**United States Department of Labor**
**Employees' Compensation Appeals Board**

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| **E.S., Appellant** | ) | |
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| **and** | ) | **Docket No. 15-0259** |
| | ) | **Issued: November 3, 2015** |
| **DEPARTMENT OF THE ARMY, U.S. ARMY PACIFIC, Fort Shafter, HI, Employer** | ) | |

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

*Case Submitted on the Record*

# DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

## *JURISDICTION*

On November 14, 2014 appellant filed a timely appeal from June 5, July 17, and October 28, 2014 merit decisions 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 merits of this case.

## *ISSUES*

The issues are: (1) whether appellant met his burden of proof to establish work-related medical conditions other than those already accepted; and (2) whether OWCP abused its discretion by denying appellant's request for authorization of foot therapy beginning January 1, 2013.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On May 5, 1989 appellant, then a 28-year-old tools and parts attendant, filed an occupational disease claim (Form CA-2) alleging that he developed bilateral plantar fasciitis and heel spur syndrome due to performing his work duties over time. His duties required standing for prolonged periods each workday.[2] Appellant first became aware of his claimed condition in February 1979 and first realized in July 1987 that it was caused or aggravated by his employment. He stopped work on December 17, 1988 and OWCP initially accepted his claim for temporary aggravation of bilateral *pes planus* (flat feet) and bilateral plantar fasciitis. Appellant returned to work on April 19, 1989 in a light-duty position for the employing establishment. He stopped work again on April 3, 1990 and was placed on the daily compensation rolls effective that date.[3]

By decision dated September 3, 1992, OWCP terminated appellant's wage-loss compensation and medical benefits effective September 20, 1992 because the opinion of Dr. Edward Gunderson, a Board-certified orthopedic surgeon serving as an OWCP referral physician, showed that he ceased to have residuals of his work injuries after that date.

Appellant was examined on December 12, 2008 by Dr. Marc A. Katz, a podiatrist serving as an impartial medical specialist.[4] Dr. Katz diagnosed plantar fasciitis, *pes* planovalgus, and tarsal tunnel syndrome. He found that appellant sustained a permanent aggravation of his underlying bilateral foot condition due to his work duties and that this continuing condition disabled him from work.

OWCP reinstated benefits and retroactively paid appellant disability compensation beginning September 20, 1992. It upgraded the accepted conditions to include permanent aggravation of bilateral *pes planus* (flat feet) and bilateral plantar fibromatosis.

Between 2010 and 2012, OWCP authorized physical therapy treatment for appellant's feet, including manual therapy. The record reveals that manual therapy techniques consisted of, but were not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage.

Appellant received treatment for his foot problems from Dr. Gary Goodman, an attending podiatrist. In a January 3, 2012 report, Dr. Goodman stated that he had been treating appellant for two years and that he had *pes planus* valgus feet and chronic bilateral plantar fasciitis which did not show marked inflammation on magnetic resonance imaging (MRI) scan testing.

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[2] Appellant's job duties included receiving and storing lawn movers, seed fertilizer, shovels, and other hardware items at a self-help store in Fort Shafter. He occasionally drove a forklift to move heavy items. In June 1981 appellant received 10 percent disability rating from the Department of Veterans Affairs for service-connected *pes planus* and, in August 1986, the disability rating was raised to 50 percent.

[3] Appellant was later placed on the periodic compensation rolls.

[4] OWCP determined that there was a conflict in the medical opinion evidence regarding appellant's work-related residuals between Dr. Gunderson and Dr. Michael K. Lee, an attending podiatrist.

Sally Marlowe, an attending nurse practitioner, indicated in an April 11, 2012 report, that appellant had received manual therapy at the Southeast Regional Arthritis Center two times per week for almost a year. She stated that this treatment included use of a Hivamat deep oscillation machine on appellant's feet.[5] Ms. Marlowe noted that there was no real cure for appellant's foot condition, but that the treatment kept his pain level even.

