United States Department of Labor
Employees' Compensation Appeals Board

S.D., Appellant	)	
and	)	**Docket No. 13-350**
	)	**Issued: August 19, 2013**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On November 29, 2012 appellant, through counsel, timely appealed the October 16, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied her recurrence claim. 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 the claim.[2]

ISSUE

The issue is whether appellant sustained a recurrence of disability on November 1, 2011 causally related to her accepted employment injury.

[1] 5 U.S.C. §§ 8101-8193.

[2] The record includes evidence received after the October 16, 2012 decision. As this evidence was not part of the record when OWCP issued its final decision, the Board is precluded from considering it for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

Appellant, a 51-year-old customer service representative, has an accepted claim for neck sprain which occurred on July 14, 2011 when she slipped and fell at work. She was in an elevator at the time. As she moved back to allow others to enter, appellant slipped and fell landing on her left hand and buttock. She described a whiplash-type injury.

A July 18, 2011 x-ray revealed mild degenerative disc disease at C5-6. There was no evidence of cervical spine fracture or dislocation. There was mild reversal of the cervical lordosis, possibly attributable to muscle spasm. Appellant received conservative treatment and underwent several weeks of physical therapy and work hardening. Based on the advice of Dr. Richard M. Skaroff, an internist, she resumed her full-time, regular duties effective August 15, 2011. She received continuation of pay from July 18 through August 12, 2011.

By the time that OWCP accepted appellant's claim, Dr. Skaroff had released her to resume her full-time, regular duties. Consequently, OWCP's August 29, 2011 acceptance letter noted that appellant's neck sprain had resolved. The letter referenced Dr. Skaroff's August 8, 2011 release to full-duty without restriction effective August 15, 2011.

On October 25, 2011 Dr. Steven Mandel, a Board-certified neurologist, examined appellant with respect to her neck and upper extremities.[3] He noted limitation of movement in the neck and positive Tinel's signs at each wrist. Dr. Mandel administered upper extremity electrodiagnostic studies (EMG/NCV) that revealed findings consistent with bilateral carpal and cubital tunnel syndromes. There was also evidence of radiculopathy affecting the C5 cervical paraspinal muscles. Dr. Mandel referred appellant to a physiatrist and a hand surgeon to address her cervical condition and bilateral upper extremity symptomatology.

On November 2, 2011 Dr. Skaroff precluded appellant from all work for the next two weeks. He did not provide a specific diagnosis but noted that she was under his care for a work-related injury.

On November 3, 2011 appellant filed a claim for recurrence of disability (Form CA-2a) beginning November 1, 2011.

Dr. Mandel referred appellant to Dr. Pedro K. Beredjiklian, a Board-certified orthopedic surgeon with a subspecialty in hand surgery. In a report dated November 7, 2011, Dr. Beredjiklian diagnosed bilateral basal joint arthritis and likely carpal and cubital tunnel syndromes. He offered no opinion on causal relationship, but noted that appellant dated the onset of symptoms back to July 14, 2011. Dr. Beredjiklian reported a history that appellant sustained a traumatic injury at work when she fell backwards. He also noted that appellant performed typing.

[3] Dr. Mandel noted having previously seen appellant in 2009. However, he did not otherwise describe appellant's prior medical history. Dr. Mandel also did not reference appellant's recent July 14, 2011 employment injury.

A November 9, 2011 magnetic resonance imaging (MRI) scan revealed disc protrusions at C2-3, C3-4 and C4-5. There was also evidence of disc degeneration with mild disc protrusions at C5-6 and C6-7.

On November 15, 2011 Dr. Skaroff advised that appellant should remain off work for another three weeks. He diagnosed cervical disc disease, left de Quervain's tenosynovitis, bilateral carpal and cubital tunnel syndromes with neuropathy.

In a November 21, 2011 follow-up report, Dr. Beredjiklian diagnosed bilateral basal joint arthritis, C5 radiculopathy and bilateral carpal and cubital tunnel syndromes. He indicated that appellant could perform sedentary work.

