United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 15-548**
	)	**Issued: May 13, 2015**
DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTER FOR MEDICARE & MEDICAID SERVICES, Woodlawn, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 15, 2015 appellant filed a timely appeal from an August 22, 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.

ISSUE

The issue is whether appellant established a recurrence of total disability beginning July 27, 2010 causally related to her March 30, 2005 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 9, 2005 appellant, then a 50-year-old management analyst, filed an occupational disease claim indicating that many years of typing, writing, using the adding machine, and computer caused several medical conditions. OWCP accepted the claim for bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome and paid benefits including surgical procedures of January 11 and June 7, 2007. Appellant stopped work on January 11, 2007 for surgery. She returned to part-time limited-duty work at home on June 19, 2007 and full-duty work with use of voice activated software on February 14, 2008.

By decision dated October 22, 2008 and corrected on November 14, 2008, OWCP issued a schedule award for 26 percent impairment of the right upper extremity and 26 percent impairment of the left upper extremity, for which appellant received a requested lump-sum award on January 13, 2009. Appellant requested increased schedule awards based on July 25 and December 9, 2009 reports from Dr. Robert W. Macht, a surgeon. In decisions dated October 30, 2009 and February 17, 2010, OWCP denied entitlement to additional schedule awards.

On June 22, 2010 appellant filed a claim for a recurrence of disability claiming wage loss from work due to a change or worsening of her accepted work-related conditions. In a July 2, 2010 statement, she stated that her physicians told her she was totally disabled from performing her job and should retire. Appellant indicated that, since her return to work in December 2007, her job continuously aggravated her approved conditions. She also requested approval to change physicians to Dr. Terrance M. O'Donovan, a Board-certified orthopedic hand surgeon.

In a June 30, 2010 certificate, Dr. O'Donovan advised that appellant should retire because of recurrence of carpal tunnel syndrome and cubital tunnel syndrome. In a July 1, 2010 note, Dr. Pradeep P. Garg, a Board-certified internist, stated that appellant was totally disabled from performing her job functions and should retire due to the recurrence of her preexisting approved bilateral carpal and cubital tunnel syndromes. He stated that, since her return to work in December 2007, appellant's job continuously aggravated her preexisting conditions.

In a July 12, 2010 letter, OWCP stated that, since appellant did not claim any lost time from work, she had not experienced a true recurrence. It noted her claim remained open for medical treatment of her accepted conditions. In a July 26, 2010 letter, OWCP denied appellant's request to change physicians. It also noted that any desire to retire should be directed to the Office of Personnel Management as she received a lump-sum schedule award payable thru November 4, 2011 and would not be able to be on OWCP's disability rolls.

On July 23, 2010 appellant filed a claim for wage-loss compensation with accompanying time analysis for the period July 27 to 30, 2010. In a July 22, 2010 note, Dr. Garg recommended she take a leave of absence from work for a period of three months due to her complaints of severe pain.

On July 31, 2010 appellant voluntarily retired. On August 10, 2010 she indicated that she suffered a true recurrence because of her retirement. In an August 19, 2010 letter, OWCP requested the employing establishment provide information regarding appellant's

accommodations for her work restrictions, whether limited-duty work was available, and whether the voice recognition software which she was provided continued to accommodate her restrictions. On August 19, 2010 it authorized appellant's request to change her treating physician to Dr. O'Donovan.

