United States Department of Labor
Employees' Compensation Appeals Board

K.B., Appellant	)	
and	)	**Docket No. 12-1438**
	)	**Issued: March 27, 2013**
U.S. POSTAL SERVICE, POST OFFICE, 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:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 22, 2012 appellant, through her attorney, filed timely appeal from March 20 and May 17, 2012 merit decisions of the Office of Workers' Compensation (OWCP) Programs. Pursuant to the Federal Employees' Compensation Act[1] (FECA), 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to justify termination of appellant's compensation benefits for her accepted injury effective November 1, 2011; and (2) whether it properly denied authorization for a left bunionectomy.

FACTUAL HISTORY

On January 25, 2008 appellant, then a 46-year-old letter carrier, filed an occupational disease claim asserting that she developed strained ligaments and muscle pain in the left foot as a result of prolonged standing and walking required in her position. OWCP accepted left foot

[1] 5 U.S.C. §§ 8101-8193.

plantar fasciitis. Appellant stopped work on January 10, 2008 and worked intermittently until stopping on April 26, 2008.[2]

Appellant was treated initially in 2008 for left plantar fasciitis by both a podiatrist and a chiropractor. A July 9, 2008 electromyogram revealed no abnormalities of the left lower extremity.

On January 28, 2009 OWCP referred appellant to Dr. Robert A. Smith, a Board-certified orthopedist, to determine if the accepted left foot plantar fasciitis had resolved. In a February 24, 2009 report, Dr. Smith noted findings of tenderness over the plantar aspect of the left heel and a small bunion deformity of the left foot unrelated to her work duties. He noted confirmation of the left plantar fasciitis with a magnetic resonance imaging scan, which was consistent with appellant's repetitive work duties and related by direct cause. Dr. Smith opined that she was not at maximum medical improvement. He advised that further chiropractic treatment was not necessary and that appellant would benefit from shock wave therapy. In a work capacity evaluation dated February 24, 2009, Dr. Smith returned her to work full time with restrictions.

On February 11, 2009 Dr. W. Scott Newcomb, a podiatrist, treated appellant for left heel pain. X-rays revealed no evidence of fracture or subluxation and no significant arthritic changes. Dr. Newcomb diagnosed left foot pain, plantar fasciitis, pronation and hallux valgus.

On June 11, 2009 OWCP referred appellant to Dr. Smith to determine if she had residuals of her accepted condition. In a June 29, 2009 report, Dr. Smith opined that she continued to have chronic plantar fasciitis related to her work activities. He noted that appellant had not reached maximum medical improvement. Dr. Smith agreed with appellant's physician's recommendation for shock wave therapy to treat the left refractory plantar fasciitis. In a work capacity evaluation he noted that appellant could return to work full time with restrictions.

On March 9, 2010 OWCP again referred appellant to Dr. Smith to determine if she had residuals of her accepted condition. In an April 26, 2010 report, Dr. Smith noted findings of chronic plantar fasciitis, a small bunion of her great toe and mild hammertoes. He opined that the diagnoses and treatment of the small bunion of the great toe and mild hammertoes were unrelated to the accepted work injury. Dr. Smith indicated that the proposed release of the plantar fascia was related to the accepted left plantar fasciitis; however, he opined that the bunionectomy surgery was unrelated to the accepted work-related condition. He noted that appellant was not at maximum medical improvement. Dr. Smith opined that she could work full time with restrictions.

