United States Department of Labor
Employees' Compensation Appeals Board

D.J., Appellant	)	
and	)	**Docket No. 16-0965**
	)	**Issued: October 5, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Bedford Park, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 6, 2016 appellant filed a timely appeal of a March 24, 2016 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.

ISSUE

The issue is whether appellant met her burden of proof to establish a traumatic injury causally related to a May 15, 2015 employment incident.

FACTUAL HISTORY

On June 5, 2015 appellant, then a 52-year-old city carrier assistant, filed a traumatic injury claim (Form CA-1) alleging that on May 15, 2015 she injured her left foot when she stepped on a rock, which caused a painful lump in her left foot, in the performance of duty. She

[1] 5 U.S.C. § 8101 *et seq.*

did not initially stop work. The employing establishment indicated that appellant "never mentioned walking on a rock prior to the initial reporting of the incident." It was noted that she "only mentioned from time to time that her foot was bothering her."

In a June 5, 2015 statement, appellant indicated that, on or around May 15, 2015, she was on her route when she stepped on a large rock. She advised that, a few days later, she noticed a lump under her foot. Appellant related that it hurt the more she walked. She indicated that on May 27, 2015 she went to the urgent care center and was placed off work as her foot was hurting and swollen. Appellant noted that on June 5, 2015 the pain intensified the more she walked.

On May 26, 2015 Dr. Steven Lubera, an emergency medicine physician, treated appellant for left foot pain and swelling.

By letter dated November 19, 2015, OWCP noted that appellant's claim initially appeared to be a minor injury that resulted in minimal or no lost time from work and was administratively handled to allow a limited amount of medical payments. However, appellant's claim was now being reopened for formal adjudication. OWCP informed her of the type of evidence needed to support her claim and afforded her 30 days to submit such evidence.

In a June 24, 2015 treatment note, Dr. Robert Sheffey, a podiatrist, noted that appellant presented with complaints of pain in the left forefoot. He advised that she had stepped on a rock while at work on May 5, 2015, shortly began experiencing pain, and noticed a lump on the bottom of her foot which remained painful and swollen. Dr. Sheffey indicated that it became more pronounced with activity. He related that appellant had been informed that she had plantar fasciitis and was told to follow up with a physician. Dr. Sheffey explained that she tried ice and heat with no alleviation of symptoms. On examination, appellant had pain on palpation at the second metatarsophalangeal joint of the left foot, moderate pain on palpation of the second interspace left, moderate discomfort on range of motion at the second metatarsophalangeal joint, and edema at the plantar aspect of the left forefoot centrally located at the second metatarsal phalangeal joint. Dr. Sheffey diagnosed enthesopathy, limb pain, and edema. He reviewed x-rays and explained that appellant appeared to be suffering from capsulitis of the second metatarsophalangeal joint of the left foot. Dr. Sheffey opined that her injury was consistent with stepping on a rock. He noted that the pain was present since the first time of stepping on a rock while at work. Dr. Sheffey placed appellant off work for four weeks.

In a July 25, 2015 treatment note, Dr. Sheffey reported that appellant presented for continued treatment for capsulitis of the second metatarsophalangeal joint of the left foot. Appellant continued to have discomfort, but was much improved. Dr. Sheffey diagnosed dermatophytosis of nail, plantar fascial fibromatosis, enthesopathy, plantar nerve lesion, limb pain, edema, hammer toe, and hallux valgus. He administered ultrasound therapy and electrical stimulation to the left foot along with strapping bilaterally to off-load metatarsal heads. Dr. Sheffey applied an "Unnas boot compressive wrap" to control swelling. He indicated that appellant would return to work on Monday and that she could remove the wrappings at that point. Dr. Sheffey explained that, if her condition did not resolve, a bunionectomy and hammertoe correction might be needed.

On November 25, 2015 Dr. Sheffey noted, in an attending physician's report the history of appellant stepping on a rock and sustaining an injury to her left foot. He checked the box marked "yes" in response to whether she had a history of "concurrent or preexisting injury or disease" and described the injury as "hallux valgus and hammer toes." Dr. Sheffey advised that x-rays revealed capsulitis with hallux valgus and hammer toes. He diagnosed capsulitis on the second metatarsophalangeal joint. Dr. Sheffey checked the box marked "yes" in response to whether he believed that the condition was caused or aggravated by an employment activity. He explained that the second metatarsophalangeal joint was injured and remained painful due to the work incident and appellant remained disabled. Dr. Sheffey also completed a duty status report of the same date advising that she remained disabled for work.

