

FACTUAL HISTORY

On September 16, 2010 appellant, then a 56-year-old resources assistant, filed a traumatic injury claim alleging that on August 26, 2010 she injured her left knee, ankle, and foot when she twisted her left knee and ankle as she fell onto pavement.² OWCP accepted the claim for an old bucket handle tear of the medial meniscus and left ankle sprain.

On May 13, 2011 Dr. Todd A. Anderson, a Board-certified orthopedic surgeon, performed a partial medial and lateral menisectomy of the left knee and a limited chondroplasty of the medial femoral condyle and patellofemoral joint. OWCP paid appellant compensation from May 13 until June 13, 2011, when she returned to her usual employment.

In a report dated July 12, 2011, Dr. Scot L. Roberg, a podiatrist, evaluated appellant for pain in her left foot. He discussed her history of a fall at work on August 26, 2010 resulting in injuries to her left leg and body and surgery on her knee. Dr. Roberg also noted that appellant had a “history of [RSD] to her upper body and upper leg secondary to carpal tunnel, cubital tunnel and [a] knee arthroscopy in 1990, 1991, [and] 1998.” He diagnosed posterior tibial tendon dysfunction and tendinitis, left ankle sprain, left plantar fasciitis, and a left midfoot sprain or arthritis. Dr. Roberg found that appellant’s symptoms were likely caused by twisting when she “injured the posterior tibial tendon while spraining the ankle...” He further attributed her plantar fascial symptoms to an antalgic gait and a low foot arch. Dr. Roberg recommended orthotics.

Dr. Roberg provided progress reports from July 26, 2011 through March 16, 2012 describing his treatment of appellant for plantar fasciitis, posterior tibial tendon dysfunction, left ankle sprain, and a possible midfoot sprain or arthritis.

Magnetic resonance imaging (MRI) scan studies of the left ankle performed October 15, 2011 and May 5, 2012 showed subcutaneous soft tissue swelling. The May 5, 2012 MRI scan study also showed either a ganglion cyst or tenosynovitis at the anterior tibial tendon, and a ganglion cyst in the navicular bone.

In a progress report dated June 15, 2012, Dr. Roberg diagnosed possible venous stasis disease, and noted that such a condition would not be covered under workers’ compensation. In an October 5, 2012 progress report, he evaluated appellant for swelling of both legs and pain in the right foot. Dr. Roberg diagnosed left plantar fasciitis, left posterior tibial tendon dysfunction and tendinitis, possible Lisfranc joint arthritis on the left, and compensation myositis of the right foot. He recommended steroids and noted that appellant had stage III kidney disease. On November 19, 2012 Dr. Roberg evaluated her for increased right foot pain. In a progress report dated December 14, 2012, he requested a bone scan. A bone scan performed March 5, 2013, revealed findings “consistent with active [RSD] of both the right and left ankles.”

² Appellant related that she began to fall on pavement outside of the employing establishment’s building. In a statement received November 22, 2010, she related that she was on the property of the employment establishment outside the door of her building.

On June 18, 2013 Dr. Roberg related that in his July 12, 2011 examination of appellant he found “multiple diagnoses which accounted for her pain that had been untreated. These included posterior tendinitis, plantar fasciitis, along with lateral ankle sprain, which was unresolved.” He indicated that her plantar fasciitis improved with treatment but that the “reduction in this pain elicited previously undiscovered mid-foot arthritis.” Dr. Roberg noted that a bone scan showed bilateral RSD of the ankles. He opined that appellant’s ankle injury likely precipitated her RSD. Dr. Roberg determined that the diagnoses of left ankle sprain, left plantar fasciitis, and RSD of the lower extremities “should be included in [appellant’s] approved diagnoses as a direct or indirect result of her injury on August 26, 2010.”

On August 12, 2013 OWCP advised appellant that she should provide a written request for claim expansion if she believed that she sustained additional conditions due to her work injury. It further requested that she submit a reasoned medical report from her attending physician explaining the relationship between these conditions and her accepted work injury.

In a letter dated December 12, 2013, OWCP noted that it appeared that appellant was claiming plantar fasciitis, RSD, and posterior tibial tendon dysfunction as a consequential injury and also alleging a recurrence of disability.³ It advised her that the medical evidence from Dr. Roberg was insufficient to meet her burden of proof and requested that she submit a reasoned report addressing causation.

