United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 18-1139**
	)	**Issued: May 21, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, 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:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 15, 2018 appellant, through counsel, filed a timely appeal from a March 22, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). 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]

[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.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that, following the March 22, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that the acceptance of her claim should be expanded to include additional conditions causally related to her accepted July 28, 2009 employment injury.

FACTUAL HISTORY

On September 4, 2009 appellant, then a 46-year-old distribution window clerk, filed a traumatic injury claim (Form CA-1) alleging that on July 28, 2009 she injured her low back and right leg when lifting mail while in the performance of duty. She stopped work on July 28, 2009. On January 26, 2010 OWCP accepted the claim for displacement of L5-S1 intervertebral disc without myelopathy. It initially paid appellant wage-loss compensation on the supplemental rolls and on September 26, 2010 she was placed on the periodic rolls.

On November 2, 2012, Dr. Michael McNett, a Board-certified family practitioner, requested authorization for treatment and pain medication for appellant's left lumbar radiculopathy and complex regional pain syndrome (CRPS). On March 29, 2013 Dr. Tony Hampton, a Board-certified family practitioner, diagnosed lumbar disc disease and reflex sympathetic dystrophy (RSD).

On January 15, 2014 OWCP referred appellant for a second opinion examination with Dr. James Elmes, a Board-certified orthopedic surgeon. In a March 8, 2014 report, Dr. Elmes advised that she had a work-related lumbar disc herniation. Regarding the diagnosis of RSD, he explained that his examination findings did not reveal any of the objective criteria that were required for a clinical diagnosis of CRPS/RSD per the American Medical Association, *Guides to the Evaluation of Disease and Injury Causation* pages 401 to 405. Dr. Elmes further opined that, if established, a diagnosis of RSD would not be work related.

On September 15, 2014 OWCP referred appellant for an impartial medical examination with Dr. Julie Wehner, a Board-certified orthopedic surgeon, to resolve a conflict in medical evidence regarding the issues of causal relationship, continuing residuals, and ability to work.[4]

On September 18, 2014 appellant requested that the acceptance of her claim be expanded to include the additional conditions of RSD and fibromyalgia affecting her right and left legs and feet, neck, and left and right shoulders. She also completed a notice of recurrence (Form CA-2a) claiming disability, causally related to the accepted July 28, 2009 employment injury, commencing January 25, 2010.

In a September 24, 2014 report, Dr. Wehner noted appellant's history of injury and related that appellant had chronic pain syndrome of unclear etiology. She noted that appellant's radiographic findings were consistent with the normal aging process, as the L5-S1 findings did not correlate with appellant's present pain symptomatology and pain level. Dr. Wehner opined that appellant most likely had a lumbar strain with a preexisting radiographic finding of a degenerative disc at L5-S1 with a small protrusion, and a temporary aggravation that would have lasted

[4] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.4 (July 2011).

approximately three months. She explained that there was no medical reason or radiographic findings to support that a lumbar strain would progress to chronic pain syndrome and also noted that there was a psychological component to chronic pain syndrome. Dr. Wehner recommended that appellant return to full-duty employment.

On October 28, 2014 OWCP referred the case record to Dr. Michael Hellman, an orthopedic surgeon acting as a district medical adviser (DMA) for review and an opinion on the issue of whether the evidence of record was sufficient to establish a causal relationship between medical conditions affecting appellant's feet, legs, shoulder, or neck and the accepted employment injury. In a November 3, 2014 report, the DMA reviewed the evidence to determine if any conditions should be added to appellant's accepted work-related condition of lumbar intervertebral disc without myelopathy. He noted that she had a lifting incident at work on June 28, 2009, and explained that an August 18, 2009 magnetic resonance imaging (MRI) scan read by Dr. Irving Fuld, a Board-certified diagnostic radiologist, revealed a central disc herniation at L5-S1, without significant central or foraminal stenosis. The DMA explained that appellant suffered from nonoccupational conditions, such as obesity, lumbar degenerative disc disease, cervical degenerative disc disease, and right foot interphalangeal (IP) fusion. He concluded that the objective evidence did not support causal relationship between an additional diagnosed condition and the accepted employment injury.

