United States Department of Labor
Employees' Compensation Appeals Board

F.L., Appellant	)	
and	)	
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTION-LA TUNA FEDERAL PRISON, Anthony, TX, Employer	)	**Docket No. 26-0254** **Issued: August 17, 2026**

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On January 17, 2026 appellant filed a timely appeal from a January 14, 2026 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.[2]

ISSUE

The issue is whether appellant has met his burden of proof to expand the acceptance of his claim to include carpal tunnel syndrome, bilateral upper limbs; other idiopathic peripheral autonomic neuropathy, bilateral lower limbs; radiculopathy, cervical region; cervical disc disorder;

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the January 14, 2026 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedures* 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.*

radiculopathy, lumbar region; and somatic dysfunction, lumbar region as causally related to, or consequential to, the accepted November 16, 2009 employment injury.

FACTUAL HISTORY

On November 16, 2009 appellant, then a 51-year-old air conditioning equipment mechanic supervisor/correctional officer, filed a traumatic injury claim (Form CA-1) alleging that on that date he sustained right knee, right wrist, and lower back conditions when he tripped over a concrete slab and fell to the floor while in the performance of duty. He stopped work on the date of injury. OWCP initially accepted the claim for bilateral wrist sprains, bilateral internal derangement of the knees, and thoracic sprain. It paid appellant wage-loss compensation on the supplemental rolls, effective January 17, 2010, and on the periodic rolls, effective February 14, 2010.[3]

In 2012, OWCP expanded the acceptance of appellant's claim to include thoracic or lumbosacral neuritis or radiculitis, as well as adjustment disorder with mixed anxiety and depressed mood. On August 9, 2012 appellant underwent OWCP-authorized left total knee arthroplasty. On January 2, 2014 he underwent OWCP-authorized right total knee arthroplasty.

In a June 5, 2023 report, Dr. Omar D. Gonzalez, a Board-certified internist, documented physical examination findings of crepitus of the knees, and swelling of the lower extremities, and overall normal muscle strength. He opined that appellant's injuries were a direct result of the accepted November 16, 2009 employment injury. Dr. Gonzalez listed the accepted conditions as resulting from the November 16, 2009 employment injury but also included conditions that he characterized as "pending approval" including strain of unspecified muscle, fascia, and tendon of the wrist/hand, radiculopathy of the thoracic region, presence of unspecified artificial knee joint, history of revision of the knee joints, muscle spasm, knee arthrosis, osteoarthritis of both knees, carpal tunnel syndrome, cervical disc disorder, lumbosacral radiculitis, lumbar sprain, spinal stenosis, and depression. He further opined that "with medical certainty per diagnostic testing" that cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition.

On July 6, 2023 Dr. Gonzalez opined that cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition. On August 16, October 3, and November 7, 2023, he opined that bilateral carpal tunnel syndrome, peripheral neuropathy of the lower extremities, cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition.

On December 1, 2023 OWCP referred appellant, along with the medical record, a statement of accepted facts (SOAF), and a series of questions, to Dr. Brian F. McCrary, an

[3] OWCP assigned the present claim OWCP File No. xxxxxx483. Under OWCP File No. xxxxxx827, it accepted appellant's traumatic injury claim for a July 12, 1999 internal derangement and bucket handle tear of the medial meniscus of the left knee. Under OWCP File No. xxxxxx174, OWCP accepted appellant's traumatic injury claim for a May 10, 2001 right knee/leg sprain and derangement of the posterior horn of the right knee medial meniscus. Under OWCP File No. xxxxxx729, it accepted appellant's traumatic injury claim for an August 2, 2006 left knee/leg sprain, left knee medial meniscus tear, and left knee internal derangement. Under OWCP File No. xxxxxx663, OWCP accepted appellant's traumatic injury claim for a March 25, 2008 neck sprain. It has administratively combined OWCP File Nos. xxxxxx483, xxxxxx174, xxxxxx729, xxxxxx663, and xxxxxx827, with the latter serving as the master file.

osteopath and Board-certified occupational medicine physician, for a second opinion examination regarding whether he sustained additional conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury.

