United States Department of Labor
Employees' Compensation Appeals Board

V.K., Appellant	)	
and	)	**Docket No. 19-0422**
	)	**Issued: June 10, 2020**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, East Boston, MA, Employer	)	

Appearances:
Stephanie N. Leet, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On December 19, 2018 appellant, through counsel, filed a timely appeal from a December 10, 2018 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 case.[3]

[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.*

[3] The Board notes that, following the December 10, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that OWCP should expand the acceptance of her claim to include right foot and bilateral hand complex regional pain syndrome (CRPS) as a consequence of her accepted August 30, 2003 employment injury.

FACTUAL HISTORY

On January 6, 2004 appellant, then a 31-year-old supervisory transportation security screener, filed an occupational disease claim (Form CA-2) alleging that she developed plantar fasciitis causally related to factors of her federal employment, including prolonged standing and walking. She noted that she first became aware of her condition and realized that it was causally related to her employment on August 30, 2003. OWCP accepted the claim for left plantar fasciitis. Appellant stopped work on July 13, 2005 and returned to full-duty work on February 27, 2006. She subsequently sustained intermittent periods of disability from work until October 4, 2011, when she stopped work completely and did not return. OWCP paid appellant wage-loss compensation on the periodic rolls effective March 11, 2012.

On May 23, 2011 Dr. Thomas E. Lyons, a podiatrist, diagnosed plantar fasciitis and performed a cortisone injection in the plantar medial aspect of the heel.[4] On October 11, 2011 he evaluated appellant for left foot pain with burning, numbness, and tingling. Dr. Lyons found that she had plantar fasciitis with neurological symptoms and diagnosed plantar fasciitis with possible RSD, possibly tarsal tunnel syndrome, or possible pain "from an etiology higher up in [appellant's] back."

On March 29, 2012 OWCP expanded the acceptance of the claim to include a left plantar calcaneal spur, a left fourth distal phalanx fracture, and left lower extremity reflex sympathetic dystrophy (RSD).

Dr. Lyle J. Micheli, a Board-certified orthopedist, treated appellant from July 6, 2012 to December 17, 2013 for plantar fasciitis and bilateral lower extremity CRPS. He noted that she complained of "freezer burn symptoms" in the bilateral lower extremities.

On May 20, 2014 Dr. Micheli evaluated appellant for bilateral foot and hand dysesthesias and neuropathic pain, noting that she had a history of CRPS. He found that she remained totally disabled from work. On March 17, 2015 Dr. Micheli found that appellant was hypersensitive to touch in the hands and feet and diagnosed bilateral CRPS of the feet.

On March 2, 2016 OWCP referred appellant, along with the statement of accepted facts (SOAF) and the medical record, to Dr. Christopher B. Geary, a Board-certified orthopedic surgeon, for a second opinion examination regarding whether she had continued residuals or disability causally related to her accepted employment injuries.

In a March 17, 2016 report, Dr. Geary reviewed the history of injury, noting that appellant had not worked since October 2011, when she underwent an injection that "made [appellant's]

[4] In a report dated February 9, 2012, Dr. Joel A. Saperstein, an orthopedic surgeon and OWCP referral physician, diagnosed peripheral neuropathy unrelated to appellant's employment injury and a heel spur. On May 29, 2014 Dr. Steven A. Silver, a Board-certified orthopedic surgeon and OWCP referral physician, diagnosed peripheral neuropathy of unknown etiology and to rule out vasculitis.

pain much worse and changed it into a freezer burn type sensation." On examination, he found a loss of hair on the feet bilaterally with thin skin consistent with RSD and a loss of sensation and tenderness to palpation over the left plantar fascia. Dr. Geary found that appellant's employment had exacerbated her underlying plantar fasciitis that had since resolved. He diagnosed RSD of the bilateral feet and bilateral upper extremities unrelated to her employment.

In a report dated November 4, 2016, Dr. Micheli noted that he was treating appellant for CRPS "caused by a nerve block given to [appellant] by an outside provider on May 23, 2011 for pain associated with a bone spur." He found that she was totally disabled from work.

On December 19, 2016 OWCP advised Dr. Geary that it had accepted as employment-related left plantar fasciitis, plantar calcaneal spur, left fourth distal phalanx fracture, and RSD of the left lower limb.[5] It requested that he clarify his opinion considering all the accepted work-related conditions in his evaluation.

In an addendum report dated January 5, 2017, Dr. Geary noted that appellant's claim had been accepted for left plantar fasciitis, plantar calcaneal spur, left fourth distal phalanx fracture, and RSD of the left lower limb. He found that she had residuals of her RSD of the left lower extremity. Dr. Geary indicated that appellant's prognosis was poor as she showed minimal improvement and continued to suffer from RSD. In a work capacity evaluation (OWCP-5c) dated March 15, 2017, he opined that appellant could work in a full-time sedentary position.