On September 22, 2015 and March 28, June 16, and July 6, 2016 counsel requested that OWCP expand the acceptance of appellant's claim to include additional work-related conditions of herniated disc, fibromyalgia, RSD, and bilateral foot contractures. He enclosed a May 30, 2015 report from Dr. Hampton, who diagnosed fibromyalgia, lumbar herniated disc and RSD.

On January 14, 2016 OWCP received a request for right foot surgery from Dr. Pamela Eernisse, a podiatrist, for part removal of metatarsal, repair of hammertoe, and removal of support implant. In a March 16, 2016 report, Dr. Eernisse opined that appellant was suffering from RSD due to a work-related injury in 2009 that necessitated multiple surgeries. She explained that appellant developed RSD as a result of the multiple surgeries to her feet which aggravated bilateral foot contractures and caused appellant's condition to worsen. Dr. Eernisse opined that the painful feet were consequential injuries which arose from the work injury of 2009. She explained that appellant previously had an electromyogram (EMG) to confirm RSD and x-ray imaging to confirm contracture bilateral hallux.

On June 10, 2016 OWCP referred the case to a DMA for review of the medical opinion provided by Dr. Eernisse. In a June 14, 2016 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon and DMA, noted that he had reviewed the record and the statement of accepted facts (SOAF). He concluded that the evidence was insufficient to support causal relationship between CRPS, RSD, and the accepted employment injury. Dr. Katz explained that appellant saw Dr. Elmes in March 2014, and that he found no atrophy in the right leg. Additionally, Dr. Elmes determined that her sensory examination was intact and there were no vasomotor changes noted or skin pallor coolness. Dr. Katz further explained the criteria to establish a diagnosis of CRPS, which must include at least one finding in three of four categories: sensory changes; vasomotor change; pseudo motor with edema or swelling; and motor trophic size with decreased range of motion, tremor or trophic change. He noted that Dr. Elmes had found none of the criteria. Additionally, Dr. Katz noted that Dr. Eernisse had not provided examination findings in her report, except for bilateral leg weakness. He concluded that she offered no convincing rationale to explain

how she had diagnosed CRPS/RSD, or to establish a causal relationship between the additional medical conditions and the accepted employment injury. Dr. Katz explained that the work injury caused a single diagnosis, displacement of lumbar disc.[5] He explained that Dr. Eernisse's report was flawed because she based her opinion upon the inaccurate premise that appellant developed RSD due to numerous surgeries that were necessitated by the employment injury of 2009.

By decision dated July 11, 2016, OWCP denied appellant's request for expansion of the acceptance of her claim to include the additional conditions of RSD and CRPS, and for authorization for medical treatment for the same conditions. It found that the weight of the medical evidence was with Dr. Katz who concluded that there were no additional work-related medical conditions.

On July 21, 2016 counsel requested a telephonic hearing before an OWCP hearing representative, which was held on March 15, 2017.

On September 19, 2016 OWCP referred appellant for a second opinion examination with Dr. Allan Brecher, a Board-certified orthopedic surgeon, to determine the nature and extent of her work-related conditions.

In an October 14, 2016 report, Dr. Brecher noted that he found no signs of RSD and opined that fibromyalgia was not caused by appellant's back injury. He explained that she had a lumbar herniated disc without clear findings on her EMG. Dr. Brecher opined that appellant's condition should have resolved within three months after her injury and there were no objective findings to support an ongoing diagnosis. He further explained that fibromyalgia was not an orthopedic problem, was not related to a herniated disc, and he concluded that she did not have fibromyalgia.

On January 9, 2017 OWCP referred appellant to Dr. Michael Kornblatt, an orthopedic surgeon, for an impartial medical examination to resolve the conflict between the treating physician, Dr. Eernisse, and the second opinion physician, Dr. Brecher.[6]

In a February 27, 2017 report, Dr. Kornblatt reviewed appellant's history of injury and treatment. He noted that she initially injured her back at work on July 28, 2009, when lifting heavy tubs of mail, stopped working, and never returned to employment. Dr. Kornblatt examined appellant and related that she had current symptoms of constant central low back pain which worsened with any type of activity, such as bending, twisting, and walking. He noted that she presented with vocal and facial pain behaviors when performing simple maneuvers such as arising from a seated to a standing position and walking with a walker.