OWCP subsequently received additional reports wherein Dr. Gonazlez recommended acceptance of additional work-related conditions. In a November 17, 2023 report, he opined that common peroneal neuropathy disorder, lumbar radiculopathy disorder, and lumbar somatic dysfunction should be considered "accepted causally related diagnoses on this injury claim." In December 5, 2023 and January 8 and 23, 2024 reports, Dr. Gonzalez opined that bilateral carpal tunnel syndrome, peripheral neuropathy of the lower extremities, cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition.

On February 14, 2024 OWCP received a January 29, 2024 report wherein Dr. McCrary documented physical examination findings of self-limited cervical range of motion (ROM) in all planes, and crepitation in both knees on ROM testing. In the upper and lower extremities, motor testing was 5/5 and sensation was intact, except over the surgical scars in both knees. Dr. McCrary indicated that the only injuries that appellant reported as occurring on November 16, 2009 were to his right knee, right wrist, and shoulder. He noted that right knee symptoms and imaging study findings were equivalent to those of the left knee and were consistent with severe osteoarthritis. Dr. McCrary indicated that appellant's left wrist and left knee were not injured on November 16, 2009, and that his right knee was back to the baseline level of chronic symptomatology by August 19, 2010. He opined that appellant's bilateral wrist sprains were not causally connected to the accepted November 16, 2009 employment injury, as his left wrist was not reported as injured and his right wrist condition was documented as resolved without sequelae by August 19, 2010. Dr. McCrary further opined that appellant did not sustain work-related internal derangement of his knees, as he did not report his left knee was injured and his right knee had returned to the baseline level of symptomatology by August 19, 2010. He asserted that thoracic sprain and thoracic/lumbosacral neuritis or radiculitis were not reported as having been sustained on November 16, 2009, and that no treatment was reported for adjustment disorder and depressed mood. Dr. McCrary opined that the right knee joint replacement surgery was documented as having been due to prior injuries, surgeries, and preexisting degenerative arthritis and was not due to the accepted November 16, 2009 employment injury. Appellant had severe bilateral knee osteoarthritis at the time of the November 16, 2009 employment incident, and a contusion to his right knee would not have been expected to significantly advance his preexisting degenerative knee condition. Dr. McCrary explained that other claimed additional conditions were not causally related to the accepted November 16, 2009 employment injury or other employment factors, noting that no cervical complaints were noted or mentioned for months after the November 16, 2009 employment injury, and that carpal tunnel syndrome was not mentioned or identified as symptomatic until approximately 2022. He asserted that peripheral neuropathy could not be causally related to appellant's fall, but rather was related to his diabetes. Dr. McCrary concluded that there was no medical evidence for aggravation, acceleration, or precipitation of work-related conditions other than those already accepted.

OWCP subsequently received a February 15, 2024 report wherein Dr. Gonzalez opined that bilateral carpal tunnel syndrome, peripheral neuropathy of the lower extremities, cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition.

In response to a development letter, OWCP subsequently received a March 11, 2024 report wherein Dr. Gonzalez opined that appellant's prior accepted work-related injuries, including the accepted November 16, 2009 employment injury, contributed to the peripheral neuropathy of his lower extremities. Dr. Gonzalez noted that appellant's cervical region would be expected to have preexisting arthritic changes given his age, but that his cervical condition was permanently accelerated by decades of repetitive work at the employing establishment which involved his cervical region. He disagreed with Dr. McCrary's opinion and opined that appellant's accepted work-related injuries, including the accepted November 16, 2009 employment injury, contributed to the additional diagnosed conditions of bilateral carpal tunnel syndrome, peripheral neuropathy of the lower extremities, cervical radiculopathy, and cervical disorder. Dr. Gonzalez explained that preexisting arthritis had been permanently accelerated/aggravated by over two decades and tens of thousands of hours of repetitive activities at work involving the cervical region, wrists, and lower extremities.

In an April 11, 2024 report, Dr. Gonzalez again opined that appellant's accepted conditions should be expanded to include bilateral carpal tunnel syndrome and idiopathic peripheral autonomic neuropathy of the lower extremities.

By decision dated April 17, 2024, OWCP denied appellant's expansion claim, finding that the medical evidence of record was insufficient to establish that he sustained additional conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury. It found that the weight of the medical evidence regarding additional work-related conditions rested with the opinion of Dr. McCrary, OWCP's referral physician.

