United States Department of Labor
Employees' Compensation Appeals Board

O.V., Appellant	)	
and	)	**Docket No. 10-281**
	)	**Issued: October 6, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Denver, CO, Employer	)	

Appearances:
Timothy Quinn, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 9, 2009 appellant, through his representative, filed a timely appeal from the August 27, 2009 merit decision of the Office of Workers' Compensation Programs, which affirmed the denial of his consequential injury claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant sustained tarsal tunnel syndrome as a consequence of his January 10, 1987 employment injury.

FACTUAL HISTORY

On January 10, 1987 appellant, then a 34-year-old mail handler, sustained an injury in the performance of duty when, following his normal eight-hour shift, he felt pain in his shoulders and upper and lower back. The Office accepted his claim for lumbosacral strain and permanent

aggravation of degenerative disc disease.[1] On May 12, 1998 appellant underwent, with the Office's authorization, a semihemilaminectomy with disc excision at L5-S1 on the left. On April 12, 2005 he received a schedule award for a seven percent impairment of the left lower extremity due to sensory and motor deficits in the L5 nerve root. The Office accepted that appellant sustained a recurrence on May 1, 2007.

A conflict in medical opinion arose on whether appellant developed tarsal tunnel syndrome as a consequence of his 1987 employment injury.[2] To resolve this conflict, the Office referred appellant, together with the case record and a statement of accepted facts,[3] to Dr. John B. Woodward, III, a Board-certified neurologist, for a referee medical evaluation.

Dr. Woodward evaluated appellant on February 2, 2009. He related appellant's history of foot complaints, which began around June 2007, and his history of back complaints, including an exacerbation of low back pain in May 2007. He described his findings on examination and reviewed the medical record, including the medical opinions that came into conflict. Dr. Woodward diagnosed foot pain with no definite clinical impression for an etiology. There were no objective findings. He thought plantar fasciitis was a possible diagnosis based on symptom reporting alone, but that was not a neurological condition, so he had no further opinion on whether it was present.

Dr. Woodward found that no diagnosis of tarsal tunnel syndrome could be made. He explained that appellant's symptoms, from his history and from the chart review, were not consistent with clinical tarsal tunnel syndrome. The nerve conduction study obtained showed normal plantar motor latencies. He added that a prior electromyogram (EMG) demonstrating some denervation of the foot intrinsics was not, in the absence of other nerve conduction or clinical findings, diagnostic for tarsal tunnel syndrome, as this was commonly identified on EMGs.

As for whether an abnormal gait might account for appellant's foot symptoms, Dr. Woodward found the question moot, as appellant did not have tarsal tunnel syndrome and as there was no neurological diagnosis or neurological gait disorder that could be identified either from his examination or from his review of the records. "I would point out the obvious: patients with plantar fasciitis or a similar foot problem will have an antalgic gait because it hurts to bear weight on the area affected in the foot."

[1] Appellant suffered upper back strains in the performance of duty in 1982 (OWCP File No. xxxxxx293) and 1984 (OWCP File No. xxxxxx528).

[2] Dr. Bennett I. Machanic, the attending neurologist, concluded that appellant developed tarsal tunnel syndrome as a consequence of back pain and abnormal gait. Dr. John D. Douthit, an Office referral orthopedic surgeon, found no physical findings that would lead one to suspect a tarsal tunnel syndrome or nerve entrapment of the posterior tibial nerve. He found that the foot pain, localized to the plantar fascia, was not related to work or an abnormal gait but to aging and an inherent pronation of appellant's foot. Dr. Alan Ng, a podiatrist and consultant to Dr. Machanic, noted a positive nerve conduction study and positive neurologic examination and diagnosed tarsal tunnel syndrome.

[3] The main statement of accepted facts is undated but appears, based on the dates appearing therein, to have been prepared some time after the middle of May 2007. The addendum is dated July 23, 2008.

In addressing questions posed by the Office, Dr. Woodward advised that appellant did not have clinical tarsal tunnel syndrome and that appellant's foot pain was not related to his January 10, 1987 injury or to an abnormal gait.