In a December 6, 2011 note, Dr. Skaroff advised that appellant was unable to work due to multiple injuries pertaining to the hands and neck caused from a fall on July 14, 2011. He diagnosed cervical disc disease and bilateral carpal tunnel syndrome. Dr. Skaroff noted that appellant had seen a specialist and anticipated undergoing a left carpal tunnel release.

A December 9, 2011 ultrasound revealed mild left carpal tunnel syndrome and normal findings with respect to the right median nerve and bilateral ulnar nerves.

Dr. Mandel referred appellant to Dr. Mitchell K. Freedman, a Board-certified physiatrist with a subspecialty in pain medicine. Dr. Freedman examined appellant on December 13, 2011. He noted that she was at work on July 14, 2011 when she tripped and fell backwards on her outstretched arms. Dr. Freedman reported that appellant's head did not hit the ground, but she did hyperextend her neck. That afternoon appellant developed right-side neck pain. She reportedly had no previous history of neck pain; but had a prior history of paresthesias into her hands and feet related to polyneuropathy. Dr. Freedman noted that appellant was initially out of work and then returned to work. Her pain subsequently worsened and she stopped work in early November 2011 and had not returned. Dr. Freedman conducted a physical examination and reviewed appellant's recent electrodiagnostic studies and cervical MRI scan. He diagnosed cervical whiplash with a differential diagnosis of zygapophyseal dysfunction. Dr. Freedman diagnosed left wrist pain and gait dysfunction. He noted that appellant's gait dysfunction was probably due to polyneuropathy. Dr. Freedman also noted that the results from Dr. Mandel's recent EMG/NCV could be related to polyneuropathy.

In a December 17, 2011 report, Dr. Skaroff noted that appellant had been a long-term patient with a history of obesity, cervical disc disease and fibromyalgia. He also noted a history of the July 14, 2011 employment injury where she "fell backwards in an elevator at work." The employment incident reportedly aggravated appellant's fibromyalgia. Dr. Skaroff stated that appellant sustained trauma to her left hand and neck. Appellant had been off work for 30 days and was treated with medications and physical therapy. Dr. Skaroff indicated that, after returning to work in August 2011, she worked for a two-month period but progressively worsened with neck discomfort, symptoms compatible with bilateral carpal tunnel syndrome and new chronic left hand pain.[4] He stated that appellant was unable to work and had returned to

[4] Dr. Skaroff noted that the now chronic left hand pain was apparently a combination of carpal tunnel syndrome and residual from trauma.

physical therapy. Dr. Skaroff identified her current medications and also referenced the results of her October 25, 2011 electrodiagnostic study and November 9, 2011 cervical MRI scan.

In a January 9, 2012 report, Dr. Beredjiklian diagnosed EMG-confirmed bilateral carpal and cubital tunnel syndromes. Appellant planned to forgo surgical intervention for the time being. Dr. Beredjiklian advised that appellant could perform sedentary work.

On January 18, 2012 OWCP received an undated report from Dr. Skaroff who noted that appellant had multiple complaints related to cervical disc disease, lumbar disc disease, fibromyalgia and carpal tunnel syndrome. Appellant experienced a progressive inability to function in the workplace. Dr. Skaroff noted a history of injury on July 14, 2011 when appellant slipped and fell at work, injuring her neck and back with difficulty getting up unassisted. He reported findings on physical examination and noted the results of appellant's recent cervical MRI scan and EMG. Dr. Skaroff noted that the MRI scan revealed disc degeneration at C5-6 as well as disc abnormalities at C2-3, C3-4 and C6-7. The EMG reportedly demonstrated carpal tunnel syndrome. Dr. Skaroff noted that appellant had been treated with physical therapy and various pain medication and nonsteroidal anti-inflammatory drugs (NSAID), but the medications were of little benefit. Appellant was a candidate for bilateral carpal tunnel release surgery and she was currently unable to work in any capacity.