Appellant explained, in a November 24, 2015 statement that, on May 12, 2015 while delivering mail, she stepped on a large piece of broken concrete, that her foot started to hurt, but that she kept working. She noted that a few days later she noticed a lump in the middle of the foot on the bottom which was very painful and inflamed. Appellant advised that she began treatment with Dr. Sheffey. She also noted that she had been disciplined for failing to timely notify her supervisor of the incident on May 12, 2015.[2]

By decision dated December 28, 2015, OWCP denied appellant's claim finding that the medical evidence failed to establish an injury causally related to the accepted May 15, 2015 work incident.

On January 6, 2016 appellant requested reconsideration. She indicated that her claim was denied because she had a preexisting condition. Appellant advised that she was attaching new medical evidence that would clarify the details of her condition.

In a January 6, 2016 report, Dr. Sheffey explained that he was providing rationale regarding appellant's proposed surgery. He indicated that she had severe capsulitis of the second metatarsophalangeal joint. Dr. Sheffey noted that appellant had underlying progressive deformities that include a hallux valgus deformity and a hammer digit deformity of the second digit. He explained that either of these two "together or isolated may cause capsulitis or as in [appellant's] case, prevent a capsulitis from healing." Dr. Sheffey further noted that there was a high percentage of the population with one or two of the deformities and the "vast percentage never experience the condition of capsulitis. Prior to [appellant's] injury she was not experiencing capsulitis." Dr. Sheffey noted:

> "In my opinion [appellant] suffered an injury to the second metatarsophalangeal joint causing capsulitis or an inflammation of the second metatarsophalangeal joint. Due to the fact that she has underlying deformities of hammer digit syndrome and hallux valgus there is significant pressure at the second metatarsophalangeal joint, which is preventing this condition from healing. Were it not for these underlying deformities I am confident that conservative treatment

[2] On November 21, 2015 appellant claimed a recurrence of disability on November 18, 2015 due to her claimed May 12, 2015 injury. She advised that she stopped work on November 21, 2015. In a December 8, 2015 letter, OWCP advised appellant that she had not experienced a recurrence under FECA because her initial claim had not been accepted.

> would have ultimately been successful in resolving [appellant's] symptoms. Conservative treatment on [appellant] has been exhausted and unfortunately, she continues to experience pain that in my opinion is due [to] the fact that these underlying deformities are impeding her ability [to] heal due to increased pressure at the second metatarsophalangeal joint. At this point in order to resolve [her] painful capsulitis which, was initiated by her work injury … I believe [that] the deformities need to be corrected to decrease the pressure at the second metatarsophalangeal joint and allow her foot to heal. Failure to surgically correct these deformities [will] likely result in continued pain for this patient."

In a February 24, 2016 statement of accepted facts (SOAF), OWCP noted that appellant continued to work until July 6, 2015. Appellant then worked one hour per day from July 6 to 15, 2015 and four hours per day from July 20, 2015. Thereafter, she returned to work full duty on July 28, 2015 and stopped work again on November 21, 2015.

On February 24, 2016 OWCP requested that an OWCP medical adviser review the record and the SOAF and thereafter address whether appellant's condition of capsulitis of the second metatarsophalangeal joint was work related. It also requested an opinion with regard to the requested surgery from Dr. Sheffey. OWCP advised that the claim had not been accepted.

In a March 7, 2016 report, OWCP medical adviser noted appellant's history of injury and treatment along with the SOAF. He found that the proposed surgery to correct the deformities was causally related to the accepted medical condition as there was a temporal relationship between the industrial injury of May 15, 2015 and the proposed surgery. The medical adviser found however that the treating physician had failed to support his diagnosis of hammertoe syndrome with evidence of radiographs demonstrating the degree of hammertoe and had failed to explain the conservative treatment he had ordered. He further opined that there was no medical evidence to support capsulitis of the left foot. The medical adviser explained that capsulitis was normally diagnosed with a magnetic resonance imaging (MRI) scan of the foot, which was not present in this case. He related that the treating physician had not explained what imaging modality was used to diagnose severe capsulitis of the foot. The medical adviser concluded that the medical evidence was insufficient to support that the capsulitis of the left foot was medically connected to the injury of May 15, 2015.

By decision dated March 24, 2016, OWCP denied modification of the prior decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish 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,[3] and that an injury was sustained in the performance

[3] *Joe D. Cameron*, 41 ECAB 153 (1989).

of duty.[4] These are the essential elements of each compensation claim, regardless of whether the claim is predicated upon a traumatic injury, or an occupational disease.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether the fact of injury has been established. There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place, and in the manner alleged.[6] In some traumatic injury cases, this component can be established by an employee's uncontroverted statement on the Form CA-1.[7] Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.[8]

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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.[9]

ANALYSIS

Appellant has alleged that on May 15, 2015 she sustained an injury to her left foot in the performance of duty. The evidence supports that the claimed event occurred. Therefore, the Board finds that appellant stepped on a rock at work as alleged.

