United States Department of Labor
Employees' Compensation Appeals Board

J.E., Appellant	)	
and	)	**Docket No. 18-0228**
	)	**Issued: August 8, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Racine, WI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 13, 2017 appellant filed a timely appeal from an August 1, 2017 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 merit decision of this case.[2]

ISSUE

The issue is whether OWCP abused its discretion by denying authorization for left lower extremity surgery.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that following the August 1, 2017 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.*

FACTUAL HISTORY

On June 9, 2002 appellant, then a 41-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he developed bone spurs in the joint of his left foot as a result of prolonged walking while delivering mail. OWCP accepted his claim for capsulitis of the first and second metatarsal cuneiform joint of the left foot secondary to dorsal exostosis. Appellant did not stop work.

Appellant was treated by Dr. John L. Bostanche, a podiatrist, on May 29 and September 24, 2002 for left foot pain. He reported walking on uneven hard surfaces throughout the day as a mail carrier when his foot became painful. Dr. Bostanche diagnosed resolving capsulitis of the first and second metatarsal cuneiform joint of the left foot secondary to dorsal exostosis and inflammation. He noted conservative treatment including orthotics, shoe changes, and anti-inflammatories provided some improvement. Dr. Bostanche opined that the significant number of years on the job and required walking accelerated the deterioration of appellant's foot structure producing deformities at the joint. He treated appellant from February 7, 2003 to October 12, 2005 for capsulitis of the first and second metatarsal cuneiform area of left foot. Dr. Bostanche advised that recent x-rays revealed further degenerative changes in the joint relative to prior x-rays. He diagnosed dorsal exostosis/capsulitis of the left foot and neuritis, dorsal nerve, secondary to dorsal exostosis of the left foot. Reports dated April 19, 2011 to October 28, 2014 noted follow up for capsulitis of the left first and second metatarsal joints and dorsal exostosis first metatarsocuneiform joint. Dr. Bostanche noted appellant's condition remained stable.

In reports dated January 6 and 20, March 3 and April 28, 2015, Dr. Bostanche treated appellant for increased left foot pain. He noted that he had long-standing chronic pain in the left foot due to changes in the mid tarsal joints and a dorsal bone spur. Appellant reported having problems walking on ice and uneven ground and continued to reaggravate the left foot. Dr. Bostanche noted conservative treatment including anti-inflammatory medications, cortisone injections, and long-standing orthotics failed and that appellant's condition was progressing. Findings on physical examination revealed pain on palpation of the first metatarsocuneiform navicular joint on the left, bony enlargements throughout the joint, pain on palpation of the plantar grade joint, and stiffness on range of motion. Dr. Bostanche noted that appellant had a plantar grade arch due to worsening joint destruction and he experienced increasing pain in the medial aspect of the foot, ankle, into the posterior tibial tendon, and sinus tarsi. He noted that x-rays revealed degenerative changes with plantar grade collapse into the mid arch joints of the first metatarsocuneiform navicular joints with significant bony changes and arthritis. Dr. Bostanche diagnosed dorsal exostosis of the first metatarsocuneiform joint on the left, arthrosis of the first metatarsocuneiform navicular joint left, posterior tibial tendinitis left, capsulitis of the left subtalar joint, and pain in the limb. He recommended fusing the arthritic joints in the mid foot to stabilize the left foot and foot structure for long-term pain control. In medical authorization records dated April 28 and December 14, 2015, Dr. Bostanche requested authorization to perform incision of the heel bone, revision of foot bones, and revision of calf tendon. On May 1, 2015 he submitted supporting documentation for the pending authorization and noted surgery was tentatively scheduled for May 13, 2015. Dr. Bostanche requested that authorization be expedited.

On December 29, 2015 OWCP notified appellant that his request for authorization of the incision of the heel bone, revision of foot bones, and revision of calf tendon could not be approved.

It indicated that the evidence was insufficient to authorize the proposed surgery because the requested treatment did not appear to be medically necessary for and causally related to the accepted conditions. OWCP requested that he submit a detailed narrative medical report from his treating physician, which provided an accurate history of injury, a firm diagnosis resulting from the injury, findings, description of treatment provided, extent of disability, and if the condition was caused or aggravated by the claimed injury.

