United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 16-1670**
	)	**Issued: April 6, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Highland Falls, NY, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 19, 2016 appellant, through counsel, filed a timely appeal from a July 29, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation and medical benefits effective April 18, 2016; and (2) whether appellant met his

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

burden of proof to establish continuing disability or residuals causally related to the accepted January 9, 2014 employment injury.

FACTUAL HISTORY

On January 9, 2014 appellant, then a 58-year-old mail carrier, filed a traumatic injury claim (Form CA-1) alleging that on that day he slipped off a step while in the performance of duty. He stated that his foot bent backwards and his ankle swelled. Appellant stopped work on January 9, 2014 and has not returned. OWCP initially accepted the claim for left calf sprain and left ankle sprain. It paid compensation benefits and placed appellant on the periodic compensation rolls effective July 27, 2014.

Appellant initially sought medical care at Nyack Hospital on January 9, 2014. He was placed in a short leg posterior orthotic glass splint (air cast) and provided with crutches.

In a January 14, 2014 report, Dr. Patrick J. Murray, an orthopedic surgeon, noted the history of injury and provided examination findings. He diagnosed left ankle sprain and left calf strain. Due to continued pain in the left ankle, Dr. Murray ordered physical therapy and a magnetic resonance imaging (MRI) scan. In a February 6, 2014 report, he reported that appellant had ongoing complaints of pain and inability to perform his normal job duties. Physical therapy was again prescribed. At his reevaluation on March 6, 2014, appellant showed no improvement. On March 14, 2014 he underwent a left ankle MRI scan. In an April 3, 2014 report, Dr. Murray diagnosed left ankle pain and left foot pain and opined that appellant was totally disabled. He recommended that appellant be evaluated by foot/ankle specialist and a neurologist as he believed that some of his symptoms were neurologic in nature.

Dr. James R. McWilliam, a Board-certified orthopedic surgeon specializing in the treatment of the foot and ankle, began treating appellant on April 10, 2014. After reviewing the March 14, 2014 MRI scan of the left ankle, he diagnosed appellant with tibialis tendinitis and plantar neuritis, which he opined was related to the twisting injury sustained at work. On July 3, 2014 Dr. McWilliam provided assessments of tibialis tendinitis, left ankle sprain, and tarsal tunnel syndrome, which he indicated were related to the twisting injury sustained at work. Although he released appellant to full-time, sedentary-type work, appellant did not resume work.

In July 2014, OWCP referred appellant, a list of questions, a statement of accepted facts (SOAF) and the medical file, to Dr. Joseph Laico, a Board-certified orthopedist, for a second opinion examination. In a September 4, 2014 report, Dr. Laico noted the history of the injury, his review of the medical record, and presented examination findings. He diagnosed tibialis posterior tendinitis and ankle strain causally related to the January 9, 2014 work incident. Dr. Laico found no clinical evidence of a left calf sprain. He opined that appellant was partially disabled due to the diagnosis of posterior tibial tendinitis. Dr. Laico explained that appellant had objective findings of bilateral calcaneal valgus, greater on the left than on the right, and that his variant was prolonging the symptoms of left tibialis posterior tendinitis. He found that clinically appellant did not present with tarsal tunnel syndrome, but his symptoms were suggestive of tarsal tunnel syndrome superimposed on posterior tibialis tendinitis. Dr. Laico also explained that appellant had preexisting bilateral calcaneal valgus. He noted that the condition of calcaneal valgus had not been aggravated by the work injury, but the morphology of appellant's left ankle

was a causative factor in his continued symptoms of left ankle pain as it stretched his tibial tendon and prolonged the resolution of his injury. Dr. Laico recommended custom-made orthotics. With regard to the left calf, he found no clinical evidence of a calf strain. This was based upon Dr. Laico's examination findings of no atrophy of the calf or intrinsic foot muscles, and no swelling or tenderness in the left calf. He opined that appellant was capable of returning to full-time, limited-duty work with restrictions of walking and climbing no more than two hours or with more than 25 pounds.

On September 10, 2014 Dr. Jamie Lyn Garber, a podiatrist, evaluated appellant's left foot for suspected old posterior tibial tendon tear. She fitted him with a prefabricated ankle-foot orthosis, multi-ligamentous ankle support, and referred him for a left foot MRI scan. Appellant underwent a left foot MRI scan on September 26, 2014, which revealed no signs of tearing of the posterior tibial tendon.