Appellant's neurologist, Dr. Mandel, reviewed Dr. Freedman's December 13, 2011 report and provided a follow-up evaluation on December 28, 2011. On January 23, 2012 Dr. Mandel noted limited movement involving appellant's neck area and significant paraspinal muscle spasms in the neck region. He indicated that appellant would follow-up with Dr. Freedman regarding physical/occupational therapy and cervical injections. Dr. Mandel saw no indication for surgical treatment. Appellant reportedly told Dr. Mandel that "she fell backwards in an elevator in July 2011, which led to an exacerbation or her underlying cervical degenerative symptomatology."

OWCP prepared a February 8, 2012 statement of accepted facts (SOAF) and referred appellant for a second opinion examination to Dr. Robert F. Draper Jr., a Board-certified orthopedic surgeon.

Appellant began physical/occupational therapy on February 28, 2012. Dr. Freedman continued to monitor her cervical whiplash/spondylosis.[5] Dr. Freedman suggested additional treatment including a cervical epidural at C6-7 and possibly facet injections, but appellant was reportedly not interested.

In a March 22, 2012 report, Dr. Beredjiklian noted that appellant was under his care for diagnosis and treatment of cubital tunnel syndrome. When he first evaluated appellant on November 7, 2011, she reportedly told Dr. Beredjiklian that the onset of her symptoms dated back to July 14, 2011 when she fell backwards at work in an elevator.

[5] In his February 14, 2012 progress notes, Dr. Freedman also reported findings of acute lower back pain which was unrelated to appellant's work injury. He advised her to follow-up with her primary physician regarding the lower back pain.

Dr. Draper examined appellant on April 20, 2012. He listed a history that on July 14, 2011 appellant had fallen backwards in an elevator and sustained a traumatic injury to her neck. Appellant reported that she sustained a whiplash injury on July 14, 2011. Appellant also noted that her neck pain was exacerbated by twisting and turning. Dr. Draper reviewed the SOAF and noted the claim had been accepted for neck sprain. He diagnosed cervical strain, cervical spondylosis at C5-6, and degenerative bulging cervical disc disease at C2-3 through C6-7. The latter diagnosis he described as preexisting and not accident related. Dr. Draper also identified several unrelated diagnoses based on her reported history. This included bilateral carpal and cubital tunnel syndromes, polyneuropathy, deep vein thrombosis and lumbar disc disease.

Dr. Draper found that appellant's employment-related cervical strain had resolved. Appellant had continued complaints in the neck due to preexisting nonaccident-related multilevel cervical degenerative disc disease. Dr. Draper stated that appellant's degenerative bulging cervical disc disease was not permanently aggravated by the accident and that she was not totally disabled for employment. He found that she was capable of performing a full-time job that did not require lifting more than 50 pounds occasionally and 25 pounds frequently. He explained that these restrictions were due to preexisting multilevel degenerative cervical disc disease and not the accident itself.

By decision dated May 2, 2012, OWCP found that the evidence did not establish that a recurrence of disability resulted from the accepted injury. It denied appellant's claim of disability beginning November 1, 2011.

Appellant requested a hearing which was held on August 13, 2012.

OWCP received additional progress notes from Dr. Freedman dated May 3 to September 20, 2012. When he saw appellant on May 3, 2012 Dr. Freedman diagnosed cervical spondylosis and questionable bilateral carpal and cubital tunnel syndromes. He recommended that she return to Dr. Mandel to see if her EMG looked severe enough whereby she might benefit from carpal tunnel releases. Dr. Freedman also noted that he and appellant discussed returning to work, and it was his impression that she was nearly ready to attempt a four-hour workday at a sedentary job. However, the final decision on a return to work date would have to await completion of physical/occupational therapy and Dr. Mandel's input regarding the need for surgery.