In a January 14, 2016 report, Dr. Bostanche noted treating appellant conservatively after the May 7, 2002 work injury to his left foot; however, appellant's condition deteriorated over the years due to walking and weight-bearing activities at work. He opined that appellant's symptoms were in direct causation to the injury of May 7, 2002 and were causing significant changes to other joints in the left foot. Examination revealed a significantly collapsed arch and swelling and pain throughout the medial lateral aspect of the left ankle joint and outer aspect of the foot. Dr. Bostanche noted his foot joints were severely arthritic and collapsed since the time of the injury causing an overall change in his foot structure and positioning causing changes to the hind foot joints and ankle. He opined that appellant's original injury and job duties accelerated his condition over the years. Dr. Bostanche diagnosed capsulitis of the first and second metatarsocuneiform joint with a dorsal exostosis on the left foot, severe arthrosis, first and second metatarsocuneiform joint left foot, subtalar joint capsulitis/arthrosis, left foot secondary to arthrosis of the first and second metatarsocuneiform joint and ankle joint capsulitis, secondary to arthrosis of the first and second metatarsocuneiform joint on the left. He opined that conservative therapy was no longer effective and he recommended surgical intervention to include fusion of the first and second metatarsocuneiform joint on the left with removal of the bone spur, correction of the subtalar joint capsulitis on the left to include a bone cut into the heel to correct the position of the joint, lengthening the Achilles' tendon in the calf since the foot collapsed and the heel bone raised, tightening the Achilles' tendon due to the changes in the foot structure.

OWCP requested that an OWCP medical adviser address whether the requested incision of the heel bone, revision of foot bones, and revision of calf tendon was warranted and necessitated by the accepted conditions. In an April 26, 2016 report, the medical adviser noted reviewing the medical record and statement of accepted facts (SOAF). He noted that Dr. Bostanche recommended a fusion for the first and second metatarsocuneiform joint on the left, correction of subtalar joint capsulitis, lengthening the Achilles tendon, and osteotomy of the calcaneus. The medical adviser indicated that there was insufficient evidence of a temporal relationship between the employment injury on May 7, 2002 and the requested osteotomy of the calcaneus with fusion in 2015. He opined that the incision of the heel bone, revision of foot bones, and revision of calf tendon was not medically necessary. The medical adviser noted an absence of imaging in the records of capsulitis or severe arthritis to support the requested osteotomy and first and second ray fusion. He diagnosed metatarsalgia and opined that the diagnosed condition did not warrant surgical intervention as there was a lack of evidence of severe arthritis or deformity to warrant a first and second ray fusion. The medical adviser advised that an adequate trial of conservative treatment was demonstrated.

Appellant continued to treat with Dr. Bostanche on April 21, 2016 for left foot pain secondary to dorsal exostosis and arch collapse. Dr. Bostanche noted findings and diagnosed dorsal exostosis left foot, subtalar joint impingement, and pain in the left foot. He opined that appellant's left foot was collapsing and he was experiencing impingement laterally.

On August 2, 2016 OWCP referred appellant to Dr. Mysore S. Shivaram, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine if the proposed surgery was medically necessary and causally related to the accepted medical conditions. In an August 22, 2016 report, Dr. Shivaram discussed appellant's work history and stated that he had current complaints of pain along the left dorsal aspect of the foot, burning sensation around the top of the foot and along the left second toe, and pain along the inner aspect of the ankle. He noted appellant's medical history was significant for bunion surgery of the left foot in 2001 and bilateral flat foot deformity. Dr. Shivaram noted findings on examination of the feet revealed evidence of bilateral severe pes planus deformity (flatfoot), healed scar on the left foot, good capillary circulation, intact sensation, limited range of motion of the left big toe, degenerative arthritis of the tarsometatarsal joint of the left big toe, small bony exostosis at the metatarsocuneiform joint along the first and second metatarsocuneiform joints, no contracture of the Achilles tendon, and no pain with range of motion of the ankle. He noted x-rays of the left ankle revealed mild degenerative changes of the ankle. X-ray of the left foot revealed pes planus deformity and minimal degenerative changes at the tarsometatarsal joint. Dr. Shivaram diagnosed degenerative arthritis of the metatarsophalangeal joint of the left big toes, status post bunionectomy of the left big toes, mild degenerative arthritis of the tarsometatarsal joint of the left first and second tarsometatarsal joint, and severe pes planovalgus. He noted that appellant had preexisting pes planovalgus deformity, which resulted in more stress being placed along the inner column of the foot causing stress along the tarsometatarsal joint and degenerative changes. Dr. Shivaram advised that in long-standing pes planovalgus deformity the calcaneus may sublux laterally resulting in degenerative changes in the subtalar joint, deficiency of the tibialis posterior tendon, and contracture of the Achilles tendon. He opined that the changes in appellant's foot were not the result of his occupation, rather, they were caused by long-standing stresses placed on the foot in the condition of pes planovalgus. Dr. Shivaram advised that appellant's foot condition and proposed surgery were not work related, but was secondary to long-standing preexisting severe flatfoot deformity unrelated to his employment as a letter carrier.