In a September 2, 2010 letter, the employing establishment advised that following appellant's 2007 surgery, they accommodated her restrictions by allowing her to work from home a few hours per week sitting in on conference calls. Upon returning to work, appellant worked light duty part time two days a week and gradually increased to full tour of duty. A complete ergonomic work space evaluation was done and her telephone was programmed so she only needed to press one or two digits for frequently dialed numbers. Appellant's computer at work was upgraded to accommodate voice software, for which extensive training was provided, and she was provided an ergonomic mouse. She was only required to push a button to turn on her computer and to enter her four digit code. An assistant performed any necessary lifting of manuals or books. Appellant was permitted to interrupt the work cycle at regular intervals throughout the day to exercise her fingers, wrists, and hands as needed. In the afternoons, she was permitted to go to the health unit to apply heat to her wrists and elbows for 20 minutes at a time as needed. Appellant was also allowed to work from home one day a week despite the fact she was not supposed to work from home because of her four-day schedule and the Master Labor Agreement. The employing establishment stated that these accommodations were in place from December 2007 until she voluntarily retired on July 31, 2010. These accommodations were made to limit appellant's use of her mouse and the keyboard; however, the employing establishment noted on several occasions appellant was observed using the keyboard against medical advice. The employing establishment advised that she was given the opportunity to reduce her 10-hour days to 8 hours, but she declined the offer.

In his June 30, 2010 treatment note and in a September 29, 2010 letter, Dr. O'Donovan stated that he made it clear to appellant when he first saw her on June 30, 2010 that she needed to see her original surgeon if she was going to claim a recurrence of her conditions.

In an October 25, 2007 electromyogram/nerve conduction velocity report, an assessment of de Quervain's tenosynovitis, bilateral, tendinitis at wrist and elbow, residuals right cubital tunnel syndrome and residual, but improved bilateral carpal tunnel syndrome, and left cubital tunnel syndrome was provided.

In a November 8, 2010 note, Dr. O'Donovan noted that appellant continued with mild discomfort in the palm after heavy activities. He also noted that she was having some depression because of early retirement secondary to recurrent symptoms.

On December 2, 2010 appellant resubmitted her June 22, 2010 recurrence claim. She indicated that her depression should be accepted as it came about as a result of her early retirement due to a recurrence of her symptoms.

OWCP referred appellant for a second opinion evaluation with Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, to ascertain the extent of her disability. In a February 22, 2011 report, Dr. Gordon reviewed the statement of accepted facts and appellant's medical record, noted her complaints and presented findings on examination. He stated that her examination was

completely unreliable as she complained on all palpation and it did not follow any anatomic distribution. Dr. Gordon found no evidence of any type of significant swelling through the hands, temperature abnormality, perspiration abnormality, modeling, ortrophic change through the nails. He obtained radiographs of both elbows, which revealed mild coronoid spurring and olecranon osteophytic change. Radiographs of both wrists revealed mild carpometacarpal and radiocarpal arthrosis bilaterally. No evidence of any type of significant diffuse osteopenia, which would be found in reflex sympathetic dystrophy, or chronic pain syndrome or causalgia was found. The following impressions were provided: concern for psychiatric disorder with orthopedic overlay; residuals of accepted bilateral carpal tunnel syndrome and cubital tunnel syndrome; and unrelated degenerative disease of the elbows and wrists. Based on his review of the medical record and his examination of the upper extremities, Dr. Gordon opined that appellant could work in a sedentary capacity, such as answering the telephone and using a toggle type device, but she could not perform any function that required repetitive motion of the elbows or wrists, pushing, pulling, or lifting. He stated that the restrictions were permanent and that she had reached maximum medical improvement. Dr. Gordon further opined that appellant's subjective complaints did not comport with her objective findings and felt her pain was out of proportion. He recommended that she seek psychological or psychiatric assessment, along with pain management. Dr. Gordon indicated that appellant's prognosis was poor because of her mental status.

By decision dated January 12, 2012, OWCP denied the alleged recurrence of June 22, 2010. Weight of the medical evidence was given to Dr. Gordon. The claim remained open for medical treatment of the accepted conditions. On January 30, 2012 appellant requested a hearing. By decision dated May 23, 2012, an OWCP hearing representative vacated the January 12, 2012 decision and remanded the case for further actions, which included the issuance of an updated statement of accepted facts and referral to a Board-certified psychiatrist for an examination and evaluation.