On April 27, 2010 appellant's attorney requested authorization for surgery for her diagnosed plantar fasciitis and bunion deformity. Appellant submitted reports from Dr. Robert K. Cohen, a podiatrist, from April 12 to 26, 2010, who treated her for left foot pain, which began in 2007. Dr. Cohen noted findings on examination and diagnosed chronic and acute plantar fasciitis of the left foot, metatarsalgia, secondary to neuritis with possible neuroma

[2]Appellant filed a claim for an injury occurring on December 5, 2005, which was accepted for, sprain of the right ankle, open wound of the right knee, ankle and leg and sprain of the lumbar region, file number xxxxxx949. On December 19, 2002 she alleged that she sustained a back injury which was denied by OWCP file number xxxxxx204. These claims are not before the Board at this time.

and hallux rigidus of the left first metatarsophalangeal joint. The podiatrist recommended cortisone injections, orthotics, night splints and left foot plantar fasciotomy and bunionectomy. Dr. Cohen opined that appellant's plantar fascia pain appeared to be related to the original work injury and was the result of a compensatory gait pattern. He noted that as a result of the compensatory gait pattern the bunion deformity may have been aggravated; however, noted that the actual bunion deformity was hereditary in nature. In reports dated May 13 and July 5, 2010, Dr. Cohen noted diagnoses and recommended a bunionectomy with first metatarsal osteotomy of the left foot, plantar fasciotomy of the left plantar fascia and plasma injections. He noted a relationship between the December 5, 2007 injury and appellant's current symptoms and advised because of her injuries she developed a compensatory gait causing her current symptoms. On July 14, 2010 Dr. Cohen performed a left foot bunionectomy and a plantar fasciotomy and diagnosed left foot hallux abducto valgus/first metatarsal phalangeal joint and left foot plantar fasciitis.

On September 21, 2010 appellant requested retroactive authorization by OWCP of the July 14, 2010 surgery performed by Dr. Cohen. In reports dated August 4 and September 24, 2010, Dr. Cohen recommended postsurgery physical therapy and opined that appellant was totally disabled from work for four to six weeks.

OWCP found that a conflict of medical opinion existed between Dr. Cohen, who indicated that the July 14, 2010 surgery was medically necessary, that appellant sustained residuals of her work-related injuries and was totally disabled, and Dr. Smith, who determined that the bunionectomy surgery was not work related and that she could return to work full time with restrictions.

To resolve the conflict OWCP, on October 5, 2010, referred appellant to a referee physician, Dr. Jerry L. Case, a Board-certified orthopedist. In an October 26, 2010 report, Dr. Case noted reviewing the record, including the history of her work injury and examining appellant. Examination revealed a slight limp on the left, limitation of motion with flexion and extension and tenderness over the metatarsal phalangeal joint and plantar fascia. He diagnosed status post endoscopic plantar fasciotomy of the left foot and bunionectomy of the left foot. Dr. Case opined that appellant could not return to work as a letter carrier at that time. However, he noted that appellant could perform duties involving walking and standing for short periods of time. Dr. Case advised that she had not reached maximum medical improvement but would do so in four to six weeks at which time she could return to unrestricted duty as a letter carrier. He concurred with Dr. Smith who opined that the plantar fasciitis surgery was work related; however, advised that the bunionectomy was unrelated to appellant's employment.

On December 22, 2010 OWCP offered appellant a position, part time, four hours per day as a modified city carrier effective January 3, 2011. On March 25, 2011 appellant accepted the position and returned to work.

In a decision dated January 5, 2011, OWCP denied the surgical bunionectomy of the left foot on the grounds that the surgery was neither warranted nor causally related to appellant's accepted work-related left foot plantar fasciitis.

On April 12, 2011 appellant requested a review of the written record. She submitted reports from Dr. Cohen dated January 20 to May 5, 2011, who diagnosed status post

bunionectomy, plantar fasciotomy and metatarsalgia of the left foot, improving. In a February 3, 2011 duty status report, Dr. Cohen noted that appellant could return to work full time with restrictions on March 7, 2011.

On July 13, 2011 an OWCP hearing representative vacated the January 5, 2011 decision and remanded the case for further medical development. The hearing representative found that Dr. Case's report was insufficiently rationalized to carry the weight of the evidence and that he improperly relied on the opinion of Dr. Smith, the second opinion physician. The hearing representative advised that the medical necessity of the bunionectomy was not identified in the medical conflict statement and the questions to the referee were incomplete.