In an October 3, 2014 report, Dr. Garber diagnosed posterior tibialis tendinitis, posterior tibial tendon dysfunction Stage 2, talipes valgus, anomalies of the foot, and musculoskeletal anomalies. She opined that appellant's tendon/ligamanetous injury caused adult-acquired flatfoot deformity and recommended surgical intervention.

In an October 27, 2014 letter, OWCP requested additional information and clarification from Dr. Laico. In an October 28, 2014 addendum report, Dr. Laico recommended that appellant's claim be expanded to include left tibialis posterior tendinitis. He opined that OWCP should not authorize the surgery recommended by appellant's physician as it was too aggressive pending appellant's response to the use of custom made orthotics.

On November 19, 2014 Dr. Garber began treating appellant for flatfoot, posterior tibial tendon dysfunction, and left *os naviculare pedis malacia*, which she opined occurred post-traumatically due to the work injury.

OWCP, on March 18, 2015, accepted the additional condition of tibialis posterior tendinitis, left side.

In an April 8, 2015 report, Dr. Garber provided an assessment of worsening flatfoot, worsening posterior tibial tendon dysfunction, and worsening *os naviculare pedis malacia*. She indicated that appellant had severe acquired flatfoot deformity due to the posterior tibial tendon dysfunction that developed as a result of his work-related injury. Surgical treatment was recommended.

In September 2015, OWCP referred appellant, a list of questions, a SOAF, and the medical record, to Dr. Mark Kramer, a Board-certified orthopedist, for a second opinion evaluation. In an October 7, 2015 report, Dr. Kramer noted the history of injury and his review of the medical records. He presented examination findings, noting that appellant ambulated normally. Appellant was noted to have nontender, prominent excessive navicular bilaterally left more than right, normal inversion of the calcaneus, normal arch, and normal forefoot. While he had evidence of mild *pes planus*, he formed a normal arch when he performed toe rises. Appellant was also able to independently toe rise on his left foot. He also had equal circumferences of the calf and was able to ambulate normally barefoot, without limping.

Measurements of the foot were equal on the right and left side with no evidence of swelling or cyanosis. Neurological examination was grossly intact. Dr. Kramer opined that there was no evidence of any ongoing disability to the left ankle. He noted that there was no evidence of any posterior tibial tendinitis as appellant could unilaterally toe rise on the left side without any discomfort and there was no discomfort along the course of the posterior tibial tendon. Dr. Kramer noted that appellant was not receiving any orthopedic treatment or physical therapy, only podiatric treatment. He opined that appellant did not require any further treatment as there was no evidence of any ongoing disability based on his evaluation. Dr. Kramer also noted that there was no evidence of calf atrophy after 21 months of persistent pain in the left ankle and concluded that appellant had no ongoing orthopedic disability to the left ankle. He opined that appellant had reached maximum medical improvement (MMI) from the left ankle sprain and that appellant was able to return to his date-of-injury position without restrictions.

In a December 10, 2015 letter, OWCP requested that Dr. Kramer clarify some of his answers. In a December 14, 2015 addendum, Dr. Kramer indicated that, while appellant had mild *pes planus*, there was no evidence of disabling pain. He explained that *pes planus* was an ordinary variant of human anatomy. Dr. Kramer indicated that, by history, there was no evidence of any preexisting condition. In response to the question of whether having flatfoot put more strain on the posterior tibial tendon, he noted that appellant had a normal examination. Dr. Kramer explained that appellant was able to single toe rise on the affected foot without any discomfort, which indicated that the posterior tibial tendon functioned fully and caused the posterior tibial tendon to contract, which elicited no complaints of discomfort. Appellant was also able to invert his ankle fully without any discomfort. Dr. Kramer reiterated that appellant was not temporarily totally disabled.

Dr. Garber continued to report that appellant's flatfoot, posterior tibial tendon dysfunction, and *os naviculare pedis malacia* had worsened, and surgical treatment was necessary.

On March 15, 2016 OWCP advised appellant that it proposed to terminate his wage-loss compensation and medical benefits. It found that the weight of the medical evidence, as represented by Dr. Kramer, established that appellant no longer had any residuals or continuing disability from work stemming from his accepted employment injury. OWCP provided him 30 days to submit evidence and argument challenging the proposed termination.

In response to its notice of proposed termination, OWCP received a March 4, 2016 return to duty letter from the employing establishment and a March 28, 2016 statement from appellant.

In an April 8, 2016 medical note, Dr. Garber continued to report that appellant's conditions of flatfoot, posterior tibial tendon dysfunction, and *os naviculare pedis malacia* had worsened and recommended surgical treatment. She indicated that his severe acquired flatfoot deformity was due to the posterior tibial tendon dysfunction that developed as a result of the work-related injury.