Appellant returned to see Dr. Freedman on June 13, 2012; however, he did not conduct a physical examination that day. Dr. Freedman again diagnosed cervical spondylosis and questionable bilateral carpal and cubital tunnel syndromes. He also reported complaints of lower back pain which were unrelated to appellant's work injury.

Dr. Mandel released appellant to return to work full time as of June 18, 2012. He indicated that appellant required an ergonomic chair and needed to be able to briefly change positions about once every hour. Dr. Freedman again noted that appellant should follow up with Dr. Mandel regarding carpal tunnel release or surgery for her ulnar nerve. He also advised that she follow up with her primary care physician regarding her lower back complaints.

On August 30, 2012 Dr. Freedman noted that he would keep her at work because it was good for her to be active. He advised that appellant could work with 10 pounds from waist to chest and she required periodic rest from typing and writing. Appellant had been unable to see Dr. Mandel; therefore, Dr. Freedman arranged for a follow-up EMG.

On September 20, 2012 Dr. Freedman administered an upper extremity EMG. She had no pain in her neck at the time and did not want a cervical/neck EMG. Physical examination revealed limited cervical mobility, but no pain. The EMG revealed borderline right carpal tunnel syndrome (CTS) without evidence of axonopathy. There was no evidence of left CTS, no evidence of bilateral ulnar nerve lesion and no evidence of cervical radiculopathy. Dr. Freedman noted that appellant was more symptomatic with respect to her cervical spondylosis. Regarding her mild right CTS, Dr. Freedman noted that she could use a splint. He stated that appellant's work-related issue was her neck, for which she was approaching maximum medical improvement. With respect to appellant's lower extremity neuropathy and back pain, he advised that she follow up with her primary care physician. Dr. Freedman noted that this was not part of a work-related injury. He also advised appellant to follow up with him in two to three months.

In an October 16, 2012 decision, the hearing representative affirmed the denial of appellant's claimed recurrence of disability beginning November 1, 2011.

LEGAL PRECEDENT

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[6] Recurrence of disability also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed her established physical limitations.[7] A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, nonperformance of job duties or other downsizing or where a loss of wage-earning capacity (LWEC) determination is in place.[8] Where an employee claims a recurrence of disability due to an accepted employment-related injury, she has the burden of establishing that the recurrence of disability is causally related to the original injury.[9] This burden includes the necessity of furnishing evidence from a qualified physician who concludes that the condition is causally related to the employment injury.[10] The physician's

[6] 20 C.F.R. § 10.5(x).

[7] *Id.*

[8] *Id.*; 20 C.F.R. §§ 10.104(c) and 10.509; *see* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.2 (June 2013).

[9] 20 C.F.R. § 10.104(b); *see* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.5a and 2.1500.6b.

[10] *See S.S.*, 59 ECAB 315, 318-19 (2008).

opinion must be based on a complete and accurate factual and medical history and supported by sound medical reasoning.[11]

ANALYSIS

OWCP accepted appellant's July 14, 2011 traumatic injury claim for a neck sprain. There is evidence of preexisting cervical degenerative disc disease, multilevel cervical disc protrusions and cervical radiculopathy which OWCP did not accept as employment related.[12] Additional diagnoses include bilateral basal joint arthritis, bilateral carpal and cubital tunnel syndromes, polyneuropathy, fibromyalgia and lumbar disc disease.

Approximately one month after her July 14, 2011 employment injury, appellant resumed her full-time, regular duties in accordance with Dr. Skaroff's August 8, 2011 findings. She continued to work for approximately two and a half months before she claimed a recurrence of disability beginning November 1, 2011.

When Dr. Mandel first saw appellant on October 25, 2011 he did not address her prior medical history or reference her July 14, 2011 employment injury.[13] The upper extremity EMG he administered revealed findings consistent with bilateral carpal and cubital tunnel syndromes, as well as evidence of radiculopathy affecting the C5 cervical paraspinal muscles. Dr. Mandel referred appellant for further evaluation. He did not offer any opinion on causal relationship. In a subsequent report, he noted that appellant stated "she fell backwards in an elevator in July 2011, which led to an exacerbation or her underlying cervical degenerative symptomatology." It is unclear whether this statement regarding "exacerbation" represents Dr. Mandel's opinion or whether it was information appellant related to him. To the extent it is the former, Dr. Mandel did not elaborate on the noted "exacerbation" and his reports were insufficient to establish causal relation.

