United States Department of Labor
Employees' Compensation Appeals Board

P.C., Appellant	)	
and	)	**Docket No. 15-1013**
	)	**Issued: June 15, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Texarkana, TX, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 31, 2015 appellant, through counsel, filed a timely appeal from a February 3, 2015 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 merits of this case.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish an aggravation of an underlying medical condition; and (2) whether appellant established a recurrence of total disability on November 19, 2010 causally related to his accepted employment injuries.

On appeal, counsel asserts that the February 3, 2015 decision is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 13, 2008 appellant, then a 57-year-old mail handler/Mark II operator, filed an occupational disease claim (Form CA-2) alleging that his employment duties caused degenerative joint disease of both feet and hallux valgus (a bunion deformity) on the right. The claim was adjudicated by OWCP under File No. xxxxxx990.

Medical evidence submitted in support of this claim included December 13, 2007 x-rays of the right and left foot that showed bilateral mild degenerative joint disease. On March 11, 2008 Dr. Laurence E. Welker, a podiatrist at the Department of Veterans Affairs (VA), noted treating appellant every three months since 2002 for severe plantar keratosis on the entire soles of both feet, onychomycosis (nail fungus) of all toenails and bilateral degenerative joint disease in the feet. He advised that all conditions resulted in extreme discomfort and extended periods of weight bearing would exacerbate the conditions.

In a March 11, 2008 report, Dr. Austin S. Reeves, a podiatrist, reported that a service-related immersion injury left appellant with a disability of chronic waxy hyperkeratotic skin that covered the entire plantar aspect of both feet. He noted that appellant was treated with periodic debridement of the hyperkeratosis in an attempt to decrease pressure and thus decrease pain so that he could ambulate with less discomfort. Dr. Reeves opined that appellant's job duties that required continuous standing had aggravated the condition over the years to a point now where he was in a state of chronic pain, noting that standing for any period of time caused discomfort such that he could no longer perform his job duties. He submitted treatment notes dated August 4, 2008 to January 21, 2008.

Dr. Andrea L. York, a VA attending Board-certified family physician, noted examining appellant on February 23, 2008 for chronic foot pain which was painful with weight bearing on examination. She reported foot x-ray findings of degenerative joint disease which was likely caused by his 30-year history of standing on his feet all day at work.

OWCP accepted the claim for hallux valgus (acquired), bilateral, on March 31, 2008. Appellant continued to work regular duty. On August 21, 2009 he filed a schedule award claim (Form CA-7).

On November 28, 2009 appellant filed a second occupational disease claim, alleging that he had developed bilateral ankle conditions due to employment activities. This claim was adjudicated by OWCP under File No. xxxxxx687.

In a July 7, 2009 report, Dr. Roshan Sharma, a Board-certified physiatrist, noted appellant's complaints of foot pain. She reported that his work involved standing on his feet. Examination of both feet demonstrated that appellant had flat feet with bilateral hallux valgus, more prominent on the right, and severe hyperkeratotic thickening of the plantar fascia. On August 17, 2009 Dr. Sharma noted that constant standing on a floor caused degenerative arthritis of feet and severe hyperkeratotic plantar lesions. She checked a form box "yes," indicating that her diagnoses were caused or aggravated by employment activity. Right and left ankle x-rays on September 24, 2009 demonstrated bilateral superior medial talar dome defect that could be

osteochondritis dissecans.[2] On November 10, 2009 Dr. Sharma reiterated her conclusions and advised that appellant had 15 percent whole person impairment.

On November 30 and December 17, 2009 Dr. Reeves, noted appellant's complaint of ankle pain at work where his job duties included standing, walking, and running machinery. He described the ankle x-ray findings and advised that appellant's work could have contributed because he stood on hard surfaces at work for a long period of time.