In a June 21, 2012 report, Dr. Goodman noted that he had referred appellant to Ms. Marlowe for foot therapy and that appellant had reported that the therapy had helped on a short-term basis. He indicated that Ms. Marlowe's treatment was the only known modality to give appellant any relief from foot pain.

On August 15, 2012 Dr. Goodman responded to an OWCP request for additional information about appellant's need for therapy services.[6] He indicated that the goal of the therapy was to reduce pain and improve functional capabilities and noted that, after some therapy sessions, appellant had reported at least a couple of days of being able to walk a little bit better. Dr. Goodman recommended continuation of therapy for as long as is necessary.[7] On October 29, 2012 he indicated that appellant's "only positive finding" was Ms. Marlowe's treatment and he recommended that the treatment be continued.

Appellant next underwent evaluation by Dr. Lawrence A. DiDomenico, an attending podiatrist. Dr. DiDomenico reported the findings of his November 20, 2012 examination and concluded that appellant had a "more permanent than temporary" aggravation of his underlying bilateral *pes planus*. He indicated that appellant also had diabetic peripheral neuropathy, tarsal tunnel syndrome, and entrapment neuropathy located at the tarsal tunnel bilaterally, deep peroneal nerve bilaterally, deep peroneal nerve distally on the right, superficial peroneal nerve on the right, and common peroneal nerve bilaterally.

In early 2013, appellant submitted a request to OWCP for authorization of manual foot therapy for the period January 1 to December 31, 2013. He requested that the therapy include use of a Hivamat machine.[8]

In a February 13, 2013 report, Dr. Peter M. Mason, a podiatrist serving as an OWCP referral physician, noted that appellant reported that his foot pain went from 10 to 7 on a 1/10 scale after Ms. Marlowe applied Hivamat machine treatment. He diagnosed plantar fasciitis, pes planus, severe biomechanical pathology secondary to tibia vara and pronation, and neuropathy with loss of sensation.

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[5] The Hivamat machine applies vibrations to muscles and is designed to reduce edema and improve blood circulation.

[6] In a May 23, 2012 letter, OWCP requested that appellant submit medical evidence regarding his request for therapy which detailed the specific functional deficits to be treated, the specific goals of the therapy, and the expected duration and frequency of treatment.

[7] In reports dated November 16, 2012 and January 3, 2012, Dr. Goodman indicated that Ms. Marlowe had been providing therapy treatment which seemed to be helpful for short periods.

[8] Appellant continued to submit requests for authorization of manual therapy for periods continuing after December 31, 2013.

By decision dated March 14, 2013, OWCP denied appellant's request for authorization of manual foot therapy. It noted that, although appellant's medical providers recommended palliative treatment of a chronic condition, OWCP had broad discretion regarding authorization of long periods of physical therapy for such palliative purposes.

Appellant requested a telephonic hearing with an OWCP hearing representative. During the hearing held on August 14, 2013, appellant's counsel at the time argued that the reports of attending physicians showed that continued therapy would be helpful in treating appellant's foot condition.

In a November 1, 2013 decision, an OWCP hearing representative affirmed OWCP's March 14, 2013 decision denying appellant's request for authorization of manual foot therapy. She indicated that the medical evidence revealed that there had been no change in appellant's foot condition and that continued therapy would not likely cure or provide lasting relief for the accepted work injury.

In a January 15, 2013 report received in December 2013, Dr. Tatiana Wellens, an attending podiatrist, diagnosed appellant with bilateral flat foot, plantar fasciitis, tarsal tunnel syndrome, and "other specified idiopathic peripheral neuropathy." Under the treatment section of her report, she indicated that appellant was given instructions on stretching and icing and advised regarding supportive shoe gear. Dr. Wellens recommended that appellant undergo bilateral tarsal tunnel release.

In a September 10, 2013 report, Dr. Samy F. Bishai, an attending Board-certified orthopedic surgeon, stated that appellant should undergo an aggressive program of physical therapy treatment to give him relief from foot pain and improve the quality of his life.