Dr. Kornblatt diagnosed lumbar degenerative disc disease and chronic pain dysfunction. He noted that the MRI scan performed in 2009 was consistent with degenerative disc disease and the records reviewed were consistent with chronic pain dysfunction as well as nonphysiologic pain behaviors noted in his physical examination. Dr. Kornblatt opined that the July 28, 2009 work incident resulted in an aggravation of preexisting L5-S1 degenerative disc disease, which was

[5] In an August 29, 2016 SOAF, OWCP noted that appellant's nonwork conditions included right foot surgery on December27, 2013, for painful hallux hammertoes that she asserted were aggravated by her previous RSD diagnosis.

[6] *Supra* note 4.

temporary in nature, as EMG findings were inconsistent with a clinical lumbar radiculopathy. He explained that RSD/CRPS "was not a result of an incident which resulted in mechanical low back pain, referred leg pain with temporary aggravation of preexisting lumbar degenerative disc disease." Dr. Kornblatt explained that CRPS was more psychogenic in nature. He indicated that appellant had reached maximum medical improvement and no further treatment was warranted.

By decision dated May 30, 2017, OWCP's hearing representative affirmed the July 11, 2016 decision, finding that the medical evidence of record was insufficient to establish that the acceptance of appellant's claim should be expanded to include additional conditions.

On December 26, 2017 appellant requested reconsideration.

In a November 17, 2017 report, Dr. Nicholas Kondelis, a Board-certified anesthesiologist, provided an opinion on causal relationship. He noted that appellant was first seen at his office on September 4, 2011, when she injured herself while lifting a bin of mail, suffered a herniated disc with radicular pain down the right lower extremity, and developed allodynia and hyperpathia in the distal right lower extremity. Dr. Kondelis explained that he did not have access to her records related to treatment for her back and he only saw her once, as she cancelled her follow-up appointment with him. He noted that appellant returned to his office for care on July 20, 2016 and was treated by other physicians in her "desperate attempt to control the pain in [appellant's] back and down into her leg."

Dr. Kondelis indicated that other physicians diagnosed CRPS and RSD and opined that appellant exhibited signs of CRPS in the right lower extremity. He advised that her physical examination showed symptoms consistent with lower back pain, paraspinal muscle spasm, and guarding and weakness in the right lower extremity. Dr. Kondelis also found symptoms compatible with CRPS, including allodynia, hyperpathia, hypoesthesia, trophic changes in the right lower extremity distally, and weakness. He determined that appellant met three out of four criteria by history and physical examination. Dr. Kondelis opined that her conditions were "due to the original injury and radicular symptoms" based on his reading of outside physician notes. He explained that the original work-related injury resulted in poorly controlled pain in the right lower extremity, and developed from neuropathic pain into sympathetically mediated pain and CRPS. Dr. Kondelis diagnosed RSD in the bilateral lower extremities, lumbar disc herniation with radiculopathy, neural foramina stenosis of lumbosacral spine, and lumbago with sciatica on the right side. Additionally, he indicated that appellant had chronic lumbar radicular pain and complicating factors of CRPS in the right lower extremity. In a February 14, 2018 report, Dr. Kondelis repeated the above-noted diagnoses.

On February 15, 2018 OWCP forwarded the case to Dr. Nizar Souayah, Board-certified in neurology and a DMA. It informed Dr. Souayah that Dr. Kondelis opined that appellant developed CRPS/RSD as a consequence of the accepted work-related injury and requested that he specifically comment on Dr. Kondelis' report dated November 17, 2017, and discuss any points of disagreement.