In December 2009, OWCP referred appellant to Dr. Austin Gleason, a Board-certified orthopedic surgeon, for an impairment evaluation.[3] In a January 12, 2010 report, Dr. Gleason provided examination findings and diagnosed bilateral "rocker bottom" foot with moderate degenerative arthritis in mid and hind-foot.

On February 1, 2010 OWCP accepted the File No. xxxxxx687 claim for other disorders of joint, ankle, and foot, bilateral. The claims were combined in March 2010.

On March 4, 2010 the VA informed appellant that he had a combined service-connected disability rating of 70 percent, 50 percent of which was due to dermatophytosis (a fungal condition) with flattened arches of feet, 30 percent due to dermatophytosis of hands, and 10 percent due to hypertensive heart disease, and 10 percent due to hypertension.[4]

On February 18, 2011 appellant filed a recurrence claim under File No. xxxxxx687. He stated that his condition worsened to where he could no longer bear weight or perform his job duties. Appellant stopped work on November 19, 2010. By letter dated March 1, 2011, OWCP informed him of the evidence needed to support his recurrence claim.

In an undated statement appellant related that his physician put him on medical leave on November 19, 2010 due to his bilateral ankle and foot disorders, and this was continued by the doctor in February 2011. He reported that his job duties required constant walking, standing, and lifting for eight hours daily on concrete, and this caused pain.

Medical evidence submitted included April 22, 2010 magnetic resonance imaging (MRI) scans of the right and left foot that were suspicious for osteochondritis dissecans. An August 14, 2010 x-ray of the right tibia/fibula demonstrated mild osteoarthritis of the knee and ankle. A left tibia/fibula x-ray that day demonstrated mild osteoarthritis of the ankle. Additional x-rays that

[2] Osteochondritis dissecans is defined as inflammation of both bone and cartilage resulting in the splitting of pieces of cartilage into the joint. *Dorland's Illustrated Medical Dictionary* (29th ed. 2000).

[3] On March 12, 2010 appellant was granted a schedule award for eight percent impairment of the right lower extremity and eight percent impairment on the left. The award was for 46.08 weeks and was to run from January 12 to November 30, 2010. In a May 16, 2013 decision, appellant was granted schedule awards for an additional 5 percent impairment of the left leg and 5 percent impairment on the right, for a total 13 percent impairment of each leg. The award was for 28.8 weeks, to run from February 14 to September 3, 2013. Much of the claim development pertaining to permanent impairment is omitted from this decision as the issue of a schedule award is not before the Board on the present appeal.

[4] The record includes VA rating examinations and decisions dated from May 3, 1979 to August 19, 2003.

day of bilateral weight bearing feet showed tendency to pes planus (flat foot) and early osteoarthritis. Bilateral ankles had mild osteoarthritis.

In treatment notes from September 13 to October 20, 2010, Dr. Sharma noted treating appellant with therapy on both ankles. On November 19, 2010 Dr. York noted in her report that he was having more foot pain, exacerbated by standing on concrete at work. Appellant also reported increased stress and anxiety at work and wanted to take medical leave for three months and then retire. Dr. York provided examination findings and diagnosed foot degenerative joint disease, chronic foot pain, depression, anxiety disorder, and chronic back pain. She completed a request for three months medical leave and recommended a return in February 2011 to assess appellant's work status.

Dr. Welker completed a December 2, 2010 treatment note in which he noted appellant's complaint of bilateral foot pain. He diagnosed onychocryptosis (in-grown toenail), onychomycosis (nail fungus), and keratosis (callus formation). On February 11, 2011 Dr. York noted that appellant continued to report foot pain, he felt he was unable to return to work, and he planned to retire on June 1, 2011. She diagnosed foot pain and ankle osteoarthritis, advised that he was unable to stand for long periods due to pain, and could not work for the period November 19, 2010 to May 31, 2011 due to his medical condition. Dr. York completed an application for family medical leave. On March 3, 2011 Dr. Welker reiterated his diagnoses. In an April 4, 2011 attending physician's report, Dr. Sharma diagnosed ankle pain and osteoarthritis caused by constant standing at work.[5]

Kathy Crank, customer service supervisor at the employing establishment, submitted information on February 11 and 28 and March 1 and 22, 2011. She reported that appellant had two claims and that during the period 2008 to 2010 he complained of foot pain and occasionally took sick leave. Ms. Crank related that on November 19, 2010 he submitted documentation for medical leave due to anxiety, depression, and foot disorder which indicated that he was unable to work from November 19, 2010 to May 31, 2011. She stated that appellant was working full duty when he stopped work on November 19, 2010.