On February 1, 2017 Dr. Edward Michna, Board-certified in anesthesiology and palliative medicine, discussed appellant's history of a 2003 bone spur on her left foot treated with a steroid injection. He noted that the pain in her left lower extremity had spread to her other extremities. Dr. Michna diagnosed peripheral neuropathy or CRPS.

In a report dated March 31, 2017, Dr. Micheli diagnosed CRPS of the feet bilaterally. He attributed appellant's CRPS of the right foot to the CRPS of the left foot that had occurred "in the context of calcaneal bone spur status post injection, as CRPS often involves different locations. It is also likely that, given that [appellant] was overcompensating, she worsened the symptoms on the right foot as well."

In an April 25, 2017 report, Dr. Micheli opined that appellant was unable to return to modified duty or work part/full time due to the residuals of her work-related conditions. He requested that her claim be expanded to include right foot CRPS and bilateral hand CRPS as consequential injuries, as those conditions directly resulted from her treatment for a bone spur in her left foot in 2011.

On June 23, 2017 OWCP determined that a conflict in medical opinion existed between Dr. Micheli and Dr. Geary regarding the extent of appellant's employment-related disability and whether she had sustained right foot and bilateral hand CRPS causally related to her accepted employment injury. It referred her to Dr. Joseph Abate, a Board-certified orthopedic surgeon, for an impartial medical examination.

In an August 21, 2017 report, Dr. Abate reviewed the SOAF and appellant's medical records. He discussed her history of an employment injury due to prolonged walking and standing

[5] Dr. Micheli continued to submit progress reports. On December 27, 2016 he advised that the left heel injection had in part triggered CRPS and opined that appellant was disabled from employment.

at work. Dr. Abate noted that on May 31, 2011 appellant had received two cortisone injections to her left foot that resulted in "severe burning pain that has never been relieved," and currently complained of the feeling of "freezer burns" in both of her hands and feet. On examination he found no discoloration, swelling, hypothermia, or skin changes, and "findings of significant to absent sensation in stocking like and glove like distribution to the wrists and ankle joints." Dr. Abate diagnosed chemotherapy-induced polyneuropathy, an asymptomatic left heel spur, and resolved plantar fasciitis. He related, "After careful, thorough review of submitted medical records, it is my opinion, based on reasonable medical certainty, that the peripheral neuropathic symptoms of [appellant's] four extremities is not related to any work injury or attempted treatment thereof, but to chemotherapy." Dr. Abate advised that the objective findings on physical examination, including appellant's feeling of freezing cold, the lack of allodynia, swelling, or redness, were inconsistent with CRPS and that it was also unlikely for the condition to extend to all extremities. He found that she had no employment-related disability, but was disabled due to her polyneuropathy caused by chemotherapy. In a work capacity evaluation (OWCP-5c) dated September 5, 2017, Dr. Abate indicated that appellant could perform a sedentary job with restrictions.

Subsequently, appellant submitted an October 31, 2016 report from Dr. Elena M. Massarotti, a Board-certified rheumatologist, who evaluated her for chronic bilateral lower extremity pain. She diagnosed CRPS, noting that the examination findings were inconsistent with lupus or rheumatoid arthritis.

On March 9, 2018 Dr. Micheli indicated that an injection that appellant had received to treat a bone spur of the left heel "had a role in triggering" CRPS. He diagnosed CRPS of the bilateral hands and feet as consequential injuries, noting that the condition was "known to affect a limb following an injury and can spread to other extremities.[6]

By decision dated April 12, 2018, OWCP denied expansion of appellant's claim to include right foot and bilateral hand CRPS as work-related conditions. It found that the opinion of Dr. Abate, as the impartial medical examiner (IME), constituted the special weight of the evidence and established that she had not sustained right foot and bilateral hand CRPS condition as a consequential injury.

On April 30, 2018 appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A telephonic hearing was held on October 12, 2018.

OWCP subsequently received an April 20, 2018 statement from Dr. Rachel Freedman, a Board-certified oncologist. Dr. Freedman related that she had treated appellant for cancer from 2009 to 2015, noting that she had received chemotherapy and Tamoxifen. She advised that neither treatment was associated with neuropathy of the feet and opined that the condition was unrelated to appellant's cancer or its treatment.