On May 11, 2024 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

OWCP subsequently received a May 24, 2024 report wherein Dr. Gonzalez opined that bilateral carpal tunnel syndrome, peripheral neuropathy of the lower extremities, cervical radiculopathy, muscle spasm, and cervical disorder should each be accepted as a residual and/or aggravation of a preexisting condition.

In reports dated June 28, July 26, and August 22, 2024, Dr. Gonzalez again opined that appellant's accepted conditions should be expanded to include bilateral carpal tunnel syndrome and idiopathic peripheral autonomic neuropathy of the lower extremities.

OWCP subsequently expanded the acceptance of the claim to include radiculopathy of the thoracic region, and presence of right artificial knee joint.

By decision dated October 1, 2024, OWCP's hearing representative set aside the April 17, 2024 decision and remanded the case to OWCP for further development. The hearing representative determined that a conflict in the medical evidence existed between Dr. Gonzalez and Dr. McCrary regarding whether appellant sustained additional conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury. The hearing representative directed OWCP, on remand, to refer appellant for an impartial medical examination regarding this matter, to be followed by a *de novo* decision.

In an October 3, 2024 memorandum, OWCP noted that a conflict in the medical evidence existed between Dr. Gonzalez and Dr. McCrary regarding whether appellant sustained additional

conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury.[4]

On October 22, 2024 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions, to Dr. Manuel Gurule, a Board-certified neurologist, for an impartial medical examination regarding whether appellant sustained additional conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury.

In November 8, 2024 and January 13, 2025 reports, Dr. Gonzalez again opined that appellant's accepted conditions should be expanded to include bilateral carpal tunnel syndrome and idiopathic peripheral autonomic neuropathy of the lower extremities.

OWCP subsequently received a December 17, 2024 report wherein Dr. Gurule, serving as the impartial medical examiner (IME), documented physical examination findings of decreased ROM of the cervical spine in all directions, decreased ROM of the ankles, and 5/5 strength in the upper and lower extremities. Dr. Gurule opined that the additional claimed conditions, including bilateral carpal tunnel syndrome, idiopathic peripheral autonomic neuropathy of the lower extremities, cervical radiculopathy, cervical disc disorder, lumbar radiculopathy, and somatic dysfunction of the lumbar region, were not causally related to the accepted employment injuries either by direct cause or aggravation. He noted that right wrist pain was reported on the date of injury, November 16, 2009, but that there was no further mention of right wrist pain during multiple follow-up visits until January 9, 2017. Dr. Gurule advised that carpal tunnel syndrome was not mentioned until February 16, 2017, a time when appellant was no longer working, and opined that the accepted November 16, 2009 employment injury or his federal work duties could not have caused this condition. He indicated that the diagnosis of idiopathic peripheral autonomic neuropathy of the lower extremities was not supported by clinical history, physical examination findings, or electrodiagnostic study findings. Dr. Gurule noted that appellant's cervical disc disorder was a degenerative disease rather than a work-related condition, and indicated that he did not report neck pain after the November 16, 2009 employment injury. He advised that diagnostic testing findings did not demonstrate the existence of cervical radiculopathy. Dr. Gurule stated that he disagreed with Dr. Gonzalez' assessment that appellant had additional conditions related to the accepted November 16, 2009 employment injury and his job duties. He opined that he had no ongoing residuals or symptoms related to the accepted November 16, 2009 employment injury which required ongoing treatment.

By decision dated January 27, 2025, OWCP denied appellant's expansion claim, finding that the medical evidence of record was insufficient to establish that appellant sustained additional conditions causally related to, or consequential to, the accepted November 16, 2009 employment injury. It found that the special weight of the medical evidence regarding additional work-related conditions rested with the opinion of Dr. Gurule, the IME.

On February 22, 2025 appellant requested an oral hearing before a representative of OWCP's Branch of Hearing and Review.

[4] The additional conditions were noted as carpal tunnel syndrome, bilateral upper limbs; other idiopathic peripheral autonomic neuropathy, bilateral lower limbs; radiculopathy, cervical region; cervical disc disorder; radiculopathy, lumbar region; and somatic dysfunction, lumbar region.