By decision dated May 4, 2011, OWCP denied appellant's claim for a recurrence of disability on November 19, 2010. Appellant timely requested a review of the written record and submitted evidence previously of record or not relevant to the period of claimed disability. In an undated statement he alleged that his original injury was aggravated by prolonged standing, lifting, and walking which caused constant ankle pain such that he could not perform his job duties.

In May 26, 2011 reports, Dr. York noted appellant's complaint of chronic foot and ankle pain which she advised directly resulted from job duties. Appellant had painful ankle range of motion and pes planus. Dr. York diagnosed degenerative joint disease of the feet and ankles, depression, and hypertriglyceridemia. She advised that appellant could not be on his feet for more than five minutes at a time and could never return to work.

[5] Appellant also submitted several Form CA-7 claims for compensation.

On June 27, 2011 Dr. Reeves reported that appellant was diagnosed with osteochondritis. He related that appellant felt unable to work, stating that his foot condition was aggravated by job duties of prolonged standing, prolonged walking, stooping, and bending, *etc.*, which contributed to his foot pain.

On June 14, 2011 Ms. Crank related that appellant presented medical documentation stating that he could never return to regular or modified duty.

In a July 25, 2011 decision, an OWCP hearing representative remanded the case for OWCP to obtain a second opinion evaluation regarding whether appellant was disabled for any period after November 19, 2010 as a direct result of his employment-related injury.

OWCP referred appellant to Dr. Robert E. Holladay, IV, a Board-certified orthopedic surgeon, for a second opinion evaluation. He was provided a set of questions and a statement of accepted facts (SOAF) that described both File Nos. xxxxxx687 and xxxxxx990. It stated that File No. xxxxxx990 was accepted for bilateral acquired hallux valgus, and that File No. xxxxxx687 was accepted for bilateral disorders of joint, ankle and foot. The SOAF indicated that appellant's job duties required standing eight hours a day on cushioned mats provided by the employing establishment, and that he could sit down and rest as needed. It listed nonwork-related foot conditions of dermatophytosis, bilateral flatfoot, talar dome lesion/osteochondritis lesions, and bilateral degenerative joint disease of the feet.

In a September 13, 2011 report, Dr. Holladay noted his review of the medical record and appellant's complaint of chronic foot pain. He described examination findings and diagnosed dermatophytosis of feet, bilateral flat feet deformity, degenerative joint disease of both feet, and anxiety/depression. In answer to OWCP questions, Dr. Holladay noted that none of the diagnosed foot conditions had been accepted as employment related. He opined that the medical evidence did not support that appellant's current ankle or foot condition was due to work duties, including his arthritic condition. Dr. Holladay further advised that the osteochondritis dissecans seen on MRI scan was not directly related to a work event, noting that this would be due to a specific trauma with inversion of the right ankle and ankle sprain, which was not identified in the case record. He concluded that, based upon his review of the available medical records, clinical examination, and history, appellant's bilateral foot and ankle condition did not worsen to the point of total disability on November 19, 2010, finding that his current foot and ankle condition was more likely related to his underlying preexisting conditions and had no relationship to a specific work injury.