On March 12, 2009 the Office denied appellant's consequential injury claim. It found that the weight of the medical evidence rested with the opinion of Dr. Woodward, the impartial medical specialist.

The Office received an April 15, 2009 EMG and nerve conduction study report from Dr. Machanic, the attending neurologist, who reported that the there was a persistence of pathology at the flexor retinaculum both on the right and left, "and this would clinically correlate with tarsal tunnel syndrome."

On July 9, 2009 Dr. Ng, the podiatric consultant, indicated that he had reviewed Dr. Woodward's report. He stated that appellant still had symptoms of tarsal tunnel syndrome, as well as plantar fasciitis. "There was a positive EMG report previously that showed a positive tarsal tunnel, which Dr. Woodward contradicted." Dr. Ng described his findings on physical examination and concluded, based on the clinical evaluation and previous results, that appellant still had tarsal tunnel syndrome, which was also contributing to plantar fasciitis symptoms. "At this point in time, I still assume and notice that he has a tarsal tunnel syndrome. To make sure of this, we will take him down to surgical intervention and secondary EMG, neutral party may be warranted."

On August 27, 2009 an Office hearing representative affirmed the denial of appellant's consequential injury claim. The hearing representative noted that Dr. Machanic's EMG report did not materially alter Dr. Woodward's opinion, "as he was previously able to review similar testing and found it, in light of his own neurological testing, to not be dispositive on the issue of the existence of [tarsal tunnel] syndrome."

On appeal, appellant's representative contends that the statement of accepted facts was flawed in failing to disclose the accepted surgery and recurrences and in misstating the effect of pain in a compensation case. He added that the hearing representative ignored Dr. Ng's latest report and did not have the expertise to discount Dr. Machanic's new EMG report.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of his duty.[4] It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent, intervening cause attributable to the employee's own intentional conduct.[5]

[4] 5 U.S.C. § 8102(a).

[5] *John R. Knox*, 42 ECAB 193 (1990); *Lee A. Holle*, 7 ECAB 448 (1955).

Causal relationship is a medical issue[6] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[7] must be one of reasonable medical certainty,[8] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[9]

The burden is upon the employee to establish by evidence that he is entitled to compensation.[10]

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 there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12]

When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist.[13]

ANALYSIS

To resolve the conflict in medical opinion on whether appellant developed tarsal tunnel syndrome as a consequence of his January 10, 1987 employment injury, the Office properly referred appellant, under section 8123 of the Act, to Dr. Woodward, a Board-certified neurologist, who determined that appellant did not have tarsal tunnel syndrome, as a consequence of his antalgic gait or otherwise.

The Office provided Dr. Woodward with a statement of accepted facts, which properly advised that the Office accepted appellant's claim for lumbosacral strain and aggravation of

[6] *Mary J. Briggs*, 37 ECAB 578 (1986).

[7] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[8] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[9] *See William E. Enright*, 31 ECAB 426, 430 (1980).

[10] *Harold Hendrix*, 1 ECAB 54 (1947).

[11] 5 U.S.C. § 8123(a).

[12] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[13] *Nathan L. Harrell*, 41 ECAB 402 (1990).

degenerative disc disease. It noted that on May 12, 1998 appellant underwent surgery, a semi-hemilaminectomy with disc excision at L5-S1 on the left, and it noted that the Office issued a schedule award in 2005 for a seven percent impairment of the left lower extremity stemming from the back.

Dr. Woodward obtained from appellant an extensive history covering the 1998 back surgery, the May 1, 2007 exacerbation of his low back pain and the June 2007 occurrence of foot symptoms. Dr. Woodward also had appellant's entire case record to review. He addressed the reports of Dr. Machanic, Dr. Douthit and Dr. Ng, as well as the results of diagnostic tests and the notes of other physicians and field nurses. Dr. Woodward further reviewed the medical record. The Board finds that Dr. Woodward based his opinion on a proper factual and medical history. Dr. Woodward had before him all of the evidence that was available, and his review of that evidence was comprehensive.