In February 24 and April 4, 2025 reports, Dr. Gonzalez indicated that he disagreed with Dr. Gurule's opinion and opined that the conditions of bilateral carpal tunnel syndrome, idiopathic peripheral autonomic neuropathy of the lower extremities, cervical radiculopathy, cervical disc disorder, lumbar radiculopathy, and somatic dysfunction of the lumbar region were causally related to appellant's federal work duties and to the accepted November 16, 2009 employment injury. In June 2 and August 6, 2025 reports, he opined that the conditions of bilateral carpal tunnel syndrome, cervical radiculopathy, cervical disc disorder, lumbar radiculopathy, lumbar somatic dysfunction, and presence of left artificial knee joint were causally related to the accepted November 16, 2009 employment injury.

An oral hearing was held on September 23, 2025. OWCP subsequently received an October 1, 2025 report wherein Dr. Gonzalez opined that appellant's bilateral ankle tendon and ligament tears were a direct and consequential result of the altered gait pattern and abnormal weight-bearing mechanics caused his bilateral total knee replacements which were performed due to the accepted November 16, 2009 employment injury. Dr. Gonzalez noted his "heavy use of the upper and lower extremities" at work, and opined that "both the originally accepted and the additional conditions" were causally related to his traumatic fall and the ongoing physical demands of his federal employment. He again requested expansion of the accepted conditions to include bilateral carpal tunnel syndrome, cervical radiculopathy, cervical disc disorder, lumbar radiculopathy, lumbar somatic dysfunction, presence of left artificial knee joint, Achilles tendinitis/Achilles tendon partial tears of the legs, sprains/tears of the anterior talofibular ligaments (ATFL) of the ankles, tenosynovitis of the ankles/feet, degenerative joint disease of the ankles/feet, osteochondritis dissecans of the left ankle/foot, old tear of tibiofibular ligament of the left ankle, and calcaneal spur of the left foot. Dr. Gonzalez opined that appellant's cervical, thoracic spine, lumbar spine, bilateral knee, bilateral wrist, bilateral ankle, and bilateral hip conditions were directly and causally related to the accepted November 16, 2009 employment injury.[5]

By decision dated December 18, 2025, OWCP's hearing representative affirmed the January 27, 2025 decision.

On December 31, 2025, appellant requested reconsideration of the December 18, 2025 decision and submitted additional medical evidence.

By decision dated January 14, 2026, OWCP denied modification of the December 18, 2025 decision.

[5] On October 30, 2025, OWCP referred appellant, along with the medical record, an updated SOAF, and a series of questions, for a second opinion examination with Dr. Everett L. Campbell, a Board-certified orthopedic surgeon, regarding whether appellant sustained additional foot or ankle conditions causally related to the accepted November 16, 2009 employment injury. OWCP subsequently received a November 20, 2025 report wherein Dr. Campbell opined that appellant's diagnosed foot/ankle conditions were causally related to the accepted November 16, 2009 employment injury. The Board notes, however, that OWCP has not issued a final decision regarding expansion of the claim to include the diagnosed foot/ankle conditions. Therefore, this issue is not presently before the Board. *See* 20 C.F.R. §§ 501.2(c) and 501.3.

LEGAL PRECEDENT

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.[6]

The claimant bears the burden of proof to establish a claim for a consequential injury.[7] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[8]

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[9] Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[10]

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 intentional misconduct.[11] The basic rule is that a subsequent injury, whether 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.[12]

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 IME) who shall make an examination.[13] For a conflict to arise, the opposing physicians' opinions must be of virtually equal weight and

---

[6] *D.H.,* Docket No. 26-0428 (issued July 17, 2026); *J.R.,* Docket No. 20-0292 (issued June 26, 2020); *W.L.*, Docket No. 17-1965 (issued September 12, 2018); *V.B.*, Docket No. 12-0599 (issued October 2, 2012); *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[7] *V.K.*, Docket No. 19-0422 (issued June 10, 2020); *A.H.*, Docket No. 18-1632 (issued June 1, 2020); *I.S.*, Docket No. 19-1461 (issued April 30, 2020).

[8] *D.S.*, Docket No. 26-0287 (issued July 10, 2026); *K.W.*, Docket No. 18-0991 (issued December 11, 2018).

[9] *G.R.*, Docket No. 18-0735 (issued November 15, 2018).