On December 13, 2012 OWCP referred appellant to Dr. Dennis M. Young, a Board-certified psychiatrist, for a psychiatric second opinion evaluation. In a December 22, 2012 report, Dr. Young noted his review of the statement of accepted facts and the medical records. He examined appellant on December 19, 2012, noting the history of injury and his findings on examination. Dr. Young stated that she was in pain, which was predominantly subjective without demonstrable physical stimuli or physical sequelae. He stated that the pain was originally caused by the work-related nerve entrapment syndromes but was now sustained by her perception of her general devaluation of her worth and identity as a valued worker and a contributing family member. Dr. Young diagnosed pain disorder, associated with both psychological factors and a general medical condition. He also diagnosed dysthymic disorder (chronic depression).

Dr. Young stated the original pain and depression of low intensity immediately following the nerve disorders in 2005 were caused by the entrapment syndromes. However, the pain subsequent to the surgeries was assessed by credible physicians to be out of proportion to objective findings. The pain of the past couple years was not sufficiently and proximately caused by the original entrapment but by appellant's emotional response to her perception of diminished status and value to herself and to significant others at work and at home. Appellant returned to her work some months after her second surgery in June 2007 and she did not stop

working until July 2010. She worked through her complaints of pain, an exacerbation of which was never supported by follow up medical evaluation. Appellant expressed distress, that her supervisors were unhappy, not with her work, but with her response to their attempts to accommodate. Dr. Young stated that he considered her to have depression of clinical significance and believed that she suffered pain disorder associated with both psychological factors and with a general medical condition (bilateral carpal and cubital tunnel syndromes). The worsening and chronicity was not because of the original disorder but because of a psychological overlay attendant to perception of not fitting in at work and appellant's perception of loss of support at work. Dr. Young concluded that unless electrophysiological testing and neurologic examination attested otherwise, her condition was not due to continued nerve damage.

In a February 7, 2013 addendum report, Dr. Young opined that appellant's depression was not caused by her initial carpal tunnel syndrome or by the corrective surgery. Appellant was able to return to work for several years before she retired in 2010. Dr. Young believed her depression was her response to feeling extruded from the work environment in which she had functioned before and where she felt valued in her usual performance. He believed appellant felt the pain of which she complained and the pain was why she could not work. The extent of that pain had psychological origins, which had to do with appellant's perception of herself as an undervalued and marginalized employee. Dr. Young opined that the carpal tunnel syndrome/surgery was not the proximate cause of her second diagnosis of dysthymic disorder nor was this much pain/impairment caused by a clinical depression and that depression was not of such severity to have kept her from working from 2007 to 2010. However, over time appellant's depression probably exacerbated her pain experience. Dr. Young recommended psychiatric/psychological treatment to improve her mood and outlook. However, even with such therapy, he opined that it was highly unlikely that appellant could return to her previous employment.

By decision dated March 28, 2013, OWCP denied appellant's recurrence claim as she had not established that she was disabled/further disabled due to a material change/worsening of her accepted work-related conditions. It found there was no material change in her orthopedic condition to support the claimed recurrence and work stoppage. OWCP also found appellant's diagnosed depression was not causally related to the original occupational conditions but rather was self-generated as a result of her perception as an undervalued and marginalized employee.

On March 14, 2014 OWCP received a March 12, 2014 letter from counsel requesting reconsideration based on new evidence.

In a February 21, 2014 letter, Dr. Allan H. Macht, a Board-certified surgeon, noted that since appellant's last visit of July 25, 2009, she had splinting and nerve studies and was seen for psychiatric evaluation. He noted that she indicated a gradual worsening of her upper extremity conditions from December 2007 to January 2010 with a precipitous worsening of both arms in February to June 2010, which culminated in her recurrence on June 23, 2010 and stopping work on July 27, 2010. Physical examination findings were presented and a diagnosis of status post release of both carpal tunnels and both ulnar nerves at the elbows was provided. Dr. Macht advised that since appellant's last visit in July 2009, she had been able to work with significant difficulty. Over the course of time, there was some worsening of condition of both arms, but starting January 2010 and extending into June 2010, there was a marked change in her condition,

based on her history. Therefore, there was a spontaneous change in appellant's medical condition, which resulted from her previous injury dated March 30, 2005 that occurred early in 2010. There was no evidence of any intervening injury or new exposure to factors causing the original illness. Dr. Macht opined that the work stoppage was causally related to this recurrence (spontaneous change in appellant's medical condition) and noted that she has a significant problem with both arms at this time. Appellant's current medical condition was causally related to her occupation and was the reason that she was unable to work.