On November 2, 2011 Dr. Skaroff excused appellant from all work for the next two weeks, but did not provide a specific diagnosis at the time. He noted that she was under his care for a work-related injury. Dr. Skaroff subsequently extended the period of disability for another three weeks, but his November 15, 2011 report did not address the cause of appellant's disability.

Dr. Beredjiklian initially saw appellant on November 7, 2011. He diagnosed bilateral basal joint arthritis and likely carpal and cubital tunnel syndromes; but he did not offer an opinion on causal relationship.[14] In a November 21, 2011 report, Dr. Beredjiklian diagnosed

[11] *Id.* at 319.

[12] Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury. *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[13] There is no evidence of ongoing medical treatment between August 12, 2011, when appellant finished physical therapy, and October 25, 2011, when she first saw Dr. Mandel.

[14] Dr. Beredjiklian noted that appellant dated the onset of symptoms back to July 14, 2011 when she fell backwards at work. He also noted that appellant did a lot of typing. However, Dr. Beredjiklian did not specifically attribute the current diagnoses to appellant's employment.

bilateral basal joint arthritis, C5 radiculopathy and bilateral carpal and cubital tunnel syndromes. He also indicated that appellant could perform sedentary work. But again, Dr. Beredjiklian did not address causal relationship. His two subsequent reports similarly did not address causal relationship. Dr. Beredjiklian merely reiterated what appellant initially told him regarding the date of onset of symptoms.

In a December 6, 2011 prescription pad note, Dr. Skaroff indicated that appellant was unable to work due to multiple injuries pertaining to the hands and neck caused from a fall on July 14, 2011. His December 6, 2011 treatment records included a diagnosis of cervical disc disease and bilateral carpal tunnel syndrome. But the physician did not explain the relationship between the current diagnoses and appellant's July 14, 2011 employment-related injury.

Dr. Skaroff's December 17, 2011 report similarly did not include a reasoned explanation regarding causal relationship. Appellant's July 14, 2011 work-related fall reportedly aggravated her fibromyalgia, as well as injuring her left hand and neck. Dr. Skaroff noted appellant's preexisting cervical degenerative disc disease, but did not address how and to what extent this condition may have been aggravated by the July 14, 2010 employment injury. He also stated that appellant's chronic left hand pain was apparently a combination of carpal tunnel syndrome and residual from trauma. But again, Dr. Skaroff offered no explanation of how he was able to distinguish the effects of CTS from the noted trauma. Although he stated that there was a causal relationship, his December 17, 2011 report is devoid of any rationale.

Dr. Freedman, a physiatrist, treated appellant between December 13, 2011 and September 20, 2012. He focused primarily on her cervical complaints. Dr. Freedman initially questioned whether appellant's bilateral upper extremity complaints were due to her prior history of polyneuropathy or due to carpal/cubital tunnel syndromes. He continued to question the latter diagnosis in subsequent reports. A September 20, 2012 EMG revealed borderline right CTS, no evidence of left CTS, no evidence of bilateral ulnar nerve lesion and no evidence of cervical radiculopathy. Appellant initially reported having landed on her left hand when she fell backwards on July 14, 2011. Dr. Skaroff similarly reported left hand trauma. Thus, the factual evidence does not establish a relationship between the July 14, 2011 work-related fall and appellant's current right upper extremity complaints.