However, with regard to the medical evidence, the Board finds the case not in posture for decision. Dr. Sheffey explained that appellant had severe capsulitis of the second metatarso-phalangeal joint that required surgery. He determined that she had underlying progressive deformities to include a hallux valgus deformity and a hammer digit deformity of the second digit and opined that either of these two together or isolated could cause capsulitis or prevent a capsulitis from healing. Dr. Sheffey pointed out that prior to appellant's injury, she had not experienced capsulitis. He opined that she had injured the second metatarsophalangeal joint causing capsulitis or an inflammation of the second metatarsophalangeal joint. Due to the fact that appellant also had preexisting underlying deformities of hammer digit syndrome and hallux valgus, there was significant pressure at the second metatarsophalangeal joint preventing the condition from healing. Dr. Sheffey explained that conservative treatment had been exhausted and that to resolve her painful capsulitis, surgery was indicated to decrease the pressure at the second metatarsophalangeal joint and allow appellant's foot to heal.

[4] *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[5] *Delores C. Ellyett*, 41 ECAB 992 (1990).

[6] *Julie B. Hawkins*, 38 ECAB 393, 396 (1987).

[7] *John J. Carlone*, 41 ECAB 354 (1989).

[8] *Id.* For a definition of the term "traumatic injury," *see* 20 C.F.R. § 10.5(ee).

[9] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

On February 24, 2016 OWCP asked its medical adviser to review the matter. In a March 7, 2016 report, the medical adviser noted appellant's history of injury and treatment along with the SOAF. Regarding the proposed surgery, he explained that the proposed surgery, to correct the deformities, was causally related to the accepted medical condition as there was a temporal relationship between the industrial injury of May 15, 2015 and the proposed surgery. The medical adviser found, however, that the proposed surgery to correct the deformities was not medically necessary as there was a lack of x-rays showing the degree of hammertoe or evidence showing failure of conservative management to justify surgery. In response to whether the capsulitis of the left foot was medically connected to the injury of May 15, 2015 he opined that there was no medical evidence to support capsulitis of the left foot. The medical adviser noted that an MRI scan was normally used to diagnose capsulitis, but there was no MRI scan present in this case. He related that it was unclear to him how the condition had been diagnosed as the treating physician had not identified the imaging method he had used. The medical adviser concluded that the medical evidence was therefore insufficient to support that the capsulitis of the left foot was medically connected to the injury of May 15, 2015.

The Board finds that the medical adviser's report is contradictory. Further, medical development is needed with regard to whether appellant has a diagnosed condition that was caused or aggravated by stepping on a rock on May 15, 2015. The medical adviser opined "yes" that the proposed surgery was causally related to an accepted medical condition, but "no" in response to whether the proposed surgery to correct the deformities was medically necessary. He also opined that the diagnosed adhesive capsulitis was not due to the May 15, 2015 work incident finding that there was no medical evidence to support that appellant had that condition due to a lack of diagnostic testing. The Board notes that, contrary to the medical adviser's statement, no condition has been accepted by OWCP as employment related. Thus, the medical adviser's opinion is of limited probative value as it is not based on an accurate factual background.[10] Finally, he did not clearly explain why he suggested that surgery was warranted for a condition he deemed to be accepted while later opining that left foot capsulitis was not causally related to the work incident. Therefore, the Board finds that the case must be remanded for further development of the medical evidence and a reasoned opinion regarding whether appellant has a work-related condition to the employment incident and, if so, whether any such conditions necessitate surgery.

Once OWCP undertakes development of the record, it has the responsibility to obtain an evaluation, which will resolve the issue involved in the case.[11] The case is remanded to OWCP to refer appellant to an appropriate Board-certified specialist for a rationalized medical opinion on whether the May 15, 2015 work incident caused or aggravated a diagnosed left foot condition. Following such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[10] *See Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions based upon an incomplete history have little probative value).

[11] *See Robert Kirby*, 51 ECAB 474, 476 (2000)*; Mae Z. Hackett*, 34 ECAB 1421 (1983).

ORDER

IT IS HEREBY ORDERED THAT the March 24, 2016 decision of the Office of Workers' Compensation Programs is set aside and remanded.

Issued: October 5, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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