In a February 3, 2014 report, Dr. John R. Lion, a Board-certified psychiatrist, performed a psychiatric evaluation of appellant on January 21, 2014. He noted the history of injury and that she elected disability retirement and stopped work in July 2010. In June 2010, appellant filed a notice of recurrence due to depression resulting from this injury, which OWCP denied. Dr. Lion noted that she underwent surgical repair of both arms in 2007 but continued to experience pain and discomfort. Various accommodations were made at work, including the installation of dictation equipment which would decrease appellant's typing and an allowance by which she could work some days from home. However, pain continued. As time progressed, appellant felt an increasing sense of frustration on the part of her employing establishment and a perception that coworkers felt negatively about her. Dr. Lion noted that several orthopedic surgeons involved in her care from 2009 to present felt her pain to be unsubstantiated by objective findings.

Appellant eventually saw a psychologist, Jack M. Long, Ph.D., in August 2007, who diagnosed her with adjustment disorder with depression and anxiety, but suspended psychotherapy. Dr. Lion noted Dr. Young's evaluation and that appellant was presently in psychotherapy. He diagnosed dysthymic disorder. Dr. Lion explained that where an injury may occur at a moment's notice, accompanying depression occurs as the injured party realizes the full limitations of the injury. He noted that Dr. Paul Apostolo, appellant's surgeon, noted her depression preoperatively in August 2006, some 18 months following her initial injury. Dr. Apostolo performed surgery in January and June 2007 and clearly recognized and documented depression as a negative force in healing during July 2007. One month later, psychologist Dr. Long also diagnosed appellant as suffering from depression. Dr. Lion stated that he viewed appellant's pain, typical or not, under the category of somatic disorders and that it was a common manifestation of depression associated with physical limitations and dysfunction. In appellant's case, the depression clearly worsened. Whereas she was once able to work despite the depression, she no longer could work at all. Dr. Lion opined that appellant manifested a depressive illness formally diagnosed as a dysthymic disorder which resulted from her initial injury and which has intensified over the years. He opined that she had been disabled from June 23, 2010 through the present as a result of this work-related psychological condition which resulted from the March 20, 2005 work-related injury.

OWCP declared a conflict in medical opinion as to whether employment factors contributed to or caused a psychiatric condition and referred appellant to Dr. Bruce M. Smoller, a Board-certified psychiatrist, for an impartial medical evaluation. In a July 27, 2014 report, Dr. Smoller reviewed the statement of accepted facts, appellant's medical record, and noted the history of injury. He noted interview findings and provided an impression of mild dysthymia on a fair to good level of functioning. Dr. Smoller stated that the fact that appellant has mild dysthymia secondary to prolonged pain is a normal state for patients with an unremitting chronic

disease. He opined that there was a relationship to the injury, especially the altercation of her lifestyle, and thus there was a causal relationship by precipitation. Dr. Smoller stated the dysthymia was of a mild nature and not disabling in any way. He indicated that the dysthymia did not need further treatment, that appellant reached maximum medical improvement and further therapy would not alter this to any degree. Dr. Smoller reiterated that she was not disabled from work due to the psychiatric condition.

By decision dated August 22, 2014, OWCP accepted the additional condition of nondisabling mild dysthymic disorder. Further treatment for the newly accepted condition was not authorized based on Dr. Smoller's July 27, 2014 impartial report.