On January 31, 2014 OWCP informed Dr. Roberg that it had accepted only an old bucket handle left medial meniscus tear and left ankle sprain due to appellant’s August 26, 2010 work injury. It noted that appellant had sustained a left ankle sprain in 2009 and a right knee contusion, left ankle strain, a chest contusion, and left wrist sprain in 2004 under other OWCP file numbers. OWCP requested that Dr. Roberg submit a report based on a complete medical history explaining the relationship between any diagnosed conditions and the August 26, 2010 employment incident.

On February 14, 2014 appellant’s attorney requested claim expansion. He submitted a November 7, 2013 report from Dr. Roberg in support of his request. Dr. Roberg related that appellant continued to have left foot pain and pain on the inside of her ankle. He diagnosed posterior tibial tendon dysfunction and likely RSD.

By decision dated February 24, 2014, OWCP denied appellant’s request to expand her claim to include RSD, plantar fasciitis, and posterior tibial tendon dysfunction. It found that the medical evidence was insufficient to establish that she sustained additional conditions as a result of her accepted August 26, 2010 work injury.

In a statement dated February 14, 2014, received by OWCP on February 26, 2014, appellant related that she periodically experienced pain and swelling of the left ankle and foot. She asserted that she did not sprain her ankle on August 26, 2010 but instead sustained posterior tibial dysfunction, plantar fasciitis, and RSD.

³ By decision dated December 12, 2013, OWCP denied appellant’s schedule award claim after finding that she had not reached maximum medical improvement.

On February 28, 2014 appellant, through counsel, requested a telephone hearing before an OWCP hearing representative. At the telephone hearing, held on July 21, 2014, she related that she continued to experience RSD bilaterally. Appellant indicated that she had a prior history of RSD in the upper extremities but not the feet.⁴ The hearing representative asked that she submit a comprehensive report addressing whether her RSD was related to her accepted work injury.

By decision dated August 29, 2014, an OWCP hearing representative affirmed the February 24, 2014 decision.⁵ He determined that Dr. Roberg's opinion was speculative and unrationalized and thus insufficient to meet appellant's burden of proof.

On appeal appellant's counsel contends that the word "likely" is not speculative.

LEGAL PRECEDENT

An employee seeking benefits under FECA⁶ 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 FECA; that the claim was filed within the applicable time limitation of FECA; that an injury was sustained while 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 claim is predicated upon a traumatic injury or an occupational disease.⁷

Causal relationship is a medical issue, and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.⁸ The opinion of the physician must be based on a complete factual and medical background of the claimant,⁹ must be one of reasonable medical certainty¹⁰ explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.¹¹

⁴ In a report dated March 1, 2002, Dr. Al Katouzian, a Board-certified anesthesiologist, related that appellant had a history of complex regional pain syndrome, (CRPS) Type I, of the bilateral upper and lower extremities. He diagnosed CRPS, Type 1, or RSD, of the upper and lower extremities.

⁵ The hearing representative indicated that he was affirming a March 5, 2013 decision; however, it is apparent from the context that this is a typographical error.

⁶ *Supra* note 1.

⁷ *Calvin E. King*, 51 ECAB 394 (2000); *Caroline Thomas*, 51 ECAB 451 (2000).

⁸ *John J. Montoya*, 54 ECAB 306 (2003).

⁹ *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

¹⁰ *Supra* note 8.

¹¹ *Judy C. Rogers*, 54 ECAB 693 (2003).

ANALYSIS

OWCP accepted that on August 26, 2010 appellant sustained a left ankle sprain and a bucket handle tear of the left medial meniscus. It paid her compensation from May 13 until June 13, 2011, when she returned to work without restrictions.

On February 14, 2014 appellant's counsel requested that her claim be expanded to include additional conditions of the left foot and ankle based on the reports of Dr. Roberg. The Board finds, however, that the medical evidence is insufficient to support that she sustained additional medical conditions as a result of her accepted August 26, 2010 employment injury.

