but there was no evidence of atrophy, loss of sensation or thenar weakness in either arm.

On March 14, 2003 Dr. Mattingly stated that appellant continued to suffer severe disability related to her May 3, 2002 injury. When he first saw her on May 14, 2002 he diagnosed a left shoulder sprain, acute lumbar sprain, acute upper back and neck sprain, trapezius myofascitis, insomnia and cephalgia. A November 2002 MRI scan of appellant's left shoulder revealed rotator cuff tendinopathy with associated muscle atrophy which was evidence of the significance of the condition. Dr. Mattingly stated that the significant and chronic

degenerative changes seen in the MRI scan of appellant's lumbar spine shortly after the injury provided insight into why her back was healing so slowly. He opined that palpable spasms and compromised range of motion were evidence of ongoing injury to appellant's lower back.

An MRI scan of March 6, 2003 revealed mild scoliosis and degenerative disc disease changes throughout the lumbar spine. The reading physician also found mild to moderate broad-based posterior disc protrusion at L5-S1, worse on right of midline, mild posterior disc bulging at L3-4 and L4-5 and mild asymmetric disc protrusion at L2-3 on the right posterolateral. Multilevel annulus fissuring and tearing was noted. The MRI scan revealed multilevel thickening of the ligamenta flava and facet degenerative changes with moderate central canal narrowing at L3-4 and L4-5 and lesser narrowing at L5-S1. There was no significant foraminal compromise in the lumbar spine.

On April 10, 2003 the Office provided the new medical evidence to Dr. Jelen. On April 16, 2003 Dr. Jelen stated that the new evidence did not change his opinion.

On May 15, 2003 the Office received the March 28, 2003 report of Dr. John Esterhai who reported that appellant's electromyogram (EMG) revealed bilateral carpel tunnel in her upper extremities, right greater than left. The EMG for the lower extremities was normal. Appellant reported that she was unable to stand for more than 15 minutes, sit for more than 10 minutes or lift more than two pounds without pain. She stated that her carpal tunnel symptoms began after her first work fall in 1995. Dr. Esterhai stated that, based on his review of appellant's studies and complaints, he believed that her symptoms were legitimate and related to her work injury.

By decision dated May 16, 2003, the Office terminated appellant's compensation benefits effective May 18, 2003. It found that the additional evidence presented by appellant did not change the weight of the medical evidence as requested by the opinion of Dr. Jelen.

On May 20, 2003 appellant requested a hearing. In an April 1, 2002 report, Dr. Thoder reported that appellant had a several-year history of complaints of pain, particularly in the right upper extremity, back, neck, hips, knees and feet. He noted a history of rotator cuff tendinopathy and tear and carpal tunnel syndrome, right worse than left. Dr. Thoder stated that appellant's history of neck and back pain, primarily on the right, precipitated her hip, knee and foot discomfort. He stated that a slipping fall at work may have contributed to both her shoulder and lower back problems.

On physical examination, Dr. Thoder found a painful and guarded arc of motion in her right shoulder, particularly in internal rotation and abduction. Appellant's right shoulder had crepitus with passive abduction to 60 degrees. The range of motion in the elbows and wrists of both arms was normal. There was a positive median nerve compression test and positive Tinel's sign at both wrists, right greater than left. Appellant had pain with axial loading and palpable grinding at the carpometacarpal (CMC) joint of the right thumb. Radiographs of the right upper extremity showed degenerative changes at the CMC joint with joint space narrowing and mild joint subluxation with medial osteophyte formation. There were no gross abnormalities at the wrist or shoulder. Appellant's neck had limited range of motion due to pain in extension and rotation to the right. Her lower extremities were normal. Lumbar x-rays showed evidence of facet arthropathy, traction osteophyte and joint space nearing, but no gross subluxation.

Dr. Thoder stated that all of appellant's right upper extremity conditions were creating a symptom consolidation that made it hard for her to function. He recommended that the conditions be treated together with anti-inflammatory medication and physical therapy.

On July 1, 2002 Dr. Thoder reported that, since his last examination, appellant had fallen at work, which aggravated her other complaints. Dr. Torg was treating her for issues related to her fall. Dr. Thoder stated that an EMG study performed on May 7, 2002 showed evidence of median motor dysfunction with motor and sensory neuropathy at the level of the wrist with focal demyelination. He noted, however, that the axonal injury that was present at his previous examination had resolved which indicated that appellant's problems were more due to mechanical and physical effects than compressive neuropathy.

In a report dated February 28, 2003, Dr. Esterhai reported that appellant was injured on May 3, 2002 when she fell as she rushed for a telephone. He stated that she received physical therapy and treatment from a pain clinic for her injuries. Dr. Esterhai reviewed an MRI scan showing disc protrusions at L3-4, L4-5 and L5-S1. Appellant described pain radiating from her spine to her buttocks and the inability to sit or stand for more than 15 minutes at a time. Dr. Esterhai noted no antalgic gait or difficulty standing. He diagnosed axial lumbosacral spine pain and stated that appellant attributed this to her work injury.