Also by decision dated August 22, 2014, OWCP affirmed the March 28, 2013 decision in part to reflect that appellant had not established her recurrence claim due to a material change or worsening of her accepted work-related conditions. It also vacated the March 28, 2013 decision in part to reflect the acceptance of a nondisabling mild dysthymic disorder.

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 has resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[2] When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence establishes that light duty can be performed, the employee has the burden to establish by the weight of reliable, probative, and substantial evidence a recurrence of total disability. As part of this burden of proof, the employee must show either a change in the nature and extent of the injury-related condition, or a change in the nature and extent of the light-duty requirements.[3]

The term disability as used in FECA means the incapacity because of an employment injury to earn the wages that the employee was receiving at the time of injury.[4] For each period of disability claimed, the employee has the burden of establishing that she was disabled for work as a result of the accepted employment injury.[5] Whether a particular injury caused an employee disability for employment is a medical issue which must be resolved by competent medical evidence.[6] The fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two.[7]

[2] 20 C.F.R. § 10.5(x).

[3] *Terry R. Hedman*, 38 ECAB 222 (1986).

[4] *Paul E. Thams*, 56 ECAB 503 (2005).

[5] *Sandra D. Pruitt*, 57 ECAB 126 (2005); *Dennis J. Balogh*, 52 ECAB 232 (2001).

[6] *G.T.*, 59 ECAB 447 (2008); *Gary J. Watling*, 52 ECAB 278 (2001).

[7] *D.I.*, 59 ECAB 158 (2007).

The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow an employee to self-certify their disability and entitlement to compensation.[8]

Generally, findings on examination are needed to justify a physician's opinion that an employee is disabled for work.[9] Appellant's burden of proving she was disabled on particular dates requires that she furnish medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury and supports that conclusion with medical reasoning.[10] Where no such rationale is present, the medical evidence is of diminished probative value.[11]

In order to establish that a claimant's alleged recurrence of the condition was caused by the accepted injury, medical evidence of bridging symptoms between his or her present condition and the accepted injury must support the physician's conclusion of a causal relationship.[12]

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 a proper factual and medical background, must be given special weight.[13]

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome and bilateral lesion of ulnar nerve and paid appropriate benefits, including surgical procedures in 2007. It subsequently accepted a nondisabling mild dysthymic disorder. Appellant eventually returned to work with accommodations to limit her use of the mouse and the keyboard from December 2007 through the date of her voluntary retirement, July 31, 2010. She filed a notice of recurrence from July 27, 2010 and continuing due to her accepted conditions, which OWCP denied.

The Board has reviewed the medical record and has found no reasoned medical opinion to support the claim that appellant sustained a spontaneous change in her medical condition on or about July 27, 2010 causally related to her accepted work-related conditions. While both Dr. O'Donovan and Dr. Garg felt appellant should seek disability retirement, their opinions were based on appellant's complaints of pain. When a physician's statements consist only of a repetition of the employee's complaints that excessive pain caused an inability to work, without making an objective finding of disability, the physician has not presented a medical opinion on

[8] *Amelia S. Jefferson*, 57 ECAB 183 (2005); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

[9] *S.F.*, 59 ECAB 525 (2008).

[10] *Ronald A. Eldridge*, 53 ECAB 218 (2001).

[11] *Mary A. Ceglia*, 55 ECAB 626 (2004).

[12] *Id.*

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

the issue of disability or a basis for payment of compensation.[14] While Dr. Garg stated in his July 1, 2010 note that, since her return to work in December 2007, appellant's job continuously aggravated her preexisting conditions, his opinion on causal relationship is of limited probative value in that he did not provide adequate medical rationale in support of his conclusions.[15] Dr. Garg did not provide any findings on examination or explain why her current condition and alleged disability were causally related to the accepted injury. While he noted appellant's complaints of pain she experienced as a result of bilateral carpal tunnel and bilateral cubital tunnel syndrome, these statements are broad and vague as they do not explain whether her accepted conditions contributed to her claimed condition and/or disability as of July 27, 2010.[16]