On July 19, 2011 OWCP referred appellant to Dr. Case for reevaluation and a supplemental report. In an August 8, 2011 report, Dr. Case noted an essentially normal examination with minimal limitation of motion with flexion and extension in the metatarsal phalangeal joint. He diagnosed status post endoscopic plantar fasciotomy of the left foot and bunionectomy of the left foot on July 14, 2010. Dr. Case noted that appellant was status post one year after left foot surgery with no complaints of pain around the plantar fascia or bunionectomy. He opined that she was capable of returning to work full time without restrictions as a letter carrier. Dr. Case noted that the bunion was a preexisting congenital condition, which gradually worsened with time and opined that the letter carrier walking route or an altered gait would not cause worsening of the bunion. Rather, he advised that a bunion became more symptomatic as it deviated laterally toward the fifth toe.

Appellant submitted reports from Dr. Cohen dated July 7 and 8, 2011, who noted that she was progressing with pain and stiffness improving.

In a decision dated September 15, 2011, OWCP denied the requested bunionectomy finding that the surgery was neither warranted nor causally related to the accepted work injury. On September 20, 2011 appellant requested a hearing.

On September 19, 2011 OWCP proposed to terminate all benefits finding that Dr. Case's October 26, 2010 and August 8, 2011 reports established no continuing residuals of her work-related conditions. In a September 28, 2011 statement, appellant disagreed with the proposed termination and asserted that Dr. Case's reports were not well reasoned and insufficient to be the weight of the evidence. She submitted an April 12, 2010 report from Dr. Cohen, previously of record.

In a decision dated November 1, 2011, OWCP terminated appellant's compensation benefits effective the same day finding that the medical evidence established that she had no continuing residuals of her accepted conditions.

On November 4, 2011 appellant requested an oral hearing that was held on February 29, 2012. She submitted reports from Dr. Cohen dated July 7 to December 19, 2011, who noted her status and opined that she could continue light-duty work.

In a decision dated March 20, 2012, an OWCP hearing representative affirmed the September 15, 2011 decision denying appellant's request for surgery.

In a decision dated May 17, 2012, an OWCP hearing representative affirmed a November 1, 2011 decision terminating appellant's medical and compensation benefits.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[3] After it has determined that an employee has disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[4] The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals of an employment-related condition, which requires further medical treatment.[5]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's claim for left foot plantar fasciitis. It found that a conflict in medical opinion existed between appellant's podiatrist, Dr. Cohen, who opined that, the July 14, 2010 surgery was work related, appellant had residuals of her work injuries and she was totally disabled and Dr. Smith, an OWCP referral physician, who determined that the bunionectomy surgery was not work related and that she could work full time with restrictions. Thus, OWCP referred appellant to Dr. Case to resolve the conflict.

The Board finds that, under the circumstances of this case, the opinion of Dr. Case is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that residuals of appellant's work-related condition ceased. Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[6]

In an October 26, 2010 report, Dr. Case diagnosed status post endoscopic plantar fasciotomy of the left foot and bunionectomy of the left foot. He noted physical findings of a slight limp on the left, limitation of motion with flexion and extension and tenderness over the metatarsal phalangeal joint and plantar fascia. Dr. Case opined that appellant could work full-time limited duty with walking and standing for short periods of time. He advised that she would reach maximum improvement within four to six weeks and then return to unrestricted letter carrier duty. Dr. Case opined that the bunionectomy performed on the left foot was unrelated to any work injury. In his August 8, 2011 supplemental report, he noted an essentially normal examination and diagnosed plantar fasciotomy and bunionectomy of the left foot. Dr. Case opined that appellant was status post one year after left foot surgery with no complaints of pain in the area of the plantar fascia or bunionectomy. He advised that a bunion was a preexisting

[3] *Gewin C. Hawkins*, 52 ECAB 242 (2001); *Alice J. Tysinger*, 51 ECAB 638 (2000).

[4] *Mary A. Lowe*, 52 ECAB 223 (2001).

[5] *Id.; Leonard M. Burger*, 51 ECAB 369 (2000).