At a hearing held on August 30, 2004 appellant testified about the events surrounding her injury and the course of her medical treatment. She stated that her employment activities were not sedentary and involved moving around and lifting heavy amounts. On October 13, 2004 appellant's supervisor, Patricia Wiggins, submitted comments on appellant's testimony. Ms. Wiggins challenged appellant's description of her job duties and stated that she spent the majority of her time sitting at her terminal. On October 16, 2004 appellant responded to Ms. Wiggins's comments.

By decision dated November 5, 2004, the Office hearing representative affirmed the May 16, 2003 decision. He found that Dr. Jelen had provided a complete factual and medical background. The Office hearing representative found that the omission of the full details of appellant's earlier workers' compensation claims were not a fatal error as the claims had been denied. He also found that Dr. Jelen's misunderstanding of the cause of appellant's preinjury work-restrictions did not substantially reduce the probative value of his report. The Office hearing representative found that Dr. Jelen's opinion regarding appellant's current condition was sufficiently rationalized to constitute the weight of medical opinion.

On March 15, 2005 appellant filed an appeal with the Board. As the Office did not supply the case record in a timely manner, by order dated September 14, 2005, the Board remanded the case for reconstruction.[1] The Board ordered that an appropriate decision be issued to protect appellant's appeal rights.

On January 22, 2007 the Office hearing representative reissued his decision affirming the Office's May 16, 2003 termination decision.

[1] Docket No. 05-926 (issued September 14, 2005).

LEGAL PRECEDENT -- ISSUE 1

Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits.[2] The Office may not terminate compensation without establishing that disability has ceased or that it is no longer related to the employment injury.[3]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition, which would require further medical treatment.[4]

The Federal Employees' Compensation Act provides that, if there is a disagreement between a physician making an examination for the United States and the physician of the employee, the Secretary must appoint a third physician to make an examination.[5] Likewise, the implementing regulation states that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office must appoint a third physician to make an examination. This is called a referee examination and the Office is required to select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[6] It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on proper factual and medical background, must be given special weight.[7]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for aggravation of lumbar strain and left arm contusion. The issue to be determined is whether it has met its burden of proof to establish that appellant has no remaining disability or residuals related to her accepted injuries.

The Office properly referred appellant for an impartial medical examination to resolve the conflict between the medical opinions of Dr. Salem and Dr. Atkinson on the issue of whether she had any disability causally related to her accepted injuries. On January 14, 2003 Dr. Jelen, a Board-certified orthopedic physician, conducted a physical examination of appellant and a review of the medical evidence. He found that appellant's presentation was consistent with the accepted conditions of aggravation of lumbar sprain and left arm contusion and that no other conditions could be linked to her accepted employment incident. Dr. Jelen found that the accepted conditions had resolved. He stated that appellant's disability related to her accepted

[2] *Elaine Sneed*, 56 ECAB 373 (2005).

[3] *Mary A. Lowe*, 52 ECAB 223, 224 (2001).

[4] *James F. Weikel*, 54 ECAB 690 (2003).

[5] 5 U.S.C. §§ 8101-8193, 8123(a).

[6] 20 C.F.R. § 10.321.

[7] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

injury had ceased. Dr. Jelen indicated that appellant had no residuals from the accepted injuries and that all of her current symptoms and findings were explained by her chronic illnesses, degenerative arthritis and preexisting conditions. He found that appellant's prognosis was poor because of her many chronic symptoms from previous injuries and preexisting degenerative changes in the spine and soft tissues of the shoulder. Dr. Jelen found that, although appellant continued to experience pain she had returned to her preinjury condition. The Board finds that the opinion of Dr. Jelen is entitled to the special weight of the medical evidence because it is well rationalized and based on a thorough physical examination and review of the medical history.

In opposition to the Office's proposed termination of her compensation benefits, appellant submitted a report from Dr. Mattingly who stated that her preexisting condition was causing her employment injuries to heal slowly. Dr. Mattingly opined that appellant's spinal spasms and limited range of motion were evidence of ongoing injury. The other medical reports appellant submitted discussed her various physical conditions but did not address their cause. On April 16, 2003 Dr. Jelen reviewed these reports and stated that they did not alter his opinion that appellant was no longer disabled as a result of her accepted employment injury.

The Office proposed termination of appellant's compensation based on Dr. Jelen's opinion that she had no remaining disability or residuals related to her accepted employment injuries. The Board finds that the Office properly relied on this opinion which resolved the conflict of medical opinion between appellant's treating physicians and the Office's second opinion physician. As Dr. Jelen's report constitutes the special weight of the medical evidence, the Office met its burden of proof to terminate appellant's wage loss and medical benefits.