Dr. Souayah reviewed the medical record and in a report dated March 2, 2018, noted that appellant developed a flare up of chronic back pain after the July 28, 2009 work injury, described as axial with diffuse lumbar tenderness and radicular symptoms. He advised that a lumbar spine MRI scan from August 18, 2009 revealed mild degenerative disc desiccation/degenerative disc

disease at L3-4 and L4-5 levels and at the L5-S1 level, and a broad-based disc herniation centrally with slight lateralization to the right. Dr. Souayah noted that appellant was diagnosed with lower back pain due to disc herniation and sciatica and that CRPS/RSD was not reported at that time. He found that the first time CRPS/RSD was reported was on February 15, 2010 approximately six months after the work injury and he advised that the diagnosis was based on the presence of allodynia with hyperesthesia in the right foot and ankle region and no evidence of edema trophic changes. Dr. Souayah opined that appellant "developed two distinctive conditions, a radicular/ musculoskeletal pain related to the work accident and a complex regional syndrome of the right lower extremities that seems to be unrelated to the work accident." This was supported by the fact that the chronic pain syndrome occurred more than six months after the work accident, did not follow radicular distribution, and hade a severity and characteristic (allodynia and hyperesthesia) different from the radicular pain. Dr. Souayah explained that there were no controlled studies supporting the fact that a radicular/ musculoskeletal syndrome could evolve into a CRPS more than six months after symptom onset.

By decision dated March 22, 2018, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[7] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[8] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[9]

When an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[10]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence.[11] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the

[7] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[8] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[9] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[10] *F.L.*, Docket No. 17-1613 (issued August 15, 2018).

[11] *M.B.*, Docket No. 17-1999 (issued November 13, 2018).

nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[12]

When an injury arises in the course of employment, every natural consequence that flows from that injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to the claimant's own conduct.[13] Thus, a subsequent injury, be it an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[14] A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, the claimant must present rationalized medical opinion evidence.[15]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish that the acceptance of her claim should be expanded to include additional conditions causally related to her accepted July 28, 2009 employment injury.

On November 2, 2012 Dr. McNett diagnosed left lumbar radiculopathy and CRPS. In a March 29, 2013 report, Dr. Hampton diagnosed lumbar cervical disc disease and RSD. However, these physicians merely provided a diagnosis with no opinion on causal relationship. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[16] These reports, therefore, are insufficient to establish appellant's claim.

In a March 16, 2016 report, Dr. Eernisse opined that appellant's RSD was due to the July 28, 2009 employment injury. However, her report is based on the assumption that appellant's foot surgeries were work related and that appellant developed RSD due to those surgeries and does not contain medical rationale to support her opinion. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.[17] The Board, therefore, finds that as Dr. Eernisse did not support her opinion with objective findings and medical rationale explaining how the July 28, 2009 employment injury caused or aggravated the diagnosed conditions, her report is of limited probative value to support that the CPRS/RSD conditions were caused by or a consequence of the accepted employment injury.[18]

[12] *M.L.*, Docket No. 18-1605 (issued February 26, 2019).

[13] *A.M.*, Docket No. 18-0685 (issued October 26, 2018); *Mary Poller*, 55 ECAB 483, 487 (2004); 1 Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* 10-1 (2006).

[14] *F.L., supra* note 10; *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139, 141 n.7 (2001).

[15] *See J.B.*, Docket No. 18-0522 (issued January 16, 2019); *Charles W. Downey*, 54 ECAB 421 (2003).

[16] *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[17] *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017).

[18] *Id.*

In a November 17, 2017 report, Dr. Kondelis commented on causal relationship between the RSD and the July 28, 2009 work injury, but indicated that he did not have access to the medical record and based his opinion on other physician's notes. In his report he failed to discuss the relationship of appellant's preexisting foot conditions and surgery prior to the work injury and their effects on his diagnoses. Dr. Kondelis also indicated that she developed allodynia and hyperpathia in the distal right lower extremity, but these are not accepted conditions. Thus, appellant has the burden of proof to establish causal relationship with regard to these conditions.[19] The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.[20] Dr. Kondelis did not support his causation opinion with objective findings and medical rationale explaining how the July 28, 2009 work injury caused or aggravated the additional diagnosed conditions.[21] Such rationale is particularly important given appellant's history of foot conditions and surgeries.[22] As such the report is of limited probative value.

