United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 09-2321**
	)	**Issued: September 15, 2010**
U.S. POSTAL SERVICE, TORRESDALE STATION, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 21, 2009 appellant filed a timely appeal from a July 2, 2009 decision of the Office of Workers' Compensation Programs that denied his claim. Pursuant to 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 met his burden of proof to establish that he has a bilateral foot condition causally related to factors of his federal employment.

On appeal appellant, through his attorney, asserts that the attending podiatrist, establishes that his foot conditions were caused or aggravated by his employment duties. Moreover, the opinion of a Board-certified orthopedic surgeon who provided an impartial evaluation for the Office is insufficient to carry special weight because his report was contradictory. Appellant further asserts that the Office improperly bypassed several physicians in selecting the impairment specialist on the grounds that they were the wrong specialty for the case.

FACTUAL HISTORY

On January 8, 2008 appellant, then a 47-year-old city letter carrier, filed a Form CA-2, occupational disease claim, alleging that excessive walking on uneven surfaces and carrying a mailbag caused injury to both feet and the right ankle. He was first aware of his condition and its relationship to work on January 2, 2007. Appellant did not stop work.

On February 6, 2006 appellant described his job duties as sorting mail for two to two-half hours daily, then pushing a hamper weighing 250 to 300 pounds to his postal vehicle and driving to his mail route to begin delivery by loading his mailbag with 25 to 30 pounds of mail and parcels. He stated that he walked for 8 to 12 hours daily on uneven ground, up and down steps, while carrying extra weight. Appellant reported that he first noticed his condition around December 2006 when he began experiencing continuous pain in the heel area when standing or walking.

An August 30, 2005 magnetic resonance imaging (MRI) scan of the lower extremities demonstrated small bilateral plantar fibromas, a small stress response in the right tibial sesamoid with early bunion formation and a Morton's neuroma in the right second intermetatarsal space and a possible small Morton's neuroma on the left involving the second intermetatarsal space. A January 16, 2006 MRI scan of the right foot demonstrated intermetatarsal bursitis at the second and third web spaces with a tiny Morton's neuroma at the third interspace; minimal osteoarthritis at the hallux sesamoid complex with bunion and edema; and focal thickening of the plantar fascia consistent with a tiny plantar fibroma. A January 9, 2007 right ankle x-ray demonstrated mild spurring and an October 2, 2007 MRI scan of the right ankle demonstrated findings consistent with acute plantar fasciitis and a multilobulated ganglion cyst arising from the posterolateral subtalar joint.

In treatment notes dated from August 22, 2005 to January 29, 2008, Dr. Carl J. Mattia, a podiatrist, diagnosed bilateral painful onychomycosis of the nails, bilateral painful calluses, bilateral bunions, bilateral plantar fibromatosis, sesamoiditis of the right foot, osteoarthritis of the right ankle, chronic bilateral plantar fasciitis, right ankle and foot tarsal tunnel syndrome and Dupuytren's contractures of both feet. He advised that these conditions were aggravated by appellant's employment duties of extensive walking, carrying and transporting heavy items and shifting and pivoting on his feet extensively. Dr. Mattia performed surgery on January 9, 2008.

In a March 4, 2008 report, Dr. Arnold T. Berman, an Office medical adviser Board-certified in orthopedic surgery, reviewed the medical record. He identified appellant's primary problem as bilateral plantar fibromatosis and advised that normal walking and ambulatory activity would cause the symptoms of the condition; however, the severity of appellant's condition and the development of Morton's neuroma indicated a congenital condition which would have developed with normal usage. Dr. Berman noted that surgery was controversial due to the congenital nature of the plantar fibromatosis and that appellant would continue to be symptomatic for the remainder of his life. He concluded that the conditions of plantar fibromatosis, Dupuytren's contracture, tarsal tunnel syndrome, right ganglion cyst, Morton's neuroma, osteoarthritis and sesamoid complex and bunions were not employment related but were the result of appellant's congenital and developmental disease and that no aggravation should be accepted. In a dated May 9, 2008 decision, the Office denied appellant's claim on the

grounds that the medical evidence was insufficient to establish that the claimed conditions were employment related.

On December 12, 2008 appellant, through his attorney, requested reconsideration. In an October 15, 2008 report, Dr. Mattia reiterated his findings and conclusions and advised that, with reasonable medical certainty, the swelling and inflammation of appellant's feet were a work-related aggravation. He stated that, having been involved in appellant's treatment for over three years, the work duties caused and aggravated many of appellant's bilateral foot conditions.