In an April 13, 2016 attending physician's report (Form CA-20), Dr. Garber noted findings of a valgus deformity of foot secondary to posterior tibial tendon dysfunction secondary to work trauma. She diagnosed tibialis tendinitis and acquired flatfoot. Surgery was again

recommended. Dr. Garber opined that appellant could perform sedentary work with no lifting, carrying, pushing, or climbing.

By decision dated April 18, 2016, OWCP terminated appellant's wage-loss compensation and medical benefits, effective that same date. It found that the weight of the medical evidence rested with Dr. Kramer's reports wherein he concluded that there were no ongoing residuals or disability causally related to appellant's accepted work-related conditions.

On April 29, 2016 OWCP received appellant's April 20, 2016 request for an oral hearing before a representative of OWCP's Branch of Hearings and Review. Appellant submitted a May 2, 2016 attending physician's report (Form CA-20) by Dr. Garber who reiterated her prior diagnoses and indicated by a checking a box marked "yes" that the conditions were employment related. She explained that "continued walking up and down stairs caused [appellant's] foot to collapse" and she checked a box marked "no" indicating that appellant could not return to work, "unless light duty." Dr. Garber reiterated her opinion that walking up and down the stairs caused appellant's foot to collapse and that reconstructive surgery was necessitated "as related to work injury." Accompanying the Form CA-20 were progress notes by her for treatment administered on an intermittent basis from January 27 until April 15, 2016. Dr. Garber emphasized the need for reconstructive surgery to prevent further deterioration of appellant's employment-related foot conditions.

An oral hearing was held on June 23, 2016.

By decision dated July 29, 2016, an OWCP hearing representative affirmed OWCP's April 18, 2016 decision terminating appellant's compensation benefits, finding that the weight of the medical evidence rested with Dr. Kramer, OWCP's referral physician, upon whose report the termination was based.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it bears the burden of proof to justify modification or termination of benefits.[3] Having determined that, an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[4] The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[5] To terminate authorization for medical treatment, OWCP must establish that the employee no longer has residuals of an employment-related condition that require further medical treatment.[6]

[3] *Curtis Hall*, 45 ECAB 316 (1994).

[4] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[5] *Furman G. Peake*, 41 ECAB 361, 364 (1990); *Thomas Olivarez, Jr.*, 32 ECAB 1019 (1981).

[6] *Calvin S. Mays*, 39 ECAB 993 (1988).

ANALYSIS -- ISSUE 1

OWCP terminated appellant's wage-loss compensation and medical benefits, effective April 18, 2016. It found that the weight of the medical opinion evidence was with Dr. Kramer, the referral physician.

The Board finds that OWCP has met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective April 18, 2016.

In his October 7, 2015 narrative report, Dr. Kramer detailed appellant's factual and medical history and reported findings upon physical examination. He opined that there was no evidence of any ongoing disability to the left ankle. Dr. Kramer noted that there was no evidence of any posterior tibial tendinitis as appellant could unilateral toe rise on the left side without any discomfort and there was no discomfort along the course of the posterior tibial tendon. He noted that appellant was only receiving podiatry treatment. Dr. Kramer opined that appellant did not require any further treatment as there was no evidence of any ongoing disability based on his evaluation. He noted that there was no evidence of calf atrophy after 21 months of persistent pain in the left ankle and concluded that appellant had no ongoing orthopedic disability to the left ankle. Dr. Kramer opined that appellant had reached MMI from the left ankle sprain and that he was able to return to his date-of-injury position without restrictions.

In his December 14, 2015 addendum report, Dr. Kramer indicated that, while appellant had mild *pes planus*, there was no evidence of disabling pain. He explained that *pes planus* was an ordinary variant of human anatomy. In response to the question of whether having flatfoot put more strain on the posterior tibial tendon, Dr. Kramer noted that appellant had a normal examination. He explained that appellant was able to single toe rise on the affected leg without any discomfort, which indicated that the posterior tibial tendon functioned fully and caused the posterior tibial tendon to contract, which elicited no complaints of discomfort. Appellant was also able to invert his ankle fully without any discomfort. Dr. Kramer reiterated that appellant was not temporarily totally disabled.

