United States Department of Labor
Employees' Compensation Appeals Board

W.M., Appellant	)	
and	)	**Docket No. 17-0337**
	)	**Issued: August 8, 2017**
DEPARTMENT OF AGRICULTURE, NATIONAL FOREST SERVICE, Albuquerque, NM, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 5, 2016 appellant, through counsel, filed a timely appeal from a September 28, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP).

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

ISSUE

The issue is whether OWCP abused its discretion by denying appellant's request for cervical surgery.

FACTUAL HISTORY

On June 30, 2004 appellant, then a 36-year-old seasonal forestry technician, filed a traumatic injury claim (Form CA-1) alleging that he suffered injuries that day to his lower back, right knee, neck, and head due to a motor vehicle accident that occurred in the performance of duty. He stopped work and returned to full duty on July 29, 2004. OWCP accepted this claim for back contusion and abrasion, neck sprain, multiple abrasions, bilateral knee contusions and right leg/knee sprain.

Under OWCP File No. xxxxxx880, appellant filed another Form CA-1 on April 27, 2005 alleging that on April 22, 2005 he sustained an injury to his lower back in the performance of duty. He did not stop work, but was placed on light duty. On July 20, 2005 appellant returned to full duty. OWCP accepted this claim for lumbar disc displacement. It combined both files with the current claim, OWCP File No. xxxxx881, as the master file.

On January 1, 2009 appellant filed a claim for a recurrence of medical treatment (Form CA-2a). He explained that he had experienced a recurrence of his lumbar strain, which was related to his June 30, 2004 employment injury.

In a report dated January 28, 2009, Dr. William G. Binegar, Board-certified in pain medicine, related that appellant was self-referred and was evaluated for low back pain, radiating into the right buttock and right thigh. Regarding appellant's cervical findings, he related that appellant's range of motion was good, he had no neck tenderness, and no pain during Lhermitte's or Spurling's tests. Dr. Binegar related diagnoses of right lower extremity radiculopathy, lumbar facet syndrome, and lumbar herniated disc. He requested authorization for lumbar epidural injections with fluoroscopy. On March 20, 2009 OWCP denied the request for lumbar epidural injections, noting that no medical evidence had been submitted regarding medical treatment between September 28, 2005 and January 2009.

On April 7, 2009 OWCP referred appellant to Dr. Paul C. Collins, a Board-certified orthopedic surgeon, for a second opinion to determine whether appellant still had residuals from

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that appellant submitted new evidence following the September 28, 2016 decision. However, since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).

the accepted injuries. In a report dated May 4, 2009, Dr. Collins related that given appellant's magnetic resonance imaging (MRI) scan findings, it appeared that appellant had an intermittent herniated disc from the June 30, 2004 and April 22, 2005 employment injuries. However, appellant's bilateral knee conditions and his neck strain had resolved.

In a report dated December 7, 2010, Dr. Joseph M. Verska, a Board-certified orthopedic surgeon, related that appellant was seen for low back and leg pain. He reported that appellant's MRI scan showed disc herniation at L4-5. Dr. Verska concluded that if appellant's pain persisted he might be a candidate for an L5 nerve block or microdiscectomy. On June 8, 2011 he related that appellant was seen in follow up. Appellant related that his back pain was ruining his life. Dr. Verska related that he had recommended a single-photon emission computerized tomography (SPECT) scan of appellant's lumbar spine and a discogram at L3-S1. On August 12, 2011 he requested authorization for surgery of appellant's lumbar spine at L4-5.

On September 8, 2011 Dr. William Stewart, an orthopedic surgeon, acting as OWCP's district medical adviser, reviewed appellant's case file and recommended that appellant's lumbar microdiscectomy be approved.

On September 14, 2011 appellant underwent approved lumbar surgery at the L4-5 level. He stopped work and submitted various claims for disability compensation (Form CA-7) beginning September 10, 2011. OWCP paid disability compensation for the period September 14 to October 22, 2011.

On October 5, 2011 OWCP expanded acceptance of appellant's claim to include herniated disc at L4-5. The record reveals that appellant worked intermittently for a nonfederal employer between November 2011 and March 2012.

On May 14, 2012 OWCP accepted appellant's recurrence claim (Form CA-2a) for a March 7, 2012 recurrence of disability. It paid disability compensation and placed appellant on the periodic rolls beginning July 1, 2012.

