

represented his wage-earning capacity on October 2, 1997. By order issued January 3, 2006,² the Board set aside a June 22, 2005 decision denying authorization for an April 28, 2005 left foot and ankle surgery and remanded the case to the Office for reconstruction of the record. The Board found that the record did not contain the Office's June 22, 2005 decision and that the Office medical adviser's report was missing from the record. The law and the facts of the case as set forth in the prior decisions are hereby incorporated by reference. The relevant facts are set forth below.

The Office accepted that on August 22, 1995 appellant, then a 39-year-old carpenter, sustained a left foot sprain and plantar fasciitis. He was terminated from federal employment on September 15, 1995 when the employing establishment was closed. The Office also accepted a recurrence of disability commencing October 21, 1998. The Office later expanded the claim to accept chronic pain disorder and major depressive disorder.³

Appellant submitted reports dated January 27, 1998 to September 3, 2003 from Dr. Steven F. Boc, an attending podiatrist, diagnosing left plantar fasciitis, heel spurs, chronic pain and instability of the left foot and ankle, possible reflex sympathetic dystrophy syndrome,⁴ tarsal tunnel syndrome, chronic gait and limb abnormalities, arthritic changes, a Morton's neuroma of the third to fourth metatarsal space, "posterior tibial and common peroneal nerve neuritis with knee pain secondary to compensation as well as radiculopathy and neuropathy." Dr. Boc attributed these diagnoses to the August 22, 1995 left foot sprain.

In an August 15, 2003 report, Dr. Robert A. Smith, a Board-certified orthopedic surgeon and second opinion physician, reviewed the medical record and a statement of accepted facts. He diagnosed "[r]esolved left foot plantar fasciitis and strain."

In periodic chart notes from September 30, 2003 to May 5, 2004, Dr. Boc found left foot and ankle pain with gait abnormalities, instability, positive Tinel's and Valliex signs, calcaneal spurring, posterior tibial, common peroneal and sural neuritis, plantar fasciitis, chronic inversion strain and heel spurs.⁵ He recommended surgery. In a December 23, 2003 report, Dr. Boc reiterated that appellant's left foot conditions with chronic instability were "directly related" to the accepted injury.

² Docket No. 05-1407.

³ The record contains a January 16, 2004 decision approving an attorney's fee request. Appellant approved this fee on September 11, 2003 and did not contest it on appeal. Therefore, this decision is not before the Board on the present appeal. On January 20, 2004 appellant claimed a low back condition related to an abnormal gait he contended was caused by the accepted left foot injury. This claim is not before the Board on the present appeal as there is no final decision of record regarding the causal relationship of a low back condition to the accepted left foot injury.

⁴ In a January 30, 2001 report, Dr. Steven Mandel, an attending Board-certified neurologist, diagnosed a possible complex regional pain syndrome of the left foot related to the 1995 injury.

⁵ Dr. Boc obtained November 17, 2003 x-rays showing degenerative joint disease of the left ankle, "calcaneal spurring, talar breaking and exostosis with degenerative joint disease." May 5, 2004 x-rays showed generalized degenerative joint disease of the left foot and ankle with impingement of the anterior ankle joint, calcaneal spurring and exostosis.

On February 4, 2004 the Office referred appellant, the medical record and a statement of accepted facts to Dr. Jatinkumar Gandhi, an orthopedic surgeon. In a March 22, 2004 report, Dr. Gandhi provided a history of injury and treatment and reviewed the statement of accepted facts. On examination he noted an antalgic gait and generalized tenderness throughout the left foot. Dr. Gandhi diagnosed chronic left foot pain with plantar neuropathy and plantar fasciitis. He opined that “there [was] a causal relationship between the accident at work in 1995 at the [employing establishment] and the current condition of his left foot.”

On May 28, 2004 Dr. Boc performed an osteotomy of the left talus, left ankle “scope” and decompression of the posterior talar navicular joint. In the operative notes, Dr. Daren Guertin, a podiatrist, who assisted Dr. Boc, noted appellant’s “history of [degenerative joint disease] (DJD), left ankle, from work-related injuries, plantar heel pain and plantar fasciitis of the left heel also from work-related injuries.” He explained that surgery was indicated as several months of conservative measures failed to alleviate appellant’s symptoms.

In August 4 and 8, 2004 notes, Dr. Boc noted that appellant’s left foot and ankle improved somewhat after surgery. However, he required further treatment and physical therapy for chronic instability, neuritis and gait abnormalities.

In a September 22, 2004 report, Dr. Boc opined that appellant’s “problems with activity, range of motion, gait abnormalities,” chronic pain, neuritis, exostosis and heel spurring were “part of the injury factor which he sustained and the degenerative changes are a result of post trauma in general.” He reiterated in October 13 and December 15, 2004 reports, that these conditions were related to appellant’s accepted left foot injury. Dr. Boc explained in a January 19, 2005 report, that appellant’s neuritis and tarsal tunnel syndrome were “work related and traumatic in nature.... It has been demonstrated that he had had a work injury in the past. The chronic discomfort and gait abnormalities ... caused increased neuritic symptoms” and persistent fasciitis.”

Appellant’s symptoms continued despite conservative treatment through April 27, 2005, including injections, strappings and orthotics. On April 28, 2005 Dr. Boc performed a left tarsal tunnel release, decompression of the common peroneal nerve of the left foot and neurolysis of the medial and lateral plantar nerves and medial calcaneal branch.