The Board finds that Dr. Kramer's opinion represents the weight of the medical evidence in this case. Dr. Kramer provided a detailed medical report reviewing the numerous medical reports and evidence of record. He unequivocally opined that appellant did not have continuing residuals of an employment-related condition and provided a medical explanation supported by objective findings. Dr. Kramer's opinion was based on an accurate background.[7]

Dr. Garber, a podiatrist, opined that appellant had residuals and disability from his work injury. However, she failed to provide a well-rationalized opinion with supporting objective evidence. In an April 13, 2015 attending physician's report and an April 8, 2016 medical note, Dr. Garber diagnosed tibialis tendinitis and acquired flatfoot. She indicated that appellant's severe, acquired flatfoot deformity was due to the posterior tibial tendon dysfunction that

[7] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

developed as a result of the work-related injury. However, Dr. Garber failed to provide objective findings to support such conditions or provide a well-rationalized opinion which addressed that *pes planus* (flatfoot) was a normal human variation and how and whether the twisting injury had caused or aggravated appellant's "severe acquired flatfoot deformity" to the point surgery was indicated.

The Board has long held that medical opinions not containing rationale on causal relationship are of diminished probative value and are generally insufficient to meet appellant's burden of proof.[8] Moreover, the Board has held that the mere fact that an employee was asymptomatic before the injury, but symptomatic after the injury is insufficient, without supporting rationale, to establish causal relationship.[9] Dr. Garber did not address the issue of appellant's underlying *pes planus* condition. For these reasons, her opinion is insufficiently rationalized to support that appellant has any residuals of his accepted conditions to cause a conflict with Dr. Kramer's opinion. The Board finds that the medical evidence of record was sufficient for OWCP to meet its burden of proof in this case. Dr. Kramer provided a well-rationalized opinion that represents the weight of the medical evidence.

On appeal, counsel reiterates appellant's argument that a conflict in medical evidence existed between Dr. Garber and Dr. Kramer. However, for the reasons set forth above, Dr. Kramer's report represents the weight of the medical evidence as Dr. Garber's reports are insufficient to cause a conflict of medical opinion with Dr. Kramer.

LEGAL PRECEDENT -- ISSUE 2

As OWCP properly terminated appellant's compensation benefits, the burden shifts to the employee to establish continuing disability after that date causally related to his or her accepted injury.[10] To establish causal relationship between the accepted conditions as well as any attendant disability claimed and the employment injury, the employee must submit rationalized medical evidence based on a complete medical and factual background supporting such causal relationship.[11] Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[12]

It is well established that OWCP must review all evidence submitted by a claimant and received by OWCP prior to issuance of its final decision.[13] As the Board's decisions are final as to the subject matter appealed, it is crucial that all evidence relevant to the subject matter of the

[8] *Carolyn F. Allen*, 47 ECAB 240 (1995).

[9] *Thomas D. Petrylak*, 39 ECAB 276 (1987).

[10] *Manuel Gill*, 52 ECAB 282 (2001). *See G.C.*, Docket No. 17-0062 (issued December 11, 2017).

[11] *R.F.*, Docket No. 16-0845 (issued July 25, 2017); *R.D.*, Docket No. 16-0982 (issued December 20, 2016).

[12] *Paul Foster*, 56 ECAB 208 (2004); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[13] *William A. Couch*, 41 ECAB 548 (1990).

claim, which was properly submitted to OWCP prior to the time of issuance of its final decision, be addressed by OWCP.[14]

ANALYSIS -- ISSUE 2

Subsequent to OWCP's April 18, 2016 termination decision appellant submitted additional medical evidence from his attending physician, Dr. Garber. In these reports, Dr. Garber consistently maintained that he continued to suffer from residuals of his employment-related foot conditions and that these conditions had progressed to the point that reconstructive surgery was warranted. Although appellant submitted these reports prior to the issuance of the July 29, 2016 decision, there is no evidence that the hearing representative reviewed them.

As OWCP's hearing representative did not review all the evidence of record prior to issuing her July 29, 2016 decision, the Board finds that the case is not in posture for decision with regard to whether appellant met his burden of proof to establish continuing residuals or disability causally related to the accepted January 9, 2014 employment injury. For this reason, the case will be remanded to OWCP to enable it to properly consider all the evidence submitted at the time of the July 29, 2016 decision. Following such further development as OWCP deems necessary, it shall issue a *de novo* decision on the issue of continuing employment-related disability or residuals.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective April 18, 2016. The Board further finds that this case is not in posture for decision as to whether he has met his burden of proof to establish continuing disability or residuals causally related to the accepted January 9, 2014 employment injury.

[14] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the July 29, 2016 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: April 6, 2018
Washington, DC

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

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

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