In a June 20, 2012 MRI scan of appellant's cervical spine, Dr. Leslie A. Saint-Louis, a Board-certified neuroradiologist, noted appellant's complaints of right shoulder pain. He observed mild-to-moderate right osteophyte stenosis, patent canal, and mild disc bulge at C5-6 and mild-to-moderate bilateral osteophytic foraminal stenosis and mild disc bulge with a small osteophyte at C6-7. In an x-ray examination of appellant's cervical spine, Dr. Saint-Louis observed normal alignment of the vertebra during flexion and extension and mild C6-7 disc space narrowing with a small posterior osteophyte.

Dr. Richard E. Manos, a Board-certified orthopedic surgeon, began to treat appellant on August 6, 2012 and in a surgery consultation report of that date related appellant's complaints of increasing back pain radiating into the bilateral lower extremities. He reviewed appellant's history, including the previous spinal surgeries and noted that appellant's condition improved for a short period of time following each surgery. Dr. Manos provided examination findings and diagnosed history of L4-5 disc herniation status post left L4-5 microdiscectomy industry related, degenerative spondylolisthesis with instability, and postlaminectomy syndrome. He explained that appellant's right-sided disc herniation was not addressed with the previous surgery and was

the cause of his ongoing right-sided pain. Dr. Manos opined that appellant's disc herniation was related to his original injury. He recommended additional lumbar spine surgery.

On October 11, 2012 appellant underwent an approved lumbar fusion surgery with Dr. Manos. He remained off work and continued to receive medical treatment.[4]

OWCP referred appellant for vocational rehabilitation.

On July 14, 2014 appellant was examined in the emergency room by Dr. Douglas Kartel, Board-certified in emergency medicine, for complaints of chronic low back pain, which radiated up to his neck and right arm. He noted that he experienced these symptoms before, but they had worsened over the past three months. Upon physical examination of appellant's neck, Dr. Kartel observed no tenderness, deformity, crepitance, or subcutaneous emphysema. Range of motion was full. Examination of appellant's back demonstrated some discomfort with palpation in the bilateral lumbar paraspinous muscle area and increased discomfort in the right-sided thoracic and cervical paraspinous muscle region. Dr. Kartel diagnosed back pain and paraspinous muscle strain with spasm. He opined that appellant was experiencing an exacerbation of chronic recurrent back pain with muscle spasm.

In a July 24, 2014 MRI scan report of appellant's cervical spine, Dr. Mark H. Awh, a Board-certified diagnostic radiologist, noted moderately large right paracentral disc protrusion at C5-6, causing rightward cord flattening and borderline central canal stenosis, likely impinging upon the right C6 nerve root. He also reported moderate disc bulge and small broad-based central and right paracentral disc protrusion at C6-7, causing mild central stenosis with ventral cord flattening, likely impinging upon the right C7 nerve root.

Dr. Manos continued to treat appellant. In August 6 and 15, 2014 narrative reports, he related that he was conducting a follow-up examination of appellant's lumbar pain that dated back to his original injury in 2004. Dr. Manos reported that appellant was almost two years out from his transforaminal lumbar interbody fusion and was undergoing physical therapy when he began to have right-sided neck pain radiating to his periscapular area with numbness and tingling into his hands. He noted that an MRI scan of appellant's cervical spine showed moderately large right paracentral disc protrusion at C5-6 as well as C6-7 creating compression of the nerves consistent with his symptoms. Upon physical examination of appellant's cervical spine,

[4] On December 17, 2013 appellant requested authorization for a second lumbar spine fusion surgery. In a decision dated January 9, 2014, OWCP denied authorization for lumbar spine fusion surgery because the medical evidence failed to establish that his current lumbar condition was a result of the June 30, 2004 employment injury. On January 15, 2014 it received appellant's request, through counsel, for a telephone hearing. By decision dated June 5, 2014, an OWCP hearing representative remanded appellant's case. He determined that OWCP needed to further develop the medical evidence to determine whether spinal surgery was medically necessary to treat appellant's June 30, 2004 employment injuries. After further medical development, OWCP denied authorization for combined lumbar spine fusion surgery in a decision dated November 21, 2014. On December 9, 2014 appellant, through counsel, received his request for a telephone hearing. In a decision dated September 4, 2015, an OWCP hearing representative remanded appellant's case for further development of the medical evidence. As OWCP is still developing the issue of authorization for lumbar spine surgery, this issue is in an interlocutory posture. *See* 20 C.F.R. § 501.2(c)(2). The only issue being considered on this present appeal is authorization for cervical surgery.