In a merit decision dated September 21, 2011, OWCP found the weight of the medical evidence rested with the opinion of OWCP referral physician Dr. Holladay and denied appellant's claim that he sustained a recurrence of disability on November 19, 2010.[6]

Appellant, through counsel, timely requested a hearing. Dr. Sharma submitted an attending physician's report on October 3, 2011 in which she reiterated that standing on concrete caused him chronic ankle and foot pain and arthritis.

[6] On September 19, 2011 appellant's retirement was approved.

On December 12, 2011 an OWCP hearing representative set aside the September 21, 2011 decision, finding that appellant did not establish a recurrence of disability. She remanded the case to OWCP to prepare a more complete SOAF and forward medical records from both File Nos. xxxxxx990 and xxxxxx687 to Dr. Holladay to address whether any work factors over appellant's course of employment contributed to the diagnosed foot and ankle conditions, and whether the evidence established that he was no longer able to perform his employment duties on November 19, 2010 due to a worsening of the conditions accepted under both claims or any other work-related condition.

On December 20, 2011 and January 5, 2012 OWCP requested that the employing establishment forward information regarding appellant's job duties.

On January 12, 2012 Ms. Crank forwarded a description of appellant's position, which he held for approximately 22 years.[7] She indicated that he worked at the employing establishment from June 1980 until he stopped on November 18, 2010 and then retired in July 2011. Ms. Crank stated that during the period 2008 to 2010 appellant was allowed to take breaks after he completed Mark II duties and before the end of his tour.

On March 5, 2012 appellant's VA disability rating was increased to 80 percent, 60 percent of which was due to dermatophytosis of hands, 50 percent due to with flattened arches of feet, 10 percent due to hypertensive heart disease, and 10 percent due to hypertension. By letter dated March 29, 2012, OWCP informed appellant that his claim had been reviewed in order to determine if a specific condition could be accepted as work related. He was informed that his claim had been updated to include: aggravation of osteochondritis dissecans, bilateral, ankle and foot.

In April 2012, OWCP again referred appellant to Dr. Holladay for a second opinion evaluation. The SOAF provided at this time was similar to that provided in 2011. The only significant difference in the two SOAFs was that the 2012 statement included the FECA definition for a recurrence of disability. Dr. Holladay was also provided definitions for precipitation, acceleration, and aggravation.

In a May 24, 2012 report, Dr. Holladay noted his review of the medical record for both claims, including his previous report, and a March 29, 2012 SOAF. He discussed both case records and the accepted conditions. Dr. Holladay provided physical examination findings and diagnosed dermatophytosis of the feet, bilateral flat foot deformities, bilateral acquired hallux valgus, and osteochondritis dissecans of both ankles. He explained that appellant had very mild hallux valgus with no severe bunion condition and no objective evidence of an ongoing active condition. Dr. Holladay further related that, although appellant had subjective pain complaints, there were no objective findings in the ankle joints to show that the osteochondritis dissecans was an ongoing, active condition. He noted that the dermatophytosis was service related and continued to be active and that this dermatological condition caused thickened calluses on the

[7] This indicated that appellant operated a Mark II machine which canceled mail by sending it onto a track with four bins. The operator would then pull the mail from the bins and place it into a two-foot tray. He would also clear jams and restart the machine. The physical requirements involved prolonged standing, walking, bending and reaching, and handling heavy containers up to 70 pounds.

plantar aspect of both feet. Dr. Holladay further noted that appellant additionally had flatfoot deformities that were service related. He opined that this condition continued to be present and was likely the origin of the appellant's ongoing complaints of pain. In a lengthy explanation, Dr. Holladay advised that the record contemporaneous with November 19, 2010 did not include objective evidence to support that the accepted conditions of bilateral hallux valgus and osteochondritis dissecans had progressed or showed clinical change such that they became totally disabling on that day or that appellant's work activities aggravated his service-related foot conditions such that on November 19, 2010 he was unable to work.

In a merit decision dated June 8, 2012, OWCP found the weight of the medical evidence rested with the opinion of Dr. Holladay and denied appellant's claim that he sustained a recurrence of disability on November 19, 2010. Appellant, through counsel, timely requested a hearing of the June 8, 2012 decision.