Appellant also received periodic treatment in early 2014 from Dr. Robert R. Reppy, an attending osteopath. In a report dated January 14, 2014, Dr. Reppy stated that appellant needed an aggressive program of physical therapy from Ms. Marlowe.[9] He diagnosed multiple bilateral foot conditions, including severe planovalgus, chronic plantar fasciitis, tarsal tunnel syndrome, peripheral neuropathy, common peroneal nerve entrapment, lateral plantar nerve entrapment, and superficial peroneal nerve entrapment.

In a report dated May 15, 2014, Dr. Eduardo L. Gonzalez, an attending family practitioner, stated that it was medically necessary that appellant continue with foot therapy, including use of a transcutaneous electrical nerve stimulation (TENS) unit.

On May 27, 2014 Dr. Earl Taitt, Jr., a Board-certified psychiatrist serving as an OWCP referral physician, stated that appellant had a mood disorder due to chronic bilateral foot pain with major depressive-like episode. He also diagnosed chronic post-traumatic stress disorder but he did not provide an opinion on the cause of this condition.

[9] In a February 18, 2014 report, Dr. Reppy noted that appellant reported that he had been treated for two years with a Hivamat machine by Ms. Marlowe which had reduced his foot pain from 9 to 7 on a 1 to 10 scale.

In a June 5, 2014 decision, OWCP affirmed its November 1, 2013 decision denying appellant's request for authorization of manual foot therapy. It found that a rationalized medical opinion had not been submitted to show that additional therapy was needed due to work-related conditions.

On June 12, 2014 appellant claimed that he sustained work-related foot conditions in addition to those already accepted by OWCP, including lateral plantar nerve entrapment, superficial peroneal nerve entrapment, common peroneal nerve entrapment, calcaneal spurs, peripheral neuropathy, and diabetic neuropathy.

By decision dated July 17, 2014, OWCP upgraded the accepted conditions to include bilateral tarsal tunnel syndrome. It found that appellant had not met his burden of proof to establish any additional work-related conditions, including lateral plantar nerve entrapment, superficial peroneal nerve entrapment, common peroneal nerve entrapment, calcaneal spurs, peripheral neuropathy, or diabetic neuropathy.

In a July 31, 2014 report, Dr. Walter Afield, an attending Board-certified psychiatrist and neurologist, indicated that use of a Hivamat machine was the only treatment that provided appellant with relief from his work-related foot pain and noted that it took his pain from 9 to 7 on a 1 to 10 scale. He recommended that appellant continue therapy treatment with the Hivamat machine.

In an August 13, 2014 report, Dr. Goodman stated that appellant reported that the pain of his fasciitis was relieved by a minimum of 40 percent following sustained therapy treatments.[10] On September 9, 2014 Dr. Reppy indicated that he was encouraging appellant to attend physical therapy sessions for his feet.

In a September 9, 2014 report, Dr. Afield noted that appellant complained of personal problems and chronic pain in his feet. He diagnosed recurrent major repressive illness (moderate) and generalized anxiety disorder.

OWCP upgraded the accepted conditions to include work-related mood disorder due to chronic bilateral foot pain with major depressive-like episode.

OWCP requested that Dr. Howard Hogshead, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, provide an opinion on appellant's request for foot surgery due to his accepted work conditions. On September 12, 2014 Dr. Hogshead noted that the Hivamat machine is a tool that is supposed to introduce tissue vibrations thereby reducing edema and promoting continued local circulation. He stated, "Less exotic methods such as massage are available at less expense. Continued treatment with this device cannot be approved."

In an October 28, 2014 decision, OWCP affirmed its June 5, 2014 decision denying appellant's request for authorization of foot therapy.

[10] Dr. Goodman completed a prescription for a Hivamat machine and a TENS unit on July 2, 2014.