In his February 21, 2014 report, Dr. Macht noted that he last saw appellant on July 25, 2009. He provided findings on examination and, based on her history, stated that she was able to work with significant difficulty but there was some worsening of condition of both arms starting January 2010 and extending into June 2010. While he opined that there was a spontaneous change in her accepted medical condition and that her work stoppage was causally related to this recurrence (spontaneous change in her medical condition), Dr. Macht failed to explain why appellant's current condition and alleged disability are causally related to the accepted work injury. He did not explain how or why her accepted conditions contributed to her claimed condition or disability as of July 27, 2010. Dr. Macht also provided no medical evidence of bridging symptoms between appellant's present condition and the accepted injury to support his conclusion of a causal relationship.[17] Thus, his report is insufficient to establish her claim.

Dr. Gordon, OWCP's second opinion physician, found that, while appellant had (improved) residuals of her carpal tunnel and cubital tunnel conditions, she was capable of working in a sedentary capacity with permanent restrictions. He also stated that her subjective complaints did not comport with objective findings and that her pain was out of proportion. The medical evidence of record therefore does not substantiate that appellant sustained a recurrence of total disability on July 27, 2010 due to her accepted physical conditions.

The Board also finds that there is no evidence of record that the accommodations the employing establishment provided were outside of appellant's medical restrictions or that they had changed.

As noted, OWCP subsequently accepted the condition of nondisabling mild dysthymic disorder. It found a conflict in medical opinion evidence arose between Dr. Young, the second opinion physician, and appellant's psychiatrist Dr. Lion, as to whether employment factors contributed to or caused a psychiatric condition and, in accord with 5 U.S.C. § 8123(a), referred

[14] *G.T.*, 59 ECAB 447 (2008); *see Huie Lee Goal*, 1 ECAB 180,182 (1948).

[15] *William C. Thomas*, 45 ECAB 591 (1994).

[16] *See supra* note 11. (Appellant has the burden of furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound rationale).

[17] *See supra* note 11.

appellant to Dr. Smoller, a Board-certified psychiatrist, for an impartial medical evaluation. In a report dated July 27, 2014, Dr. Smoller provided a history, results on examination, and reviewed medical evidence. Based on an accurate factual and medical background, he found appellant has mild dysthymia secondary to prolonged pain and that there was a causal relationship to her work factors by precipitation. Dr. Smoller stated the dysthymia was of a mild nature and not disabling in any way. He further stated the dysthymia did not need further treatment and appellant's condition was relatively unchanging and maximum medical improvement had been reached. Dr. Smoller reiterated that she was not disabled from work due to the psychiatric condition. This represents a medically sound explanation of the opinion offered.

The Board therefore finds that Dr. Smoller provided a rationale medical opinion in this case. As a referee physician, Dr. Smoller's report is entitled to special weight. This evidence established a psychological component to appellant's work-related condition, but found that it did not disable appellant from working on July 27, 2010.

Appellant has submitted insufficient probative medical opinion evidence to establish her recurrence of disability claim. The medical evidence of record is unsupported by rationalized medical evidence to demonstrate that the accepted condition prevented her from working.[18] Accordingly, the Board finds that appellant has not met her burden of proof.

Appellant contends that she has provided *prima facie* evidence to establish an overall worsening of her accepted conditions leading to her recurrence of injury and medical retirement. As explained above, there is no probative medical opinion evidence to establish that she had a material change in her medical condition such that she was totally disabled as a result of her accepted work conditions beginning July 27, 2010.

Appellant may submit new evidence or argument as part of a formal written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant failed to establish a recurrence of disability on or after July 27, 2010 causally related to her March 30, 2005 employment injuries.

[18] *A.M.*, Docket No. 09-1895 (issued April 23, 2010) (when a claimant stops work for reasons unrelated to the accepted employment injury, there is no disability within the meaning of FECA).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated August 22, 2014 is affirmed.

Issued: May 13, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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