United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 18-0234**
	)	**Issued: September 14, 2018**
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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 13, 2017 appellant filed a timely appeal from a July 20, 2017 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 the case.

ISSUE

The issue is whether appellant met her burden of proof to establish that her complex regional pain syndrome (CRPS) was a consequence of her accepted conditions of left tarsal tunnel syndrome, left plantar fibromatosis, and lumbar sprain.

FACTUAL HISTORY

On September 7, 2012 appellant, then a 45-year-old window clerk, filed an occupational disease claim (Form CA-2) alleging that as a result of standing at the retail window on a concrete

[1] 5 U.S.C. § 8101 *et seq.*

floor she sustained left foot nerve damage, plantar fascia, fractures, joint separation, and inflammation. OWCP accepted her claim for left tarsal tunnel syndrome, left plantar fibromatosis, and lumbar sprain.[2]

Appellant stopped work intermittently and returned to part-time light duty. OWCP initially paid her wage-loss compensation benefits on the supplemental rolls and, effective February 10, 2013, it converted her wage-loss compensation and medical benefits to the periodic rolls.

Dr. Daniel Luetkehans, a podiatric surgeon, performed multiple surgeries including a February 16, 2012 release of tibial nerve in the left medial calcaneal branch with a tarsal tunnel release, a September 19, 2012 removal of screws and plate, a May 20, 2014 resection of joint with arthrodesis of left calcaneal cuboid joint, and a May 17, 2016 removal of plates and screws.

Dr. Luetkehans also referred appellant to other physicians for treatment. On March 8, 2013 he referred her to Dr. Drason Gastezski, a physician Board-certified in anesthesiology and pain medicine, for an evaluation of CRPS. In a March 25, 2013 report, Dr. Gastevski diagnosed: (1) left lower extremity CRPS; (2) right low lumbar facet arthropathy with axial low back pain; and (3) bilateral paraspinous muscle spasm with myofascial pain. He proceeded to treat appellant with a series of injections through March 14, 2014. Dr. Faris Abusharif, a physician specializing in anesthesiology and interventional pain management, began treating her on August 20, 2014. He diagnosed appellant with CRPS, and treated her with injections.

In a letter dated November 8, 2016, appellant asked that her claim be expanded to include the condition of CRPS. She stated that, after multiple surgeries on her left foot, she had sustained nerve damage from the nerve being wrapped around the hardware plate that was inserted into her foot for approximately one year.

In a November 8, 2018 medical report, Dr. Luetkehans opined that the diagnosis of CRPS should be an accepted condition as it was related to appellant's original work injury. He summarized his treatment of her. Dr. Luetkehans noted that appellant was originally injured at work as a postal worker. He indicated that she eventually had surgery with an arthrodesis of the fourth and fifth metatarsocuboid joint with internal fixation of the left foot. Dr. Luetkehans referred appellant to Dr. Gastezski for evaluation of CRPS on March 8, 2013. He noted that she had two sympathetic blocks for diagnosed CRPS and initially had 100 percent relief of her symptoms of CRPS, but she then suffered a recurrence. Dr. Luetkehans opined that, as appellant had relief of her pain following the injections, he determined that she had CRPS and this was related to her original work injury. He noted that she was still being treated for CRPS by Dr. Abusharif.

On November 30, 2016 OWCP referred appellant's record to OWCP's medical adviser for a determination as to whether she had CRPS and, if so, whether it was a consequence of the

[2] Appellant had a prior employment-related claim, in OWCP File No. xxxxxx593, that OWCP accepted for lumbar sprain which occurred on July 12, 2011 while she was lifting heavy boxes. This case is open for medical treatment only. OWCP administratively combined OWCP File No. xxxxxx593 with the current claim, OWCP File No. xxxxxx046, with the latter serving as the master file.

accepted, work-related injury. In a reply dated December 20, 2016, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and OWCP's medical adviser, noted that appellant did have ongoing clinical difficulties with regard to her left foot, but that they were due to surgical complications and she definitely did not meet the diagnostic criteria for CRPS citing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*)[3] Table 15-24, *Diagnostic Criteria for Complex Regional Pain Syndrome,* and Table 15-25, *Objective Diagnostic Criteria Points for Complex Regional Pain Syndrome.*[4] He noted that, while appellant certainly had pain complaints and weakness as a result of multiple operations, the objective criteria listed in Table 15-25 had not been met. Dr. Berman noted, *inter alia,* that there were no atrophic changes, and no vasomotor changes in skin color or symmetry. Therefore, he determined that the diagnosis of CRPS could not be made and the acceptance of the claim should not be expanded to include CRPS. Dr. Berman also noted that the surgical indications were questionable. He noted that there had been at least four operative procedures, and that each was highly questionable with regard to indications as well as specific choice of operative procedures and techniques. Dr. Berman noted that all surgeries were done by a podiatrist without any orthopedic consultation. He indicated that conservative measures were not utilized for the fullest extent prior to surgical intervention and therefore the claimant's clinical management did not meet the standard of care. Dr. Berman concluded that the mechanism of injury, the surgery, and subsequent events were not competent to produce CRPS, and that the reasons for the neurogenic pain was complications of the surgical intervention.