On July 12, 2011 Dr. Roberg discussed appellant's history of injuring her left leg and side of body on August 26, 2010 and her prior history of RSD of the upper extremity and upper leg due to prior surgeries in 1990, 1991, and 1998. He diagnosed posterior tibial tendon dysfunction and tendinitis, left ankle sprain, left plantar fasciitis, and a left midfoot sprain or arthritis. Dr. Roberg opined that appellant's current condition likely resulted from a twisting injury to the posterior tibial tendon when she sprained her ankle. He further attributed the plantar fasciitis to a gait change and low foot arch. Dr. Roberg's opinion that appellant sustained posterior tendinitis and dysfunction "likely" due to twisting her ankle is couched in speculative terms and thus of diminished probative value.¹² Further, he did not provide any rationale for his causation finding. A mere conclusion without the necessary rationale explaining how and why the physician believes that a claimant's accepted exposure could result in a diagnosed condition is not sufficient to meet a claimant's burden of proof.¹³ Dr. Roberg also attributed the diagnosed left plantar fasciitis to a gait change after her ankle sprain and a low foot arch. He did not, however, provide any rationale for his opinion that she sustained left plantar fasciitis as a consequence of her work injury and thus it is of little probative value.¹⁴

In progress reports dated July 26, 2011 to March 16, 2012, Dr. Roberg treated appellant for plantar fasciitis, posterior tibial tendon dysfunction, left ankle sprain, and a possible midfoot sprain or arthritis. On June 15, 2012 Dr. Roberg diagnosed possible venous stasis disease, and noted that such a condition would not be covered under workers' compensation. In a progress report dated October 5, 2012 he noted that appellant had bilateral pain and swelling of the legs and right foot pain. Dr. Roberg diagnosed left plantar fasciitis, left posterior tibial tendon dysfunction and tendinitis, possible Lisfranc joint arthritis on the left, and compensation myositis of the right foot. He also noted that appellant had stage III kidney disease. On November 19, 2012 Dr. Roberg evaluated her for increased right foot pain. In his progress reports, however, he did not address causation. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of diminished probative value on the issue of causal relationship.¹⁵

¹² *Id.*

¹³ See *Beverly A. Spencer*, 55 ECAB 501 (2004).

¹⁴ See *V.G.*, Docket No. 13-1462 (issued November 26, 2013); *C.S.*, Docket No. 12-1573 (issued April 2, 2013).

¹⁵ *S.E.*, Docket No. 08-2214 (issued May 6, 2009); *Conard Hightower*, 54 ECAB 796 (2003).

In a report dated June 8, 2013, Dr. Roberg advised that he had found additional diagnoses causing appellant's symptoms of pain at the time of his June 12, 2011 evaluation, including plantar fasciitis, unresolved ankle sprain, and posterior tendinitis. He noted that a bone scan showed RSD of the ankles bilaterally. Dr. Roberg opined that appellant's ankle sprain was "likely" the precipitating cause of her RSD and determined that she sustained a left ankle sprain, left plantar fasciitis, and RSD of the lower extremities as a result of her August 26, 2010 work injury. His finding that her ankle sprain "likely" caused RSD is speculative in nature and thus insufficient to meet her burden of proof.¹⁶ Further, Dr. Roberg did not provide rationale in support of his causation finding to explain how the sprain could have precipitated the diagnosed conditions. Where appellant claims that a condition not accepted or approved by OWCP was due to her employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury through the submission of rationalized medical evidence.¹⁷ Such rationale is particularly necessary given that Dr. Roberg found a preexisting history of RSD in the upper leg in his June 12, 2011 report and as appellant has evidence of RSD bilaterally rather than only on the injured side.

In a progress report dated November 7, 2013, Dr. Roberg listed findings on examination and diagnosed dysfunction of the posterior tibial tendon and likely RSD. He did not, however, address causation and thus his report is of little probative value on the issue of causal relationship.¹⁸

On appeal appellant's counsel argues that "likely" is not speculative. The Board has held, however, that while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion must be expressed in terms of a reasonable degree of medical certainty.¹⁹ Dr. Roberg's finding that appellant's ankle sprain "likely" caused her RSD and other left foot and ankle conditions is equivocal in nature and thus of diminished probative value²⁰ especially in light of the lack of any medical rationale for such a conclusory statement.

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 and 20 C.F.R. §§ 10.605 through 10.607.

¹⁶ See *Ricky E. Storms*, 52 ECAB 349 (2001).

¹⁷ See *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

¹⁸ See *A.D.*, 58 ECAB 149 (2006).

¹⁹ See *G.J.*, Docket No. 14-907 (issued November 10, 2014); *Caroline Thomas*, *supra* note 7.

²⁰ *B.S.*, Docket No. 15-2 (issued February 27, 2015); *Cecilia M. Corley*, 56 ECAB 662 (finding that medical opinions which are speculative or equivocal are of diminished probative value).

CONCLUSION

The Board finds that appellant has not met her burden of proof that she sustained plantar fasciitis, posterior tibial tendon dysfunction, and RSD of the lower extremities causally related to an August 26, 2010 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the August 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 15, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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