LEGAL PRECEDENT -- ISSUE 2

Once the Office meets its burden of proof to terminate appellant's compensation benefits, the burden shifts to appellant to establish that she had disability causally related to her accepted injury.[8] She must submit rationalized medical evidence to establish the causal relationship between her continuing disability and the employment injury.[9] To be rationalized, the opinion must be based on a complete factual and medical background of the claimant[10] and must be one of reasonable medical certainty,[11] explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[12] Neither the fact that a disease or condition manifests itself during a period of employment nor the belief

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

[9] *Id.*

[10] *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

[11] *John W. Montoya*, 54 ECAB 306 (2003).

[12] *Judy C. Rogers*, 54 ECAB 693 (2003).

that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[13]

ANALYSIS -- ISSUE 2

Following the termination of her benefits, appellant requested reconsideration of the Office's decision based on the reports of Dr. Esterhai and Dr. Thoder. The issue to be determined is whether appellant has submitted medical evidence sufficient to establish her ongoing disability.

In a report dated February 28, 2003, Dr. Esterhai, a Board-certified orthopedic surgeon, reported that appellant was injured on May 3, 2002 when she fell as she rushed for a telephone. He reviewed an MRI scan showing disc protrusions at L3-4, L4-5 and L5-S1 and noted that she described pain radiating from her spine to her buttocks and the inability to sit or stand for more than 15 minutes at a time. Dr. Esterhai found that appellant had no antalgic gait or difficulty standing. He diagnosed axial lumbosacral spine pain. Though appellant attributed her back condition to her work injury, Dr. Esterhai made no findings as to the cause of her condition. On March 28, 2003 Dr. Esterhai stated that appellant's condition was unchanged from her previous examination. He reported that her upper extremity EMG revealed bilateral carpel tunnel in her upper extremities, but that her lower extremity EMG was normal. Appellant stated that her carpal tunnel symptoms began after her first work fall in 1995. Dr. Esterhai stated that, based on his review of appellant's studies and complaints, he believed that her symptoms were legitimate and related to her work injury.

The Board notes that Dr. Esterhai's reports do not state specifically which conditions he attributes to appellant's May 3, 2002 injuries or provide adequate rationale for this opinion. The Board has held that a medical opinion not fortified by medical rationale is of little probative value.[14] Therefore, the Board finds that Dr. Esterhai's reports are insufficient to establish appellant's ongoing disability.

In an April 1, 2002 report, Dr. Thoder, reported that appellant had a several-year history of complaints of pain, particularly in the right upper extremity, back, neck, hips, knees and feet. He noted a history of right rotator cuff tendonopathy and tear and carpal tunnel syndrome in her wrists. Dr. Thoder stated that appellant's neck and back pain, primarily on the right, precipitated her hip, knee and foot discomfort. He stated that a slipping fall at work may have contributed to both her shoulder and lower back problems. On physical examination, Dr. Thoder found guarded motion in appellant's right shoulder, particularly in internal rotation and abduction and crepitus with passive abduction to 60 degrees. There was a positive median nerve compression test and positive Tinel's sign at both wrists. Radiographs of the right upper extremity were grossly normal for the wrist and shoulder. Appellant's neck had limited range of motion due to pain in extension and rotation to the right. Her lower extremities were normal. Lumbar x-rays showed evidence of facet arthropathy, traction osteophyte and joint space nearing, but no gross subluxation. Dr. Thoder stated that all of appellant's upper right extremity conditions were

[13] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[14] *David L. Scott*, 55 ECAB 330 (2004).

creating a symptom consolidation that made it hard for her to function. He recommended that the conditions be treated together with anti-inflammatory medication and physical therapy. On July 1, 2002 Dr. Thoder reported that since his last examination appellant had fallen at work which aggravated her other complaints.

The Board finds that the reports of Dr. Thoder are insufficient to establish appellant's ongoing disability. His first report predated her injury and therefore is irrelevant to the issue of whether appellant has any remaining disability or residuals related to her May 3, 2002 injury. Dr. Thoder's second report did not make any specific findings related to his broad statement that appellant's fall had aggravated her preexisting complaints. Because his finding is not rationalized it is of little probative value.

The Board finds that appellant failed to meet her burden of proof to establish continuing employment-related disability or residuals causally related to her May 5, 2002 employment injuries.

CONCLUSION

The Board finds that the Office properly terminated appellant's compensation benefits effective May 18, 2003 on the grounds that she had no disability or residuals causally related to her accepted injuries. The Board further finds that appellant has not established continuing disability or residuals related to her accepted employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers Compensation Programs dated January 22, 2007 is affirmed.

Issued: February 6, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board