In an April 11, 2017 report, Dr. Luetkehans responded to the report of Dr. Berman. He alleged that Dr. Berman appeared to be biased against podiatric surgeons. Dr. Luetkehans indicated that it did not appear that Dr. Berman had any specialty in foot and ankle conditions. He noted that he had been in practice for 26 years after completing a residency in foot and ankle surgery. Dr. Luetkehans further noted that he was Board-certified by the American Board of Foot and Ankle Surgery in rear foot reconstruction and ankle surgery. He also noted that he was Board-certified in wound management. As to the medical question at issue, Dr. Luetkehans opined that appellant met the criteria for CRPS. He noted that she had hyperesthesia and allodynia, vasomotor changes and skin changes, decreased range of motion, chronic edema, and temperature changes. Dr. Luetkehans further noted that he referred appellant to Dr. Gastevski who treated her with injections and that she responded well to the injections and had an increase in skin temperature to the left foot. He noted that this is pathognomonic for CRPS. Dr. Luetkehans opined that no additional imaging or testing was warranted if the sympathetic injections was positive. He noted that appellant had nonsurgical treatment prior to surgical intervention. Dr. Luetkehans contended that Dr. Berman's comment that the typical mechanism for injury for CRPS/reflex sympathetic dystrophy was a crush injury was simply untrue, and that CRPS often followed trivial injuries or was a complication of surgery, as occurred in her case. He noted that appellant has been treated by Dr. Gastevski for CRPS and Dr. Abusharif for pain treatment and additional sympathetic blocks for CRPS, so two pain specialists had treated her for CRPS. Dr. Luetkehans concluded that she met the criteria for CRPS which was a complication and consequence following surgery that was approved by OWCP for the accepted work-related injury, and asked that CRPS be added to the

[3] A.M.A., *Guides* (6th ed. 2009).

[4] *Id.* at 453-54.

approved diagnoses. In a November 8, 2016 letter, he reiterated that appellant was being treated for CRPS related to her original work injury.

On April 27, 2017 OWCP determined that a conflict in medical opinion existed between appellant's physician, Dr. Luetkehans, and OWCP's medical adviser, Dr. Berman, as to whether the claimed CRPS was consequentially related to, aggravated, or accelerated by the accepted conditions. OWCP prepared a new statement of accepted facts (SOAF) on April 27, 2017 wherein it listed appellant's accepted conditions as left foot tarsal tunnel syndrome, plantar fibromatosis, and lumbar sprain.

On May 24, 2017 OWCP referred appellant, along with the SOAF, to Dr. Matthew L. Jimenez, a Board-certified orthopedic surgeon, for an impartial medical examination. In a June 29, 2017 impartial medical opinion, Dr. Jimenez conducted a physical examination and reviewed her records. He determined that appellant did not have a work-related injury that was documented. Dr. Jimenez noted that there was no evidence of any event or issue at work that met the criteria for work-related injury and she clearly had multiple surgeries many of which he believed were unnecessary. Therefore, he opined that none of appellant's symptoms at this point were related in any way to any alleged work-related event, but clearly related to her multiple surgeries. Dr. Jimenez also determined that she did not have CRPS and that if she did it was not employment related. He explained that appellant did not have clinical or radiographic evidence of CRPS. Dr. Jimenez also noted that he did not believe that any diagnostic test at this point would be useful. He did note that appellant had evidence of fusions in her midfoot regions and they had created a symptom complex, which was permanent, but this symptom complex was not work related and was instead related to what appears to be unnecessary surgeries. Dr. Jimenez noted that she did have significant disability including loss of motion in her hindfoot and midfoot, and permanent scars and numbness and tingling in her nerve distribution related to the multiple surgeries that she had undergone.

By decision dated July 20, 2017, OWCP denied expansion of the acceptance of appellant's claim to include CRPS. It found that, pursuant to the opinion of the impartial medical examiner, the medical evidence did not demonstrate that weakness or impairment caused by her accepted work-related injury or illness led to an aggravation of the original injury or to a new injury as required for coverage under FECA.