[6] *Solomon Polen*, 51 ECAB 341 (2000). *See* 5 U.S.C. § 8123(a).

congenital condition which gradually worsened over time and was unrelated to her work injury. Dr. Case further opined that appellant's letter carrying walking route or altered gait would not cause a worsening of the bunion rather the bunion became more symptomatic as it deviated toward the fifth toe. He opined that appellant was capable of returning to work full time without restrictions as a letter carrier.

The Board finds that Dr. Case had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Case is a specialist in the appropriate field. He clearly opined that appellant had no work-related reason for disability at the time that wage-loss and medical benefits were terminated. Dr. Case's opinion as set forth in his reports of October 26, 2010 and August 8, 2011 is found to be probative evidence and reliable. The Board finds that his opinion constitutes the weight of the medical evidence and is sufficient to justify OWCP's termination of wage-loss and medical benefits for the accepted conditions.

After Dr. Case's examination, appellant submitted reports from Dr. Cohen who diagnosed status post bunionectomy and plantar fasciotomy and metatarsalgia of the left foot, improving. In a February 3, 2011 duty status report, Dr. Cohen noted that she was status post fasciotomy and bunionectomy and could work full time with restrictions. Other reports from him dated July 7 to December 19, 2011 noted that the diagnosed mild plantar fasciitis was under control and he opined that appellant could continue to work full-time light duty. Although Dr. Cohen supported that she had continuing symptoms, none of the reports specifically address how any continuing condition or disability was causally related to the accepted employment condition of December 5, 2007.[7] Rather, he opined that appellant could return to work full-time limited duty. The Board also notes that OWCP did not accept the diagnosed bunion and bunionectomy as being work related.[8]

Consequently, the medical evidence submitted after Dr. Case's reports is insufficient to overcome his report or to create another conflict in the medical evidence.[9] The Board finds that his opinion constitutes the weight of the medical evidence and is sufficient to justify OWCP's termination of wage-loss and medical benefits for appellant's accepted condition.

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(a) and 20 C.F.R. §§ 10.605 through 10.607.

[7] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[8] *See Jaja K. Asaramo*, 55 ECAB 200 (2004) (for conditions not accepted or approved by OWCP, the claimant bears the burden of proof to establish that the condition is causally related to the employment injury).

[9] *See S.J.*, Docket No. 09-1794 (issued September 20, 2010) (submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict). *See also Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990). The Board notes that Dr. Cohen's report did not contain new findings or rationale on causal relationship upon which a new conflict might be based.

LEGAL PRECEDENT -- ISSUE 2

Section 8103 of FECA[10] 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 OWCP considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of monthly compensation.[11] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under section 8103, with the only limitation on OWCP's authority being that of reasonableness.[12] 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.[13] In order to be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury.[14]

Proof of causal relationship in a case such as this must include supporting rationalized medical evidence. Thus, in order for a surgery to be authorized, appellant must submit evidence to show that the requested procedure is for a condition causally related to the employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[15]

ANALYSIS -- ISSUE 2

As noted, OWCP accepted the claim for left foot plantar fasciitis. On April 27, 2010 Dr. Cohen requested authorization to perform a left foot bunionectomy. OWCP determined that a conflict in medical opinion existed between appellant's attending podiatrist, Dr. Cohen, who indicated that the need for the bunionectomy was attributable to appellant's work and Dr. Smith, an OWCP referral physician, who determined that the bunionectomy surgery was not work related. OWCP referred appellant to Dr. Case to resolve the conflict.

The Board finds that, under the circumstances of this case, the opinion of Dr. Case is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that the July 14, 2010 bunionectomy surgery was not work related. Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[16]

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[10] *Supra* note 1.

[11] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[12] *James R. Bell*, 52 ECAB 414 (2001).

[13] *Claudia L. Yantis*, 48 ECAB 495 (1997).

[14] *Cathy B. Mullin*, 51 ECAB 331 (2000).

[15] *Id.*

[16] *Solomon Polen, supra* note 6. *See* 5 U.S.C. § 8123(a).