In a September 21, 2012 report, Dr. Welker advised that appellant had been his patient since 2002 with diagnoses of severe plantar keratosis involving the soles of both feet, onychomycosis of all toenails, and degenerative joint disease of both feet. He noted that appellant's work involved prolonged standing which worsened the painful keratosis. In a September 24, 2012 report, Dr. Reeves, an attending podiatrist, diagnosed dermatophytosis of the feet, bilateral flatfoot deformities, bilateral hallux valgus, and bilateral osteochondritis of the ankles. He noted that he had only treated appellant for severe dermatophytosis which created a severe hyperkeratotic film that spanned the entire plantar aspect of his feet that was deep and hardened and required periodic paring. Dr. Reeves opined that appellant's job duties, including increased standing, caused the hyperkeratosis to build up and increased osteochondritis pain.

A hearing was held on October 1, 2012 regarding appellant's recurrence claim. Appellant testified that he stopped work in November 2010 because his feet became worse.

In a November 28, 2012 decision, an OWCP hearing representative affirmed the June 8, 2012 decision finding that the weight of the medical evidence rested with Dr. Holladay's opinion.

On October 7, 2013 appellant, through counsel, requested reconsideration of the November 28, 2012 decision. He submitted a March 20, 2013 report in which Dr. Reeves, appellant's podiatrist, noted that he had treated appellant regularly since 2008 for a severe hyperkeratotic formation of the plantar aspect of both feet and that he also suffered from osteochondritis dissecans of both ankles. Dr. Reeves noted that appellant stopped work due to his foot and ankle ailments because job duties of standing and walking exacerbated both conditions.

In a merit decision dated May 29, 2014, OWCP denied appellant's claim that he sustained a recurrence of disability on November 19, 2010 or that the claim should be expanded to include aggravation of an underlying medical condition. Appellant thereafter appealed to the Board. By order dated October 31, 2014, the Board dismissed the appeal at appellant's request.[8]

[8] Docket No. 14-1806 (issued October 31, 2014).

Appellant again requested reconsideration with OWCP on November 5, 2014. He submitted a September 22, 2014 report in which Dr. Reeves noted that appellant's hyperkeratotic foot condition was aggravated by his job duties of walking and standing on a hard surface which stimulated his feet. Dr. Reeves described appellant's treatment and concluded that his work activity contributed to his eventual disability because it caused an exacerbation of his underlying pathology.

In a merit decision dated February 3, 2015, OWCP denied modification of the prior decisions, finding that appellant did not meet his burden of proof to establish a recurrence of disability on November 19, 2010 because the medical evidence did not establish that the accepted conditions had worsened or that his claim should be expanded to include an aggravation of an underlying medical condition.

LEGAL PRECEDENT -- ISSUE 1

A claimant seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[9]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[10] 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 employee.[11] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[12]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of direct and natural results and of claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[13]

[9] 20 C.F.R. § 10.115(e),(f); *see Jacquelyn L. Oliver*, 48 ECAB 232-36 (1996).

[10] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[11] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[12] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[13] Arthur Larson & Lex K. Larson, *The Law of Workers' Compensation* § 3.05 (2014); *see Charles W. Downey*, 54 ECAB 421 (2003).

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision as to whether appellant's preexisting foot conditions were aggravated by his work duties as a mail handler/Mark II operator. Appellant stopped work on November 19, 2010 and filed a recurrence claim.

The accepted conditions under OWCP File No. xxxxxx990 was bilateral hallux valgus (acquired). Under File No. xxxxxx687, the claim was accepted for other disorders of joint, ankle, and foot, bilateral; and aggravation of osteochondritis dissecans, ankle and foot, bilateral. The two claims were combined in March 2010. Appellant also had preexisting severe dermatophytosis of both feet and flattened arches that were service related and for which he received VA disability compensation. Other specific foot conditions not accepted included talar dome lesion/osteochondritis lesions, and bilateral degenerative joint disease of the feet.