## ***LEGAL PRECEDENT -- ISSUE 1***

An employee seeking benefits under FECA 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 timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any specific condition for which compensation is claimed is causally related to the employment injury.[11] The medical evidence required to establish a causal relationship between a claimed specific condition and an employment injury is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[12]

## ***ANALYSIS -- ISSUE 1***

OWCP accepted appellant's case for permanent aggravation of bilateral *pes planus* (flat feet) and bilateral plantar fibromatosis;[13] bilateral tarsal tunnel syndrome; and mood disorder due to chronic bilateral foot pain with major depressive-like episode. Appellant alleged that he sustained a number of other work-related conditions. In a July 17, 2014 decision, OWCP determined that he did not meet his burden of proof to establish work-related medical conditions other than those already accepted.[14]

The Board finds that appellant did not establish work-related medical conditions other than those already accepted.

On appeal, appellant stated that several physicians diagnosed foot conditions, including tibial and peroneal nerve disorders, that had not been accepted by OWCP and he claimed that these conditions were also employment related. The record does contain a number of reports in which additional foot conditions were in fact diagnosed. For example, in a November 20, 2012 report, Dr. DiDomenico, an attending podiatrist, diagnosed diabetic peripheral neuropathy, and entrapment neuropathy located at the deep peroneal nerve bilaterally, deep peroneal nerve distally on the right, superficial peroneal nerve on the right, and common peroneal nerve bilaterally. In a January 15, 2013 report, Dr. Wellens, an attending podiatrist, diagnosed "other specified idiopathic peripheral neuropathy." On February 13, 2013 Dr. Mason, a podiatrist serving as an OWCP referral physician, diagnosed severe biomechanical pathology secondary to tibia vara and pronation, and neuropathy with loss of sensation. In a report dated January 14,

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[11] *J.F.*, Docket No. 09-1061 (issued November 17, 2009).

[12] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

[13] OWCP initially accepted temporary aggravation of bilateral *pes planus* (flat feet) and bilateral plantar fasciitis. Plantar fibromatosis is a form of plantar fasciitis.

[14] OWCP noted that appellant had not met his burden of proof to establish any additional work-related conditions, including lateral plantar nerve entrapment, superficial peroneal nerve entrapment, common peroneal nerve entrapment, calcaneal spurs, peripheral neuropathy, or diabetic neuropathy.

2014, Dr. Reppy, an attending osteopath, diagnosed peripheral neuropathy, common peroneal nerve entrapment, lateral plantar nerve entrapment, and superficial peroneal nerve entrapment.

The Board finds, however, that appellant did not meet his burden of proof to establish work-related medical conditions other than those already accepted because none of these medical reports contain a rationalized opinion that he has work-related foot conditions beyond those already accepted. The Board has held that 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.[15]

On appeal, appellant also alleged that he sustained a more serious consequential emotional condition than had been accepted by OWCP. He argued that the opinion of Dr. Taitt, a Board-certified psychiatrist serving as an OWCP referral physician, justified the acceptance of post-traumatic stress syndrome. The Board notes that, in a May 27, 2014 report, Dr. Taitt diagnosed chronic post-traumatic stress disorder. However, Dr. Taitt did not provide an opinion on the cause of this condition and the record contains no basis to upgrade appellant's accepted consequential emotional 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.

## ***LEGAL PRECEDENT -- ISSUE 2***

Section 8103(a) of FECA states in pertinent part: "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 Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation."[16]

The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[17] The only limitation on OWCP's authority is that of reasonableness.[18] 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.[19]

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[15] *See Charles H. Tomaszewski*, 39 ECAB 461 (1988).

[16] 5 U.S.C. § 8103.

[17] *Vicky C. Randall*, 51 ECAB 357 (2000).

[18] *Lecil E. Stevens*, 49 ECAB 673 (1998).

[19] *Rosa Lee Jones,* 36 ECAB 679 (1985).

In order to be entitled to reimbursement of medical expenses, it must be shown that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.[20] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[21]

Section 8123(a) of FECA provides in pertinent part: "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."[22] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[23] In situations where 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.[24]

## ***ANALYSIS -- ISSUE 2***

Between 2010 and 2012, OWCP did authorize physical therapy treatment for appellant's feet, including manual therapy. Appellant requested authorization of manual foot therapy, including use a Hivamat deep oscillation machine, for the period beginning January 1, 2013 continuing. OWCP denied appellant's request, indicating that a rationalized medical opinion had not been submitted to show that additional therapy was needed due to work-related conditions.