LEGAL PRECEDENT

It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause attributable to the employee's own intentional conduct.[5] In discussing the range of compensable consequences, once the primary injury is causally connected with the employment,

[5] *Albert F. Ranieri*, 55 ECAB 598, 602 (2004).

then 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.[6]

The Board has held that, if a member weakened by an employment injury contributed to a later injury, the subsequent injury will be compensable as a consequential injury if the further medical complication flows from the compensable injury so long as it is clear that the real operative factor is the progression of the compensable injury.[7]

A claimant bears the burden of proof to establish a claim for a consequential injury.[8] As part of this burden, he or she must present rationalized medical opinion evidence showing causal relationship.[9] Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, 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]

Section 8123(a) of FECA provides that, if there is a disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[12] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13] For a conflict to arise, the opposing physician's viewpoints must be of "virtually equal weight and rationale.[14] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[15]

[6] *Charles W. Downey*, 54 ECAB 421-23 (2003).

[7] *S.M.*, 58 ECAB 166 (2008); *Raymond A. Nester*, 50 ECAB 173, 175 (1998); *see also M.M.*, Docket No. 17-1532 (issued January 23, 2018).

[8] *S.E.*, Docket No. 17-1601 (issued January 19, 2018).

[9] *Id.*

[10] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

[11] *I.J.*, 59 ECAB 408 (2008); *Ruthie M. Evans*, 41 ECAB 416 (1990).

[12] 5 U.S.C. § 8123(a); 20 C.F.R. § 10.32(b). *See R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4 2009) (the district medical adviser, acting on behalf of OWCP, may create a conflict in medical opinion).

[13] 20 C.F.R. § 10.321.

[14] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[15] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

ANALYSIS

The Board finds that this case is not in posture for decision due to an unresolved conflict in the medical evidence.

OWCP accepted appellant's claim for left tarsal tunnel syndrome, left plantar fibromatosis, and lumbar sprain. Appellant then requested that her claim be expanded to include CRPS. By decision dated July 20, 2017, OWCP denied expansion of the acceptance of her claim.

Appellant's treating physicians, Dr. Luetkehans, Dr. Gastevski, and Dr. Abusharif, found that appellant had CRPS and treated her with injections and surgery. Dr. Berman, OWCP's medical adviser opined that she did not meet the criteria for a diagnosis of CRPS as set forth in the A.M.A., *Guides*. He further noted that appellant's surgeries were questionable. Due to the conflict in medical opinion with regard to whether she had CRPS, on May 24, 2017 OWCP referred her to Dr. Jimenez for an impartial medical examination, along with a SOAF, a list of specific questions, and the medical record. In the SOAF, OWCP noted that it accepted appellant's claim for left tarsal tunnel syndrome and left plantar fibromatosis, and lumbar sprain. It noted that these conditions were sustained due to her repetitive motion and as a result of standing on concrete floors.

Dr. Jimenez did not rely on the SOAF when formulating his opinion. He premised his report on the fact that appellant did not have a work-related injury that was documented, despite the fact that the SOAF clearly indicated that her standing on concrete floors during her employment caused her left tarsal tunnel syndrome, left plantar fibromatosis, and lumber sprain.[16] Dr. Jimenez disregarded the findings of the SOAF and did not rely on this document for determination with regard to her CRPS. The Board finds that his report is of diminished probative value as the opinion disregarded critical elements of the SOAF and is therefore flawed.[17] The Board notes that it is the function of a medical expert to give an opinion only on medical questions, not to find facts.[18]

To be given special weight, an opinion of an impartial medical specialist must be based on a proper factual background and medical opinion based on an incomplete or inaccurate history are of limited probative value.[19] Furthermore, Dr. Jimenez concluded that appellant's symptoms were causally related to her unwarranted surgeries. However, residuals resulting from surgery or treatment authorized by OWCP are compensable.[20]

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[16] *See N.C.*, Docket No. 15-1855 (issued June 3, 2016) (the Board reversed OWCP's termination of the claimant's wage-loss compensation and medical benefits because it had relied on the opinion of the impartial medical examiner who determined that the claimant merely sustained soft tissue injuries as a result of two employment incidents, instead of the accepted conditions in the SOAF which included lumbosacral radiculitis of the lower extremities, lumbar acquired spondylolisthesis, and L5 spondylosis).

[17] *P.S.*, Docket No. 15-0253 (issued May 22, 2015).

[18] *Paul King*, 54 ECAB 356 (2003). Furthermore, to be given special weight, the opinion of an impartial medical specialist must be based on a proper factual background.

[19] *M.R.*, Docket No. 17-0634 (issued July 24, 2018).

[20] *See M.P.*, Docket No. 15-0361 (issued September 27, 2016).

As the conflict between appellant's physicians, including Dr. Luetkehans, and OWCP's medical adviser, Dr. Berman, remains unresolved, the case will be remanded to OWCP for selection of a new impartial medical specialist to evaluate whether appellant has CRPS and whether this condition is causally related to her federal employment. Following this and other development deemed necessary, OWCP shall issue a *de novo* decision in this case.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 20, 2017 is set aside, and this case is remanded to OWCP for further development consistent with this decision.

Issued: September 14, 2018
Washington, DC

Christopher J. Godfrey, 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