As reported by the employing establishment, appellant began work there in 1980 and had been a Mark II machine operator for approximately 22 years when he stopped work in November 2010. The Mark II machine canceled mail by sending it onto a track with four bins. The operator would then pull the mail from the bins, place it into a two-foot tray, and would also clear jams and restart the machine. The physical requirements involved prolonged standing, walking, bending, reaching, and handling heavy containers weighing up to 70 pounds.[14]

In its February 3, 2015 decision, OWCP found that the weight of the medical evidence rested with Dr. Holladay who provided second opinion evaluations. The Board finds, however, that a conflict in the medical evidence exists with respect to whether any of appellant's diagnosed foot conditions were aggravated by his work duties.

As a preliminary matter, the Board finds that further definition is required regarding the accepted "other disorders of joint, ankle, and foot, bilateral." It is unclear exactly what conditions have been accepted, and because appellant has preexisting and service-related foot conditions, it is important that specific accepted conditions be defined.

Appellant submitted numerous reports from his doctors describing bilateral foot and ankle conditions. Dr. York, a VA family physician, advised on February 23, 2008 that appellant had foot x-ray findings of degenerative joint disease which were likely caused by his 30-year history of standing on his feet at work. In May 2011, she noted appellant's complaint of chronic foot and ankle pain, painful ankle range of motion, and pes planus. Dr. York advised that his foot and ankle conditions were a direct result of his job duties. She concluded that appellant could not be on his feet for more than five minutes at a time and could never return to work.

Dr. Sharma, an attending physiatrist, first advised in August 2009 that constant standing caused appellant's degenerative arthritis of the feet and severe hyperkeratotic plantar lesions. She reiterated this opinion on October 3, 2011.

Dr. Welker, an attending podiatrist, advised on September 21, 2012 that appellant had been his patient since 2002 with diagnoses of severe plantar keratosis involving the soles of both

[14] *Supra* note 7.

feet, onychomycosis of all toenails, and degenerative joint disease of both feet. He noted that appellant's work involved prolonged standing which worsened the painful keratosis.

Dr. Reeves, also an attending podiatrist, submitted reports dated June 27, 2011, September 24, 2012, March 20, 2013, and September 22, 2014. He reported that he had treated appellant regularly since 2008 and diagnosed dermatophytosis of the feet, bilateral flatfoot deformities, bilateral hallux valgus, and bilateral osteochondritis of both ankles. Dr. Reeves noted that appellant's severe dermatophytosis created a severe hyperkeratotic film that spanned the entire plantar aspect of his feet, was deep and hardened, and required periodic paring. He opined that appellant's job duties of prolonged standing, walking, stooping, and bending caused the hyperkeratosis to build up, and increased osteochondritis pain, which aggravated his underlying pathology and contributed to his eventual disability.

OWCP referred appellant to Dr. Holladay, a Board-certified orthopedic surgeon, in 2011 and 2012, and the physician provided reports on September 13, 2011 and May 24, 2012. In the 2011 report, Dr. Holladay diagnosed dermatophytosis of the feet, bilateral flat foot deformity, degenerative joint disease of both feet, and anxiety/depression. He noted that these were not accepted conditions. Dr. Holladay concluded that, based upon his review of the available medical records, clinical examination, and history, appellant's bilateral foot and ankle conditions did not worsen to the point of total disability on November 19, 2010, finding that his current foot and ankle conditions were more likely related to his underlying preexisting conditions and had no relationship to a specific work injury. In his May 24, 2012 report, Dr. Holladay discussed evidence from both case records. He additionally diagnosed bilateral acquired hallux valgus, and osteochondritis dissecans of both ankles. Dr. Holladay noted that the dermatophytosis was service related and continued to be active, and that this dermatological condition caused thickened calluses on the plantar aspect of both feet. He further noted that appellant additionally had flatfoot deformities that were service related. Dr. Holladay opined that this condition remained present and was likely the cause of appellant's ongoing pain complaints. He advised that the record contemporaneous with November 19, 2010 did not include objective evidence to support that the accepted conditions of bilateral hallux valgus and osteochondritis dissecans had progressed or showed clinical change such that they became totally disabling on that day or that his work activities aggravated his service-related foot conditions such that on November 19, 2010 he was unable to work.