After conducting a thorough physical examination and obtaining nerve conduction studies, Dr. Woodward determined that appellant did not have tarsal tunnel syndrome. He reasoned that appellant's symptoms, from the history provided and as reflected in the medical record, were not consistent with clinical tarsal tunnel syndrome. Appellant's description of pain predominantly on the ball of the foot, with tenderness there that reproduced the pain, was not consistent with tarsal tunnel syndrome, nor was the numbness identified in appellant's right foot and foreleg compatible with tarsal tunnel syndrome or a plantar neuropathy. Also, the nerve conduction study Dr. Woodward obtained showed normal plantar motor latencies. Dr. Woodward added that Dr. Machanic's EMG, which demonstrated some denervation of the foot intrinsics, was not, in the absence of other nerve conduction or clinical findings, diagnostic for tarsal tunnel syndrome because such denervation was commonly identified on EMGs. Dr. Woodward did not deny that appellant had foot pain. He allowed that plantar fasciitis was a possible diagnosis. But as a neurologist, he was able to rule out tarsal tunnel syndrome, as a consequence of appellant's antalgic gait or otherwise.

The Board finds that Dr. Woodward's opinion is well rationalized. Dr. Woodward well explained how symptomatology, clinical findings and diagnostic testing allowed no diagnosis of tarsal tunnel syndrome. Because his opinion was well rationalized and based on a proper factual and medical background, the Office properly found that it was entitled to special weight in resolving the conflict on the issue of consequential tarsal tunnel syndrome.

After the Office denied appellant's consequential injury claim on March 12, 2009, it received additional relevant evidence, including an April 15, 2009 EMG and nerve conduction study report from Dr. Machanic who concluded that the findings clinically correlated with tarsal tunnel syndrome. In a July 9, 2009 report, Dr. Ng examined appellant and concluded that he still had tarsal tunnel syndrome, which was also contributing to symptoms of plantar fasciitis.

The Board will therefore set aside the hearing representative's August 27, 2009 decision affirming the denial of appellant's consequential injury claim and will remand the case for further development. Dr. Woodward should be asked to review this additional evidence and submit a well-reasoned supplemental report explaining whether it affects the opinion he provided on February 2, 2009. After such further development of the evidence as may become necessary, the Office shall issue an appropriate final decision on appellant's consequential injury claim.

Appellant's representative argues that the hearing representative ignored Dr. Ng's latest report and improperly discounted Dr. Machanic's latest EMG. As noted, the case is remanded for Dr. Woodard to address this evidence. The Board does not find that the statement of accepted facts was flawed. The statement of accepted facts properly disclosed the May 12, 1998 semihemilaminectomy with disc excision at L5-S1 on the left. The statement did not disclose the accepted recurrence on May 1, 2007, but the Board finds no prejudice to Dr. Woodward in that omission. Dr. Woodward was well aware of appellant's exacerbation of low back pain in May 2007. He discussed the exacerbation in his report. Whether the Office found that appellant was administratively entitled to compensation for that exacerbation was immaterial to the medical issue before Dr. Woodward.

Appellant's representative noted that pain due to an employment-related condition can be the basis for the payment of compensation for disability,[14] but the operative phrase is "due to an employment-related condition." A conflict arose on whether appellant's employment-related condition -- lumbosacral strain, aggravation of degenerative disc disease and the May 12, 1998 back surgery -- caused tarsal tunnel syndrome. Dr. Woodward, the impartial medical specialist, addresses that issue and will be asked to address whether the evidence submitted after the denial of appellant's claim alters his opinion.

CONCLUSION

The Board finds that this case is not in posture for decision. A supplemental report from the impartial medical specialist is warranted.[15]

[14] *Barry C. Peterson*, 52 ECAB 120 (2000).

ORDER

IT IS HEREBY ORDERED THAT the August 27, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: October 6, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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