Dr. Manos reported findings of positive Spurling's maneuver on the right with radiating pain in the right with radiating pain in the right C6-7 distribution and diminished right C6 reflex. Neurological examination showed some decreased tone of his triceps and biceps. He diagnosed acute onset of cervical radiculitis and right C5-6 and C6-7 herniated nucleus pulposus (HNP) with radiculopathy, progressive motor weakness. Dr. Manos recommended anterior cervical decompression and fusion surgery at C5-6 and C6-7. He opined that the surgery was part of his work-related injury since appellant injured his neck while in physical therapy.

On August 28, 2014 Dr. Manos requested neck spine fusion surgery.

On January 29, 2015 appellant underwent a cervical discectomy and fusion, which was not approved.

In a January 29, 2015 examination note, Scott Ward, a certified physician assistant, noted that appellant had undergone cervical surgery for complaints of neck pain and right radicular arm pain. Upon physical examination, he observed positive Spurling's maneuver on the right and negative Hoffman test. Forward flexion was to the chin three inches from his chest and extension was limited to 20 degrees. Mr. Ward diagnosed right C5-6 and C6-7 HNP with radiculopathy. He reported that appellant's cervical condition was accepted as a work-related injury on June 30, 2004. Mr. Ward explained that it was not unusual for there to be some progression in the initial injury to create appellant's current symptoms.

OWCP referred appellant's claim, along with the medical record and statement of accepted facts (SOAF), to Dr. Michael Shevlin, a Board-certified orthopedic surgeon, for examination and an opinion as to whether appellant's January 29, 2015 cervical surgery was medically necessary to treat appellant's accepted June 30, 2004 employment injury. In a June 11, 2015 report, Dr. Shevlin reviewed appellant's history and provided findings upon physical examination. He observed some limited extension and flexion of appellant's cervical spine with no specific point tenderness. Dr. Shevlin diagnosed axial cervical and thoracic pain. He opined that, although appellant's current diagnoses were not related to the accepted June 30, 2004 employment injury, the work injury may have hastened the underlying cervical disease. Dr. Shevlin noted that after the initial diagnosis of neck sprain, there was no medical documentation of continued neck pain until 2012, eight years after the June 30, 2004 employment injury. He concluded that cervical surgery was not recommended to treat appellant's accepted June 30, 2004 employment injury. Dr. Shevlin provided a work capacity evaluation form, which indicated that appellant could work with restrictions.

OWCP determined that a conflict in medical opinion existed as to whether cervical surgery was necessary to treat appellant's accepted June 30, 2004 and April 22, 2005 employment injuries. It referred appellant's claim to Dr. Glen Shapiro, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion to resolve the conflict in medical opinion evidence.

In an August 18, 2015 report, Dr. Shapiro reviewed appellant's history, including the SOAF, and noted appellant's accepted conditions of back contusion, back abrasions, neck sprain, right leg contusion, right leg abrasion, left knee contusion and abrasion, and displacement of lumbar intervertebral disc without myelopathy. He accurately described the June 30, 2004 and

April 22, 2005 employment injuries and provided a detailed evaluation of appellant's medical records. Dr. Shapiro noted that in 2013 appellant began physical therapy treatments, which he believed "flared his neck issue." He related appellant's current complaints of neck, back, and leg pain and anxiety. Upon examination of appellant's neck, Dr. Shapiro reported decreased flexion with no spasm or tenderness with deep palpation. Spurling's, Adson's, and Waddell's tests were negative. Dr. Shapiro indicated that there was no sign of thoracic outlet syndrome. He further reported right-sided radicular pain and decreased right-sided rotation with neck extension. Dr. Shapiro noted healed incisions in appellant's lower cervical and lumbar spine. Examination of appellant's lumbar spine revealed no warmth, erythema, or tenderness. Straight leg raise testing was negative bilaterally. Dr. Shapiro reported that examination of appellant's upper extremities showed no measurable weakness and no other focal deficits. Deep tendon reflexes were positive bilaterally.