On October 26, 2016 Dr. Bostanche noted that appellant developed degenerative changes to the first metatarsocuneiform joint on the left foot, which caused a collapse of the arch and changes to the surrounding joints of the left foot. He noted that these changes were beyond the normal progression of preexisting condition and opined that appellant's employment injury accelerated his condition beyond the normal course. Dr. Bostanche diagnosed degenerative arthritis of the tarsometatarsal joints, left first and second metatarsals and severe pes planovalgus deformity of the left foot. He advised that the changes to the left foot were not from a preexisting condition; rather, he indicated that appellant's work injury and job duties significantly accelerated the condition. Dr. Bostanche recommended surgical intervention to correct the degenerative arthritis changes to the left foot.

OWCP determined that there was a conflict in medical opinion between the treating podiatrist, Dr. Bostanche, who indicated that the proposed surgery was medically necessary and causally related to the accepted medical conditions, and OWCP's second opinion physician, Dr. Shivaram and OWCP's medical adviser, who opined that appellant's foot condition and proposed surgery was secondary to preexisting severe flatfoot deformity and not related to the employment injury of May 7, 2002.

In a medical authorization record dated April 18, 2017, Dr. Bostanche requested authorization to perform incision of the heel bone, revision of foot bones, and revision of calf tendon.

On April 19, 2017 OWCP scheduled an impartial medical examination with Dr. Bradley M. Fideler, a Board-certified orthopedic surgeon. It provided Dr. Fideler with a SOAF, which noted appellant's claim was accepted for capsulitis of the first and second metatarsal cuneiform joint of the left foot secondary to dorsal exostosis.

In a May 22, 2017 report, Dr. Fideler detailed the history of the injury and appellant's treatment. He reviewed the SOAF. Dr. Fideler noted findings on examination of normal heel-to-toe gait, significant flatfoot deformity of both feet, loss of normal arch in left foot, pain within the metatarsal cuneiform joint with an osteophyte, pain laterally due to significant collapse of his arch and flatfoot deformity, and hind foot valgus impinging laterally. He diagnosed severe pes planus flatfoot deformity of the left foot with the development of degenerative arthritis of the first and second metatarsal cuneiform joints and significant hind foot valgus due to the collapsing midfoot. Dr. Fideler opined that appellant's condition was preexisting and the development of the degenerative changes within the midfoot was related to the deformity within his midfoot. He noted that appellant's standing and walking for extended distances carrying a mailbag aggravated the condition, but he found no evidence that his work activity was directly related to the development of the degenerative condition. Dr. Fideler opined that appellant's condition, due to significant pes planus and hind foot valgus, may have developed regardless of his occupation as a postal carrier. He noted that appellant had no residuals of the accepted capsulitis of the first and second metatarsal cuneiform joint, left foot secondary to dorsal exostosis. Dr. Fideler opined that the proposed surgical fusion of the metatarsocuneiform joint, calcaneal osteotomy, and Achilles tendon lengthening were not related to any specific work activities rather they were related to his preexisting planovalgus condition. He opined that appellant's condition was preexisting due to preexisting pes planovalgus deformity and hind foot valgus and the proposed surgery was not directly related to the accepted work injury.

On April 20, 2017 Dr. Bostanche noted findings on examination and diagnosed subtalar joint impingement, degenerative arthritis of the left first and second tarsometatarsal joints, severe pes planovalgus deformity on the left, left dorsal exostosis first metatarsocuneiform joint, pain in left limb, and left posterior tibial tendinitis. He noted appellant's condition was worsening and recommended surgical intervention.

In a decision dated August 1, 2017, OWCP denied authorization for incision of the heel bone, revision of foot bones, and revision of calf tendon. It based its decision on the report of Dr. Fideler, the referee physician, who opined that the proposed surgery was not medically necessary or causally related to the accepted employment-related conditions. Consequently, OWCP accorded Dr. Fideler's report special weight.

LEGAL PRECEDENT

Section 8103(a) of FECA provides for the furnishing of services, appliances, and supplies prescribed or recommended by a qualified physician which OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability, or

aid in lessening the amount of monthly compensation.[3] In interpreting section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[4] OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on OWCP's authority is that of reasonableness.[5]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[6] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[7] Therefore, in order to prove that the procedure is warranted, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[8]

Section 8123(a) 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.[9]

ANALYSIS

The Board finds that OWCP did not abuse its discretion in denying authorization for left lower extremity surgery.

OWCP properly declared a conflict in medical opinion between appellant's physician, Dr. Bostanche, who recommended surgery, and the DMA and second opinion examiner, Dr. Shivaram, who opined that appellant's foot condition and proposed surgery was secondary to preexisting severe flatfoot deformity and not related to the work injury of May 7, 2002. Consequently, it referred appellant to Dr. Fideler to resolve the conflict, pursuant to 5 U.S.C. § 8123(a). The Board finds that the opinion of Dr. Fideler is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight to establish

[3] 5 U.S.C. § 8103(a).