On December 31, 2008 the Office referred appellant to Dr. Kevin F. Hanley, a Board-certified orthopedic surgeon, for a second opinion evaluation. An attached statement of accepted facts described appellant's job duties. In a January 20, 2009 report, Dr. Hanley reviewed the statement of accepted facts and medical record. He listed appellant's complaint of bilateral foot pain and provided findings on physical examination. Dr. Hanley diagnosed tarsal tunnel syndrome, right, surgically treated and bilateral plantar fasciitis. He disagreed with Dr. Mattia's opinion regarding causation, advising that appellant's underlying problem was constitutional and congenital and its development was not due to appellant's work activities. Dr. Hanley stated, "clearly, temporary aggravation of symptomatology can occur during the course of a workday, but absent the original constitutional predisposition to develop these conditions, those activities would not be symptom-producing … I believe that the aggravation that did occur was quite temporary and did not cause permanent substantive changes in the foot itself and [was] not the cause for the need of surgical intervention." He concluded that appellant was not disabled. In an attached work capacity evaluation, Dr. Hanley advised that appellant could perform his usual job duties without restrictions.

On February 2, 2009 Dr. Berman reviewed the medical record including Dr. Hanley's report and reiterated that appellant's job duties did not aggravate his preexisting condition, the surgery was not medically necessary for any bilateral foot condition and that a work-related diagnosis was right foot strain that had resolved.

The Office determined that a conflict in medical evidence arose between the opinions of Dr. Mattia and Dr. Hanley regarding whether appellant's job duties had aggravated his foot conditions and the need for surgery. The record indicates that Dr. Donald Leatherwood and Dr. Jack Abboudi were bypassed for selection as the referee physicians because they were the wrong specialty for the case and that Dr. Nicholas DiNubile was bypassed because he did not take referee appointments.

By letter dated February 25, 2009, the Office informed counsel that a conflict in medical evidence had been created and an impartial evaluation was scheduled with Dr. Joseph L. Eremus, a Board-certified orthopedic surgeon. In a March 23, 2009 report, Dr. Eremus reviewed the medical records and noted appellant's complaint of cramping hammertoes and right foot pain near the heel, with some numbness in the back of the arch at the surgical incision site and in the ball of the foot. On examination, there were slight hammertoes at the second and third toes bilaterally and small nodules in the midportion of the plantar fascia, larger on the left. There was no swelling present and Tinel's sign was negative. Sensation to pinprick was normal with the exception of a slight decrease over the deep peroneal area between the first and second toes and metatarsal heads on the dorsum of the foot and tenderness at the anterior medial tubercle of the calcaneous in the left foot but not the right. Dr. Eremus agreed with the opinions of Dr. Berman

and Dr. Hanley that appellant's plantar fibromatosis and Dupuytren's contracture were not related to his work and were hereditary. The plantar fasciitis, ganglion cyst, neuroma, osteoarthritis and tarsal tunnel syndrome were degenerative, although there could be some other condition such as neuropathy or root symptoms that could accentuate symptoms of tarsal tunnel. Dr. Eremus concluded that none of these conditions were caused by appellant's work, stating that day-to-day activities of any kind could aggravate the symptoms. He noted, "this is not related exclusively to any work but is related to the day-to-day activities of living in multiple venues." Dr. Eremus diagnosed plantar fasciitis of the right foot that was not caused by direct cause, precipitation, acceleration or aggravation beyond any normal daily activities, stating that the condition was often more aggravated by periods of rest than with activity and that the aggravation that would occur with any day-to-day activities was temporary and had ceased because of his surgical treatment. He advised that the surgery of January 9, 2008 could be considered medically necessary but that it was due to appellant's plantar fasciitis that was not caused by work. Dr. Eremus found residual complaints of pain and opined that appellant was not disabled and had no physical limitations as a result of his complaints of proximal plantar fasciitis of the right foot.

In a merit decision dated July 2, 2009, the Office found that the opinion of Dr. Eremus represented the weight of medical evidence. It denied modification of the May 9, 2008 decision.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing 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 the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[2]

Office regulations define the term "occupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or shift."[3] To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion must be one of reasonable medical certainty and must be supported by medical rationale

[1] 5 U.S.C. §§ 8101-8193.