Dr. Shapiro diagnosed chronic low back pain, chronic neck pain with right-sided radiculopathy, and general body deconditioning. He indicated that appellant's chronic low back pain and general deconditioning were related to the accepted June 30, 2004 employment injury. Dr. Shapiro opined that appellant's current neck injury and symptoms were not related to the June 30, 2004 employment injury. He explained that "a period of more than 8 years (2004 – 2012) elapsed during which time the patient did not seek any form of medical attention nor are there any medical records available for treatment of his neck pain, symptoms, or radiculopathy." Dr. Shapiro indicated that the only suggestion that appellant's neck pain was related to the accident was that he stated he was undergoing periodic and intermittent massage therapy for neck pain. He reported that for the same reasons, he did not think appellant's neck issues, including the January 29, 2015 cervical surgery, were the result of the accepted June 30, 2004 employment injury. Dr. Shapiro indicated that no further medical imaging, diagnostic testing, conservative or surgical interventions were recommended. He noted that appellant may benefit from a functional capacity evaluation (FCE) to determine current work capacity.

OWCP denied appellant's request for authorization of cervical surgery in a decision dated November 12, 2015. It found that the medical evidence was insufficient to establish that the requested cervical surgery was necessary to address the effects of his employment injuries.

On November 17, 2015 OWCP received appellant's request, through counsel, for a telephone hearing before an OWCP hearing representative.

Appellant submitted an October 27, 2015 report by Dr. Manos who related appellant's complaints of ongoing left radicular symptoms and continued back pain. Upon physical examination of the cervical spine, Dr. Manos observed intact sensation and 5/5 motor strength. Range of motion demonstrated forward flexion, extension, and lateral rotation to 30 degrees. Dr. Manos diagnosed a history of work-related neck and back injuries and subsequent surgeries on his neck with anterior cervical decompression and fusion to C5 to C7. He also diagnosed a history of transforaminal lumbar interbody fusion L4-5 with a chronic radiculopathy and neuropathic pain. Dr. Manos opined that "on a more medical probable basis than not" that both of appellant's back and neck symptoms and resultant surgeries were a direct and proximate result of the June 30, 2004 employment injury. He explained that given the type of motor vehicle accident that occurred on June 30, 2004 and appellant's employment as a firefighter, it was on a

"more medical probable basis" that the injury could have progressed to the point where appellant began to have increasing neck pain and radiculopathy.

On July 14, 2016 a telephone hearing was held. Appellant was represented by counsel. Counsel indicated that appellant used his own insurance for his cervical surgery because he could not put it off any longer. Appellant related that after the surgery he got sensation back in his fingers and his condition improved. He stated that he always had cervical symptoms since the 2004 employment injury, but he put off the symptoms because he thought it was from guarding from his lower back injury. Counsel requested that OWCP review Dr. Manos's October 27, 2015 report because it was not considered in the previous decision.

By decision dated September 28, 2016, an OWCP hearing representative affirmed the November 12, 2015 decision. She found that the medical evidence of record was insufficient to establish that appellant's cervical condition and subsequent surgery were causally related to the accepted June 30, 2004 employment injury. The hearing representative determined that the special weight of medical opinion evidence rested with Dr. Shapiro, the impartial medical examiner, who determined in an August 18, 2015 report that appellant's current cervical symptoms and surgery were not related to the accepted injury.

LEGAL PRECEDENT

Section 8103(a) of FECA provides for the furnishing of services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening in the amount of monthly compensation.[5] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[6] OWCP has broad administrative discretion in choosing the means to achieve this goal.[7] The only limitation on OWCP's authority is that of reasonableness.[8]

Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[9]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditure is incurred for treatment of the

[5] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[6] *W.T.*, Docket No. 08-812 (issued April 3, 2009); *A.O.*, Docket No. 08-580 (issued January 28, 2009).

[7] *Vickey C. Randall*, 51 ECAB 357 (2000).

[8] *D.C.*, 58 ECAB 629 (2007); *Mira R. Adams*, 48 ECAB 504 (1997).

[9] *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990).

effects of an employment-related injury or condition.[10] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[11] Therefore, in order to prove that the surgical procedure is warranted, appellant must submit medical evidence to show that the procedure was for a condition causally related to the employment injury and that the surgery was medically warranted.[12] Both of these criteria must be met in order for OWCP to authorize payment.[13]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[14] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15] When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[16]

ANALYSIS

OWCP accepted that on June 30, 2004 appellant sustained a work-related injury as a result of a motor vehicle accident that occurred in the performance of duty. His claim was accepted for back contusion and abrasion, neck sprain, multiple abrasions, bilateral knee contusions and right leg/knee sprain. OWCP combined this claim with a new traumatic injury claim for an April 22, 2005 employment injury, which was accepted for lumbar disc displacement and later expanded to include herniated disc at L4-5. Appellant underwent authorized lumbar surgeries on September 14, 2011 and October 11, 2012.