Because the medical reports submitted by appellant did not establish that the July 28, 2009 employment injury caused or aggravated additional diagnosed conditions, these reports are of limited probative value[23] and are insufficient to establish her claim.

In a March 8, 2014 report, Dr. Elmes, a second opinion physician, determined that appellant did not have any of the objective criteria that were required for a clinical diagnosis of CRPS/RSD. Additionally, Dr. Wehner examined appellant on September 24, 2014 and explained that there was no medical rationale to support that a lumbar strain would progress to chronic pain syndrome.

In a November 3, 2014 report, Dr. Hellman, a DMA, determined that no bilateral or upper extremity conditions should be accepted.[24] He explained that appellant had numerous nonwork-related conditions, including obesity, lumbar and cervical disc disease, and a right foot IP fusion. On June 14, 2016 Dr. Katz, a DMA, found that the medical evidence of record was insufficient to establish the diagnosis of CRPS/RSD.

In an October 14, 2016 report, Dr. Brecher, a second opinion physician, found no signs of RSD and explained that fibromyalgia was not caused by a back injury, was not an orthopedic problem, and was not related to a herniated disc.

[19] *See L.S.*, Docket No. 18-1494 (issued April 12, 2019); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[20] *See supra* note 17.

[21] *See K.W.*, Docket No. 10-0098 (issued September 10, 2010).

[22] *See P.H.*, Docket No. 16-0654 (issued July 21, 2016); *S.R.*, Docket No. 16-0657 (issued July 13, 2016).

[23] *See Linda I. Sprague*, 48 ECAB 386, 389-90 (1997).

[24] The Board notes that sending a second opinion report to a DMA is discretionary. However, under the circumstances of this case where a second opinion physician had already opined on the issue of causation, the Board questions the repeated use of this procedure throughout the remainder of this claim. *See supra* note 4 at Part 2 -- Claims, *Developing and Evaluating Medical Evidences*, Chapter 2.810.8 (September 2010).

OWCP indicated that Dr. Kornblatt, was selected to resolve a conflict between the treating physician, Dr. Eernisse, and the second opinion physician, Dr. Brecher, as to whether additional conditions were causally related to the accepted employment injury. However, there was no true conflict of record when appellant was referred to Dr. Kornblatt because the opinion of Dr. Eernisse was based on an inaccurate premise that appellant's surgeries and foot conditions were work related. Because there was no conflict to resolve, Dr. Kornblatt cannot be considered an impartial medical specialist under section 8123(a) of FECA.[25]

In a March 2, 2018 report, Dr. Souayah, a DMA, concluded that appellant's CRPS and RSD conditions were not work related.

The Board finds that appellant has not met her burden of proof to establish additional conditions causally related to her accepted July 28, 2009 employment injury.

On appeal counsel asserts that appellant provided an "excellent" medical report on reconsideration to support causal relationship. However, for the reasons set forth above, the medical evidence of record was insufficient to establish that the accepted July 28, 2009 employment injury caused or aggravated additional conditions.[26]

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

[25] *See John D. Jackson*, 55 ECAB 465 (2004) (a simple disagreement between two physicians does not, of itself, establish a conflict; to constitute a conflict of medical opinion, the opposing physicians' reports must be of virtually equal weight and rationale).

[26] By decision dated December 19, 2018, OWCP expanded the acceptance of her claim to include additional conditions in the case. However, the Board and OWCP may not have concurrent jurisdiction over the same issue in a case. Consequently, any decision by OWCP on an issue pending before the Board is *null* and *void*. *See Douglas E. Billings*, 41 ECAB 880, 895 (1990). As OWCP issued the December 19, 2018 decision after appellant's appeal to the Board on May 15, 2018, and as it is on the same issue pending before the Board, it is *null* and *void*. *See* 20 C.F.R. § 501.2(c)(3).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that the acceptance of her claim should be expanded to include additional conditions causally related to her accepted July 28, 2009 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the March 22, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 21, 2019
Washington, DC

Christopher J. Godfrey, 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