[2] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[3] 20 C.F.R. § 10.5(ee).

explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[4]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[5] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a 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 nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[6] 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.[7]

Section 8103 of the Act provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances and supplies prescribed or recommended by a qualified physician, which the Office considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of the monthly compensation.[8] While the Office is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[9]

The selection of referee physicians is made by a strict rotational system using appropriate medical directories. The Physicians' Directory System (PDS), including physicians listed in the American Board of Medical Specialties (ABMS) directory and specialists certified by the American Osteopathic Association, should be used for this purpose. The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality. This is accomplished by selecting specialists in alphabetical order as listed in the roster chosen under the specialty and/or subspecialty heading in the appropriate geographic area and repeating the process when the list is exhausted.[10]

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[11] When the case is referred to an

[4] *Roy L. Humphrey*, *supra* note 2.

[5] *D.G.*, 59 ECAB ____ (Docket No. 08-1139, issued September 24, 2008).

[6] *Id.*

[7] *Roy L. Humphrey*, *supra* note 2.

[8] *Id*. at § 8103; *see L.D.*, 59 ECAB ____ (Docket No. 08-966, issued July 17, 2008).

[9] *Kennett O. Collins, Jr*., 55 ECAB 648 (2004).

[10] *L.W.*, 59 ECAB ____ (Docket No. 07-1346, issued April 23, 2008).

[11] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[12]

ANALYSIS

The Board notes that the Office properly bypassed Drs. Leatherwood and Abboudi in selecting Dr. Eremus as the impartial medical examiner. Under the PDS, the Office selects a physician from an alphabetical roster chosen under the specialty or subspecialty in the appropriate geographic area.[13] A search of the ABMS directory showed that both Dr. Leatherwood and Dr. Abboudi, while Board-certified orthopedic surgeons, have subspecialties as hand surgeons. This is not the proper subspecialty to render an opinion in a case regarding foot conditions. The Office properly selected Dr. Eremus from the roster of qualified physicians to perform the impartial medical examination.

The Board, however, finds that Dr. Eremus' March 23, 2009 report is not sufficiently rationalized to be entitled to special weight. A conflict in medical evidence therefore remains unresolved.

The Office determined that a conflict in medical opinion arose between Dr. Mattia, an attending podiatrist, who advised that appellant's work duties caused and aggravated appellant's foot conditions, and Dr. Hanley, an orthopedic surgeon and Office referral physician, who found that appellant's underlying problem was congenital and that, if an employment-related aggravation occurred, it was temporary and not the cause a permanent condition or the cause of the need for surgery. It properly referred appellant to Dr. Eremus for an impartial opinion.

In denying the claim, the Office relied on Dr. Eremus' March 25, 2009 report to determine that appellant's foot conditions and the need for surgery were not caused or aggravated by his federal employment. The Board, however, finds that Dr. Eremus' opinion is equivocal and speculative and is of diminished probative value.[14]

Dr. Eremus advised that appellant's plantar fibromatosis and Dupuytren's contracture were hereditary, that the plantar fasciitis, ganglion cyst, neuroma, osteoarthritis and tarsal tunnel syndrome were most likely degenerative and that other conditions such as neuropathy or root symptoms could accentuate symptoms of tarsal tunnel, none of these conditions were caused by his work. He also advised, however, that "certainly, in day-to-day activities of any kind, including those listed ... could be noted to aggravate symptoms. This is not related exclusively to any work but is related to the day-to-day activities of living in multiple venues." Dr. Eremus diagnosed plantar fasciitis, right foot, not employment related and advised that the condition was more often aggravated by periods of rest than with activity and that any aggravation would occur with day-to-day activities, that it was temporary and had ceased following the January 9, 2008 surgery. The Board has long held that any contribution of employment factors is sufficient to

[12] *Manuel Gill*, 52 ECAB 282 (2001).

[13] *Id*.

[14] *See L.R. (E.R.)*, 58 ECAB 369 (2007).

establish the element of causal relationship.[15] Dr. Eremus did not provide a clear opinion for ruling out appellant's employment activities as an aggravating factor in the development of his bilateral foot conditions. He further advised that the January 9, 2008 surgery was not caused by an employment-related condition. However, as Dr. Eremus advised that any activity, including work activity, could aggravate appellant's symptoms. His opinion on this issue is not well rationalized and insufficient to resolve the conflict medical evidence. For this reason, the case will be remanded to the Office to seek clarification from Dr. Eremus regarding these issues. If Dr. Eremus is unable to clarify his opinion, the Office should refer appellant to a second impartial medical specialist.[16]

CONCLUSION

The Board finds that the case is not in posture for decision on whether appellant's conditions and need for surgery were caused or aggravated by his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the July 2, 2009 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded to the Office for proceedings consistent with this opinion of the Board.

Issued: September 15, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[15] *Roger W. Griffith*, 51 ECAB 491 (2000).

[16] *I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).