Dr. Binegar, in his January 28, 2009 report, related normal cervical spine examination findings. Dr. Collins related in his April 7, 2009 second opinion report that appellant's accepted cervical strain had resolved. Dr. Verska noted in his June 8, 2011 report that appellant's back complaints were ruining his life, but he offered no similar commentary regarding appellant's cervical spine. It was not until June 20, 2012 that Dr. Saint-Louis noted that an MRI scan of appellant's cervical spine revealed mild disc bulge at C5-6, mild-to-moderate bilateral

[10] *See Debra S. King*, 44 ECAB 203, 209 (1992).

[11] *Id.; see also Bertha L. Arnold*, 38 ECAB 282 (1986).

[12] *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

[13] *See Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[14] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[15] 20 C.F.R. § 10.321.

[16] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

osteophytic foraminal stenosis, and mild disc bulge at C6-7. Dr. Saint-Louis however offered no opinion regarding the cause of these conditions, or whether they required surgical intervention. It was not until appellant was seen by Dr. Manos that cervical fusion surgery was recommended for a work-related injury.

On August 15, 2014 Dr. Manos, appellant's treating physician, requested authorization for neck spine fusion surgery. Dr. Shevlin, an OWCP second opinion examiner, opined that the cervical surgery was not necessary to treat appellant's work-related injuries. OWCP determined that a conflict in medical opinion existed and referred appellant's claim to Dr. Shapiro, an impartial medical examiner, for review and examination in order to resolve the conflict in medical opinion regarding whether appellant's January 29, 2015 cervical surgery was medically necessary to treat appellant's work-related injuries. OWCP denied appellant's request for authorization for cervical spine surgery finding that the special weight of medical opinion evidence rested with the opinion of Dr. Shapiro, who served as the impartial medical examiner.

The Board finds that OWCP did not abuse its discretion by denying authorization for appellant's 2015 cervical fusion surgery.

In an August 18, 2015 report, Dr. Shapiro reviewed appellant's history, including the SOAF, and noted appellant's accepted conditions of back contusion, back abrasions, neck sprain, right leg contusion, right leg abrasion, left knee contusion and abrasion, and displacement of lumbar intervertebral disc without myelopathy. He related appellant's current complaints of neck, back, and leg pain and anxiety. Upon examination of appellant's neck, Dr. Shapiro reported decreased flexion with no spasm or tenderness with deep palpation, right-sided radicular pain, and decreased right sided rotation with neck extension. Spurling's, Adson's, and Waddell's tests were negative. Dr. Shapiro diagnosed chronic low back pain, chronic neck pain with right-sided radiculopathy, and general body deconditioning. He reported that appellant's chronic low back pain and general deconditioning were related to the accepted June 30, 2004 employment injury, but appellant's current neck injury and symptoms were not related to the June 30, 2004 injury. Dr. Shapiro explained that "a period of more than 8 years (2004 – 2012) elapsed during which time the patient did not seek any form of medical attention nor are there any medical records available for treatment of his neck pain, symptoms, or radiculopathy." He reported that for the same reason, he did not think appellant's neck issues, including the January 29, 2015 cervical surgery, were the result of the accepted June 30, 2004 employment injury.

In situations where the case is referred to an impartial medical specialist for the purpose of resolving a medical conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[17] The Board finds that Dr. Shapiro provided a well-rationalized opinion based on a complete background, his review of the accepted facts, the medical record, and his examination findings. Dr. Shapiro's opinion that

[17] *Guiseppe Aversa*, 55 ECAB 164 (2003).

the cervical surgery was not medically warranted is entitled to special weight and represents the weight of the evidence.[18]

The only limitation on OWCP's authority is approving or disapproving service under FECA is one of reasonableness.[19] In the instant case, appellant requested surgery. OWCP obtained an impartial medical examination through Dr. Shapiro who clearly found the surgery not warranted. It therefore had sufficient evidence upon which it made its decision to deny surgery and did not abuse its discretion.[20]

CONCLUSION

The Board finds that OWCP did not abuse its discretion in denying appellant's request for cervical surgery.

ORDER

IT IS HEREBY ORDERED THAT the September 28, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 8, 2017
Washington, DC

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

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

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

[18] *P.F.*, Docket No. 16-693 (issued October 24, 2016).

[19] *Daniel J. Perea*, 42 ECAB 214, 221 (1990).

[20] *Supra* note 18.