The Board finds that there is a conflict in the medical opinion evidence regarding appellant's need for foot therapy due to his accepted foot conditions.

In multiple reports dated beginning in late 2012, Dr. Goodman, an attending podiatrist, recommended that appellant continue with manual foot therapy, including use of a Hivamat machine, in order to treat and provide pain relief from his accepted work-related foot conditions.[25] In several reports completed in 2013 and 2014, he noted that foot therapy helped provide relief to appellant from work-related pain and also seemed to improve his functional capacity to walk. For example, on August 15, 2012, Dr. Goodman noted that appellant reported at least a couple of days of being able to walk a little bit better after foot therapy. He recommended continuation of therapy for as long as is necessary. In an August 13, 2014 report, Dr. Goodman stated that appellant reported that the pain of his fasciitis was relieved by a

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[20] *Bertha L. Arnold*, 38 ECAB 282 (1986).

[21] *Zane H. Cassell*, 32 ECAB 1537 (1981); *John E. Benton*, 15 ECAB 48 (1963).

[22] 5 U.S.C. § 8123(a).

[23] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[24] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[25] Dr. Goodman completed a prescription for a Hivamat machine and a TENS unit on July 2, 2014.

minimum of 40 percent following sustained therapy treatments.[26] In a report dated January 14, 2014, Dr. Reppy, an attending osteopath, stated that appellant needed to continue with an aggressive program of physical therapy using the Hivamat machine.[27] On May 15, 2014 Dr. Gonzalez, an attending family practitioner, noted that it was medically necessary that appellant continue with foot therapy, including use of a TENS unit. In a July 31, 2014 report, Dr. Afield, an attending Board-certified psychiatrist and neurologist, indicated that use of a Hivamat machine was the only treatment that provided appellant with relief from his work-related foot pain and noted that it took his pain from 9 to 7 on a 1 to 10 scale. He recommended that appellant continue therapy treatment with the Hivamat machine.

In contrast, an OWCP physician recommended against continuation of authorization of foot therapy, including the use of a Hivamat machine. Dr. Hogshead, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, noted on September 12, 2014 that the Hivamat machine was a tool that is supposed to introduce tissue vibrations thereby reducing edema and promoting continued local circulation. He stated, "Less exotic methods such as massage are available at less expense. Continued treatment with this device cannot be approved."

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence between appellant's attending physicians and the OWCP physician, Dr. Hogshead, pursuant to 5 U.S.C. § 8123(a), regarding appellant's need for foot therapy and use of the Hivamat machine due to his accepted foot conditions. On remand OWCP should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After carrying out this development, OWCP should issue a *de novo* decision regarding appellant's claim for authorization of foot therapy beginning January 1, 2013.

## ***CONCLUSION***

The Board finds that appellant did not meet his burden of proof to establish work-related medical conditions other than those already accepted. The Board further finds that the case is not in posture for decision regarding whether OWCP abused its discretion by denying appellant's request for authorization of foot therapy beginning January 1, 2013.

[26] Although Dr. Goodman acknowledged that appellant's relief from pain was temporary, he repeatedly indicated that foot therapy, including use of a Hivamat machine, was the only modality which seemed to help in the treatment of appellant's accepted foot conditions.

[27] In a February 18, 2014 report, Dr. Reppy noted that appellant reported that he had been treated for two years with a Hivamat machine which had reduced his foot pain from 9 to 7 on a 1 to 10 scale.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the July 17, 2014 decision of the Office of Workers' Compensation Programs, regarding the denial of additional accepted conditions, is affirmed. The October 28 and June 5, 2014 decisions of OWCP, regarding the denial of additional medical treatment, are set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: November 3, 2015
Washington, DC

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

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

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