In an October 26, 2010 report, Dr. Case diagnosed status post endoscopic plantar fasciotomy of the left foot and bunionectomy of the left foot. He noted that the bunionectomy performed on the left foot was unrelated to any work injury. In a supplemental report, dated August 8, 2011 Dr. Case advised that appellant's diagnosed bunion was a preexisting and congenital condition and unrelated to her work injury. He opined that the bunion gradually worsened with time and that neither her letter carrier walking route nor an altered gait would cause worsening of the bunion. Rather, appellant's bunion became more symptomatic as it deviated laterally toward the fifth toe and became more prominent in shoes.

The Board finds that Dr. Case's opinion as set forth in his reports of October 26, 2010 and August 8, 2011 is probative evidence and reliable. The Board finds that his opinion constitutes the weight of the medical evidence and establishes that the July 14, 2010 left foot bunionectomy was unrelated to appellant's employment.

After Dr. Case's examination appellant submitted reports from Dr. Cohen dated January 20 to May 5, 2011, who noted diagnoses and eventually returned her to work full time with restrictions. Other reports from Dr. Cohen dated July 7 to December 19, 2011 continued noting diagnoses and her work status. The Board notes that appellant's claim was not accepted for a left foot bunion. These reports did not explain the causal connection between the left foot bunion and subsequent bunionectomy and the accepted occupational disease claim accepted for left foot plantar fasciitis of December 5, 2007.[17]

Consequently, the medical evidence submitted after Dr. Case's reports are insufficient to overcome his report or to create another conflict in the medical evidence. The Board finds that his opinion constitutes the weight of the medical evidence and is sufficient to establish that the July 14, 2010 left foot bunionectomy was not indicated in the treatment of appellant's employment-related occupational disease commencing on December 5, 2007.

For a surgical procedure to be authorized, a claimant must show that the surgery is medically warranted and is for a condition causally related to an employment injury.[18] Because appellant did not submit a reasoned medical opinion explaining how the accepted occupational disease caused or contributed to her need for a left foot bunionectomy, OWCP properly acted within its discretionary authority to deny authorization for the requested surgery. Therefore, the Board finds that OWCP did not abuse its discretion under section 8103 in denying approval of left foot bunionectomy.

On appeal, appellant asserts that Dr. Case's reports were flawed as they were based on an inaccurate job history and an inaccurate statement of accepted facts. The Board has reviewed Dr. Case's reports and cannot fault them on this ground. Dr. Case reviewed appellant's history and, as noted above, demonstrated an awareness of her job duties as a carrier. The impartial medical adviser addressed her work duties noting in his October 2010 report that she worked "full duty as a walking letter carrier in the city of Philadelphia, being on her feet all day in a

[17] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[18] 5 U.S.C. § 8103; *see also R.C.*, 58 ECAB 238 (2006) (where the Board found that, for a surgery to be authorized, a claimant must submit evidence to show that the requested procedure is for a condition causally related to the employment injury and that it is medically warranted).

walking route" and in his August 2011 report he noted that appellant "has returned to work walking a partial mail route in Pennsylvania on 2011. [Appellant] did not start her walking route until April, but now she is walking six blocks of her route." The Board finds that Dr. Case set forth his opinion based on an accurate knowledge of her work duties. Appellant further asserts Dr. Case's reports were unrationalized and insufficient to carry the weight of the evidence. The Board also finds this argument without merit. Dr. Case provided findings on examination, reviewed the diagnostic testing and demonstrated an awareness of appellant's work duties. The impartial medical adviser addressed appellant's accepted injury and asserted that she did not have residuals of the left foot plantar fasciitis and found the bunion to be a congenital condition unrelated to her work duties. Therefore, the Board finds this argument to be without merit.

CONCLUSION

The Board finds that OWCP has met its burden of proof to terminate benefits effective November 1, 2011. The Board also finds that OWCP properly denied appellant's claim for authorization of the left foot bunionectomy.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 17 and March 20, 2012 are affirmed.

Issued: March 27, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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