On June 17, 2005 the Office requested that an Office medical adviser explain whether “the attached April 28, 2005 surgery be approved.” In a June 20, 2005 report, an Office medical adviser noted reviewing unspecified medical records. He stated that “Dr. Smith on August 15, 2003 concluded that the foot injury has resolved requiring no further treatment.” The Office medical adviser stated that, as the medical records did not indicate objective work-related findings, the April 28, 2005 surgery should not be approved.

By decision dated June 22, 2005, the Office denied authorization for the April 28, 2005 surgical procedures. On January 3, 2006 the Board set aside the June 22, 2005 decision and remanded the case for reconstruction of the record. Appellant submitted additional reports from Dr. Boc. In a June 27, 2005 report, Dr. Boc opined that appellant’s “chronic instability of the left foot and left ankle, fasciitis, pain and swelling were “all related to his work injury.” In a July 27, 2005 letter, he asserted that his staff contacted the Office prior to the April 28, 2005

surgery but were not informed that a prior authorization was required. In chart notes from August 17 to September 19, 2005, Dr. Boc newly observed erythema, edema and rubor in the left foot and ankle with hypersensitivity and paresthesias. He diagnosed continued neuritis, tarsal tunnel syndrome and plantar fasciitis.

By decision dated January 25, 2006, the Office denied authorization for the April 28, 2005 surgery on the grounds that the medical evidence was insufficient to establish a causal relationship between the procedures and the accepted injury. The Office noted that Dr. Smith's August 2003 "independent" report found that the accepted left foot injury had resolved. It also noted Dr. Gandhi's second opinion report but did not evaluate its probative value. The Office found that Dr. Boc's reports contained insufficient rationale explaining how and why the accepted injury caused the conditions necessitating the April 28, 2005 surgery. It found that "[a]fter reviewing Dr. Boc's reports and x-rays," there was "no indication that" the diagnosed neuritis and "tarsal tunnel syndrome were due to the work injury of August 22, 1995, nor are supported by diagnostic testing and objective findings. ... Therefore, the surgery cannot be approved as the medical evidence ... [did not] support that the left foot surgery [was] medically indicative [sic] or causally related."

LEGAL PRECEDENT

Section 8103 of the Federal Employees' Compensation Act⁶ 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.⁷ In interpreting section 8103, the Board has recognized that the Office has broad discretion in approving services provided under the Act. The only limitation on the Office's authority is that of reasonableness.⁸ 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.⁹

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.¹⁰ This burden of proof includes providing supporting rationalized medical evidence. Thus, in order for surgery to be authorized, appellant must submit evidence to show that these

⁶ 5 U.S.C. §§ 8101-8193.

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

⁸ *Mira R. Adams*, 48 ECAB 504 (1997).

⁹ *Daniel J. Perea*, 42 ECAB 214 (1990).

¹⁰ *Cathy B. Mullin*, 51 ECAB 331 (2000).

are for a condition causally related to the employment injury and that these were medically warranted. Both of these criteria must be met in order for the Office to authorize payment.¹¹

ANALYSIS

The Office accepted that appellant sustained a left foot sprain and plantar fasciitis on August 22, 1995. Dr. Boc, an attending podiatrist, requested that the Office authorize a left tarsal tunnel release, left peroneal nerve decompression and neurolysis of the left medial and plantar nerves and medial calcaneal branch, performed on April 28, 2005. He submitted several reports from September 22, 2004 to January 19, 2005 stating that appellant's gait abnormalities, chronic instability, heel spurs, neuritis, tarsal tunnel syndrome and plantar fasciitis were all attributable to the August 22, 1995 injury.

To determine whether the April 28, 2005 procedure was work related, the Office referred the medical record to an Office medical adviser for review. In a June 20, 2005 report, he noted that Dr. Smith, a Board-certified orthopedic surgeon and second opinion physician, opined on August 15, 2003 that the accepted left foot injury had resolved. Based on Dr. Smith's opinion and a lack of rationale from Dr. Boc, the medical adviser stated that the proposed surgery should not be approved.

The Office initially denied surgical authorization by June 22, 2005 decision, set aside by the Board's January 3, 2006 order. The Office then denied appellant's request for surgical authorization by decision dated January 25, 2006. It found that Dr. Boc did not provide sufficient rationale to establish that the diagnosed neuritis and tarsal tunnel syndrome were work related. The Office further found that Dr. Smith's August 15, 2003 second opinion report was sufficient to establish that the accepted left foot injury had resolved. It noted Dr. Gandhi's March 22, 2004 second opinion report but did not comment on his finding that appellant's left foot condition continued to be work related. Also, the Office did not explain why it accorded greater weight to Dr. Smith's second opinion report over Dr. Gandhi's second opinion report. The Board finds that the Office has not provided sufficient justification for preferring Dr. Smith's opinion to that of Dr. Gandhi.¹²

While Dr. Boc's medical reports lack sufficient medical rationale to establish that the April 28, 2005 surgical procedures were necessitated by sequelae of the accepted injury, their detailed physical findings and consistent support for causal relationship are sufficient to require further development of the medical evidence.¹³ Therefore, the Board will remand the case to the Office for further development of the evidence. This development shall include requesting that Dr. Boc provide a supplemental, clarifying report regarding any causal relationship between the April 28, 2005 surgery and the accepted August 22, 1995 injury. Following this and any other development the Office deems necessary, the Office shall issue an appropriate decision in the case.

¹¹ *Id.*

¹² *Steven P. Anderson*, 51 ECAB 525 (2000).

¹³ *John J. Carlone*, 41 ECAB 354 (1989).

CONCLUSION

The Board finds that the case is not in posture for a decision as it must be remanded for further development regarding the causal relationship of the April 28, 2005 surgery to the accepted injury.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 25, 2006 is set aside and the case remanded for further development consistent with this decision.

Issued: October 5, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board