As noted, Dr. Freedman focused primarily on appellant's cervical complaints. He initially diagnosed cervical whiplash and later, cervical spondylosis. Dr. Freedman's December 13, 2011 report included a detailed history of appellant's July 14, 2011 employment injury. He was also privy to her November 9, 2011 cervical MRI scan results which noted multilevel degenerative disc disease with disc protrusions. Although aware of appellant's July 14, 2011 employment injury, Dr. Freedman did not specifically offer an opinion regarding whether her current cervical condition was either caused or aggravated by the July 14, 2011 work-related fall. He noted that her other conditions -- neuropathy and lumbar complaints -- were unrelated to the work injury. Dr. Freedman did not provide a fully reasoned explanation regarding the cause of her ongoing cervical complaints or disability.

The reports from Drs. Skaroff, Mandel, Beredjiklian and Freedman each fail to establish a causal relationship between appellant's July 14, 2011 employment injury and her claimed recurrence of disability beginning November 1, 2011. OWCP accepted the claim for neck sprain

only and appellant has not established that her other diagnosed conditions were causally related to the July 14, 2011 employment injury. As noted, where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury.[15]

In February 2012, OWCP referred appellant to Dr. Draper to address whether her current complaints were related to the July 14, 2011 employment injury. Pending further development of the record, OWCP continued to authorize medical treatment ostensibly related to the claimed recurrence of disability.[16]

In his April 20, 2012 report, Dr. Draper diagnosed cervical strain, cervical spondylosis at C5-6, and degenerative bulging cervical disc disease at C2-3 through C6-7. He found that appellant's employment-related cervical strain had resolved. Dr. Draper further found that appellant's ongoing neck complaints were due to preexisting nonaccident-related multilevel degenerative cervical disc disease. He explained that the July 14, 2011 employment injury had not permanently aggravated appellant's degenerative cervical disc disease. Although Dr. Draper imposed certain work limitations, he stated that the restrictions were due to preexisting multilevel degenerative cervical disc disease and not the accident itself. He also indicated that appellant's history of bilateral carpal/cubital tunnel syndromes, polyneuropathy, deep vein thrombosis and lumbar disc disease were all unrelated to her employment injury.

Appellant's counsel argued that Dr. Draper's opinion lacked probative value because he relied on an inaccurate SOAF. He correctly noted that the February 8, 2012 SOAF mistakenly identified appellant's place of employment as "Coatsville (sic) VAMC." However, Dr. Draper did not include that misinformation in his April 20, 2012 report. He correctly reported that appellant was employed as a "customer service representative for the IRS." Moreover, whether appellant worked in Philadelphia or nearby Coatesville, PA is not particularly material or germane to the current issue. The Board finds that Dr. Draper provided a well-reasoned medical opinion upon which OWCP properly relied in denying appellant's claimed recurrence of disability.

Appellant's counsel also argued that OWCP improperly terminated medical benefits without prior notice. He referenced the penultimate paragraph in OWCP's May 2, 2012 decision which reads as follows: "Based on these findings, the claim for recurrence is denied. Medical treatment is not authorized and prior authorization, if any, is terminated." When read in its proper context, the above-noted paragraph should not give pause for concern.

As previously noted, while the recurrence claim was under development OWCP authorized medical treatment, including physical/occupational therapy which was ostensibly related to appellant's claimed recurrence of disability beginning November 1, 2011. Once the recurrence claim had been denied, OWCP properly advised that recurrence-related medical treatment was no longer authorized. To date, OWCP has not issued a formal decision

[15] *See supra* note 12.

[16] On January 30, 2012 OWCP specifically advised appellant that her July 14, 2011 injury claim remained open for medical care.

terminating medical benefits with respect to appellant's July 14, 2011 neck sprain. The hearing representative's October 16, 2012 decision currently before the Board contains no statement relevant to ongoing medical treatment.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision.[17]

CONCLUSION

Appellant failed to establish an employment-related recurrence of disability on or after November 1, 2011.

ORDER

IT IS HEREBY ORDERED THAT the October 16, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 19, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[17] *See* 5 U.S.C. § 8128(a); 20 C.F.R. §§ 10.605-10.607.