If there is disagreement between a physician for OWCP and the employee's physician, OWCP will appoint a third physician who shall make an examination.[15] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[16] As noted above, compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury.[17]

[15] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[16] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[17] *Supra* note 12.

A number of appellant's physicians indicated that his keratotic foot condition that was service related was aggravated by his job duties that required constant standing. Of particular significance are the reports from June 2011 to September 2012 of Dr. Reeves, an attending podiatrist. He began treating appellant in 2008 and opined that his serious service-related condition was aggravated by prolonged standing at work which contributed to his eventual disability. Likewise, both Dr. Sharma and Dr. Weller advised that prolonged standing at work contributed to appellant's foot/ankle condition and disability. As noted above, the position appellant held for 22 years required prolonged standing.

Conversely, Dr. Holladay, an OWCP referral physician, while noting appellant's preexisting service-related conditions, advised in May 2012 that his work activities had not aggravated his service-related foot conditions such that on November 19, 2010 he was unable to work. The Board further notes that the SOAF provided to Dr. Holladay in his last examination on May 24, 2012, did not indicate that aggravation of osteochondritis dissecans, ankle and foot, bilateral, had been accepted. He clearly opined that there was no objective medical evidence to demonstrate ongoing progressive changes of this diagnosed condition or that it remained active.

The Board finds the opinions of appellant's physicians to be of equal weight with the opinion of Dr. Holladay as to whether appellant's service-related foot condition was aggravated by his work duties, especially prolonged standing, and, if so, whether he became disabled on November 19, 2010. The Board will set aside the February 3, 2015 decision and remand the case for OWCP to refer appellant to an appropriate impartial medical specialist to resolve the conflict.

On remand OWCP shall prepare an updated SOAF covering both File Nos. xxxxxx990 and xxxxxx687 with accurate accepted conditions listed under each file. The SOAF should include a description of appellant's specific job duties, including physical requirements. OWCP should then refer appellant, the case record, and the updated SOAF to an appropriate specialist, for review of the case record for both case File Nos. xxxxxx990 and xxxxxx687. The impartial specialist should be asked to provide a rationalized opinion as to whether appellant's job duties aggravated his preexisting service-related condition or any other preexisting foot or ankle condition and whether this caused a recurrence of disability on November 19, 2010. After this and such further development as it deems necessary, OWCP shall issue a *de novo* decision.[18]

In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.

[18] The Board notes that the record indicates that appellant's retirement was approved effective September 19, 2011 and that he is receiving VA disability benefits for his service-related foot conditions. Appellant has also received schedule award compensation for 13 percent impairment of each lower extremity. Section 8116 of FECA limits the right of an employee to receive compensation. While an employee is receiving compensation, he or she may not receive salary, pay, or remuneration of any type from the United States. This includes civilian retirement pay, and also when OWCP has found that a disability was sustained in civilian federal employment and VA has held that the same disability was caused by military service. 5 U.S.C. § 8116; *see* 20 C.F.R. § 10.421. When OWCP discovers concurrent receipt, it must declare an overpayment of compensation and give the usual due process rights. *L.J.*, 59 ECAB 264 (2007).

CONCLUSION

The Board finds that this case is not in posture for decision as to whether appellant's preexisting foot conditions were aggravated by his work duties as a mail handler/Mark II operator. A conflict in medical evidence has been created which requires further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the February 3, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: June 15, 2016
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