[4] *G.M.*, Docket No. 18-1710 (issued June 3, 2019); *Dale E. Jones*, 48 ECAB 648, 649 (1997).

[5] *G.M., id*.; *Daniel J. Perea*, 42 ECAB 214, 221 (1990) (abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or administrative actions, which are contrary to both logic, and probable deductions from established facts).

[6] *G.M., supra* note 4; *Debra S. King*, 44 ECAB 203, 209 (1992).

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

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

[9] 5 U.S.C. § 8123(a); *see Guiseppe Aversa*, 55 ECAB 164 (2003).

that the proposed surgery was not medically necessary and causally related to the accepted employment-related conditions.[10]

In a May 22, 2017 report, Dr. Fideler reviewed appellant's history and noted findings on examination. He diagnosed severe pes planus flatfoot deformity of the left foot with the development of degenerative arthritis of the first and second metatarsal cuneiform joints and significant hind foot valgus due to the collapsing midfoot. Dr. Fideler opined that appellant's condition was preexisting and the development of the degenerative changes within the midfoot was related to the deformity within his midfoot. He noted that prolonged standing and walking carrying a mailbag aggravated appellant's condition, but he found no evidence that his work activity was directly related to the development of the degenerative condition. Dr. Fideler believed that appellant's condition may have developed regardless of his occupation as a postal carrier due to significant pes planus and hind foot valgus. He further advised that the aggravation of appellant's condition was not beyond normal progression. Dr. Fideler noted that appellant had no residuals of the accepted capsulitis of the first and second metatarsal cuneiform joint of the left foot secondary to dorsal exostosis. He opined that the proposed surgical procedure fusion of the metatarsocuneiform joint, calcaneal osteotomy and Achilles tendon lengthening was not related to any specific work activities; rather, they were related to his preexisting planovalgus condition. Dr. Fideler opined that appellant's condition was preexisting and due to preexisting pes planovalgus deformity and hind foot valgus. He further opined that the proposed surgery was to treat the degenerative condition and flatfoot deformity and was not directly related to the accepted employment injury.

The Board finds that Dr. Fideler had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Fideler is a specialist in the appropriate field. He indicated that the proposed surgery was not related to any specific work activities; rather, it was related to his preexisting planovalgus condition and hind foot valgus. The Board finds that Dr. Fideler's opinion constitutes the special weight of the medical evidence and establishes that the proposed surgery was not medically necessary and causally related to the accepted employment-related conditions.

Subsequent to Dr. Fideler's report, appellant submitted an April 20, 2017 report from Dr. Bostanche who noted positive findings on examination and diagnosed subtalar joint impingement, degenerative arthritis of the left first and second tarsometatarsal joints, severe pes planovalgus deformity, left dorsal exostosis first metatarsocuneiform joint, pain in left limb, and left posterior tibial tendinitis. Dr. Bostanche noted appellant's condition was progressively worsening and he recommended surgical intervention. However, his report failed to provide a rationalized opinion regarding the causal relationship of the proposed surgery to the employment injury and also address why it was medically warranted.[11] Dr. Bostanche did not provide the necessary medical explanation as to how the proposed surgery would cure, reduce the period of

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

[11] *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

disability, or aid in lessening the amount of monthly compensation.[12] The Board notes that Dr. Bostanche had been on one side of the conflict resolved by Dr. Fideler and his report is similar to his prior reports and are therefore insufficient to overcome the special weight of Dr. Fideler's report or to create a new medical conflict.[13] The Board notes that Dr. Bostanche's reports do not contain new findings or rationale upon which a new conflict might be based.

As noted, the only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[14] Because appellant did not submit a reasoned medical opinion explaining how the May 7, 2002 work injury caused or contributed to his need for the requested surgery, OWCP properly acted within its discretionary authority to deny authorization for the requested equipment. Therefore, the Board finds that OWCP did not abuse its discretion under section 8103 in denying approval of the proposed surgery.

On appeal appellant argues that he needed the proposed surgery to aid in his recovery from the accepted medical conditions. As discussed, appellant did not show that the surgery was medically necessary or reasonable to treat his ongoing employment-related problems with his left foot. The medical evidence of record is insufficient to establish causal relationship and OWCP did not abuse its discretion in denying authorization for the proposed surgery.

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.

CONCLUSION

The Board finds that OWCP did not abuse its discretion by denying authorization for left lower extremity surgery.

[12] *See E.J.*, Docket No. 10-0743 (issued November 2, 2010).

[13] *See Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990).

[14] *Supra* note 5.

ORDER

IT IS HEREBY ORDERED THAT the August 1, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 8, 2019
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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