[10] *Id.*

[11] *W.S.*, Docket No. 26-0313 (issued June 15, 2026); *I.S.*, *supra* note 7; *A.M.,* Docket No. 18-0685 (issued October 26, 2018); *Mary Poller,* 55 ECAB 483, 487 (2004).

[12] *J.M.*, Docket No. 19-1926 (issued March 19, 2021); *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139, 141 n. 7 (2001).

[13] 5 U.S.C. § 8123(a); *see E.L.,* Docket No. 20-0944 (issued August 30, 2021); *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

rationale.[14] In situations where the case is properly 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.[15]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP found that a conflict in the medical opinion evidence existed between Dr. Gonzalez, an attending physician, and Dr. McCrary, an OWCP referral physician, on the issue of whether appellant sustained carpal tunnel syndrome, bilateral upper limbs; other idiopathic peripheral autonomic neuropathy, bilateral lower limbs; radiculopathy, cervical region; cervical disc disorder; radiculopathy, lumbar region; and somatic dysfunction, lumbar region as causally related to, or consequential to, the accepted November 16, 2009 employment injury.[16] The Board notes, however, that Dr. McCrary did not acknowledge several of the conditions listed in the SOAF as having been accepted by OWCP as causally related to the accepted November 16, 2009 employment injury, including bilateral internal derangement of the knees, left wrist sprain, thoracic sprain, and thoracic or lumbosacral neuritis or radiculitis. The Board has held that the findings of an OWCP referral physician or IME must be based on the factual underpinnings of the claim, as set forth in the SOAF.[17] OWCP's procedures provide that when an OWCP referral physician, IME, or district medical adviser renders a medical opinion based on an SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[18] As noted, Dr. McCrary provided an opinion that was not in keeping with the SOAF, and the Board thus finds his opinion is of diminished probative value and insufficient to create a conflict in medical opinion with Dr. Gonzalez.[19]

OWCP referred appellant, pursuant to section 8123(a) of FECA, to Dr. Gurule for an impartial medical examination. However, as no true conflict existed in the medical opinion evidence, the Board finds that his December 17, 2024 report may not be afforded the special weight

[14] *R.C.*, Docket No. 26-0309 (issued June 11, 2026); *P.R.*, Docket No. 18-0022 (issued April 9, 2018); *see also Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts,* 30 ECAB 1010 (1980).

[15] *See T.G.,* Docket No. 24-0803 (issued July 24, 2026); *D.M.,* Docket No. 18-0746 (issued November 26, 2018); *R.H.,* 59 ECAB 382 (2008); *James P. Roberts*, *id*.

[16] *See supra* notes 12 through 14.

[17] *See T.G.*, *supra* note 15; *A.D.*, Docket No. 20-0553 (issued April 19, 2021).

[18] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3a(10) (October 1990).

[19] *See D.J.,* Docket No. 26-0321 (issued June 12, 2026).

of an IME and should instead be considered for its own intrinsic value.[20] The referral to Dr. Gurule is therefore considered to be that of a second opinion evaluation.[21]

As there remains an unresolved conflict in the medical evidence, the case must be remanded or further development. On remand, OWCP shall refer appellant, together with the case record and an updated SOAF, to a specialist in the appropriate field of medicine for an impartial medical examination to resolve the above-described conflict in the medical evidence between Dr. Gonzalez and Dr. Gurule. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[20] *See S.W.*, Docket No. 21-0290 (issued November 5, 2021) *F.R.*, Docket No. 17-1711 (issued September 6, 2018); *Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996).

[21] *L.G.*, Docket No. 20-0611 (issued February 16, 2021). *See also M.G.*, Docket No. 19-1627 (issued April 17, 2020); *S.M.*, Docket No. 19-0397 (issued August 7, 2019) (the Board found that at the time of the referral for an impartial medical examination there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination); *see also Cleopatra McDougal-Saddler*, *id.* (the Board found that, as there was no conflict in medical opinion evidence, the report of the physician designated as the IME was not afforded the special weight of the evidence, but instead considered for its own intrinsic value as he was a second opinion specialist).

ORDER

IT IS HEREBY ORDERED THAT the January 14, 2026 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 17, 2026
Washington, DC

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

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

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