In a report dated September 27, 2018, Dr. Micheli noted that appellant had CRPS of the left foot originating from either an injury or an injection in the foot for chronic plantar fasciitis and

[6] On August 3, 2017 Dr. Micheli noted that appellant had a sprain of the fourth metatarsophalangeal joint and a recurrence of ingrown toenails. He treated her on February 3, 2018 for bilateral foot and hand CRPS and worsening bilateral big toe ingrown toenails.

bone spur of the left heel. He diagnosed "regional pain syndrome, a neuropathic disease of unknown origin that can occur after immobilization, trauma, or an injury and could spread "to other areas of the same extremities or adjacent…." Dr. Micheli noted that the physician who had treated appellant for cancer had opined that her chemotherapy was "not associated with the neuropathy of [appellant's] feet and hands" and that he agreed with this conclusion. He opined that the regional pain syndrome of her extremities was "more likely related to [appellant's] initial injury of plantar fasciitis and bone spur which occurred in the course of her work participation."

On October 3, 2018 Dr. Elliot W. Yoo, a Board-certified physiatrist, evaluated appellant for bilateral foot and hand pain. He noted her history of work-related foot pain due to a calcaneal bone spur treated with a steroid injection in 2011 that had resulted in increased pain. On examination Dr. Yoo found reddish palms, a somewhat shiny and red surface of the feet and heel, no hair on the dorsum of the feet, hyperalgesia over the metatarsals, and allodynia of the toes at all five digits bilaterally. He diagnosed CRPS/neuropathic pain of the feet and hands, chronic pain syndrome, and central pain sensitization.

By decision dated December 10, 2018, an OWCP hearing representative affirmed the April 12, 2018 decision.

LEGAL PRECEDENT

The claimant bears the burden of proof to establish a claim for a consequential injury.[7] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relationship. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[8]

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[9] 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.[10]

In discussing the range of compensable consequences, once the primary injury is causally connected with the employment, 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 the claimant's own conduct as an independent intervening cause. The basic rule is that, a subsequent injury,

[7] *I.S.*, Docket No. 19-1461 (issued April 30, 2020).

[8] *K.W.*, Docket No. 18-0991 (issued December 11, 2018).

[9] *G.R.*, Docket No. 18-0735 (issued November 15, 2018).

[10] *Id*.

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.[11]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] OWCP's implementing regulations provide that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. 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] Where a case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[14]

ANALYSIS

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

OWCP properly determined that a conflict in medical opinion existed between Dr. Micheli, appellant's treating physician, and Dr. Geary, the second opinion examiner, on the issue of whether appellant sustained right foot and bilateral hand CRPS as a consequence of her accepted August 30, 2003 employment injury. Accordingly, it referred her to Dr. Abate for an impartial medical examination and an opinion to resolve the conflict.[15]

As noted, when a case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[16]

The Board finds that the report of Dr. Abate is insufficient to carry the special weight of the evidence. In an August 21, 2017 report, Dr. Abate reviewed the medical record, the SOAF, and appellant's history of an August 30, 2003 employment injury. On examination he found no swelling, discoloration, hypothermia, or skin changes of the hands and feet, full range of motion, no allodynia, and absent sensation in a stocking and glove-like distribution at the wrists and ankle joints. Dr. Abate found that appellant's symptoms of peripheral neuropathy in all of her extremities were unrelated to her employment injury or to treatment of the employment injury, but instead resulted from chemotherapy administered for cancer. He noted the lack of objective findings on examination of the hands and feet was inconsistent with CRPS and was more consistent with chemotherapy induced polyneuropathy. Dr. Abate diagnosed chemotherapy induced polyneuropathy, a left heel spur, symptomatic, and resolved plantar fasciitis. However, in finding

[11] *K.S.*, Docket No. 17-1583 (issued May 10, 2018).

[12] 5 U.S.C. § 8123(a).

[13] 20 C.F.R. § 10.321.

[14] *V.K.*, Docket No. 18-1005 (issued February 1, 2019); *D.M.*, Docket No. 17-1411 (issued June 7, 2018).

[15] *G.B.*, Docket No. 19-1510 (issued February 12, 2020); *R.H.*, 59 ECAB 382 (2008).

[16] *Supra* note 14.

appellant's symptoms of neuropathy in her extremities unrelated to her federal employment, he disregarded the SOAF, which set forth the accepted conditions in the claim, including RSD of the left lower extremity, also called CRPS, Type 1. The Board has explained that when an IME disregards a critical element of the SOAF, such as disagreeing with the acceptance of a condition in the claim, that opinion is insufficient to resolve the existing conflict in the medical opinion.[17] OWCP provided Dr. Abate with a SOAF to ensure his report was based on a proper factual background.[18] The Board finds that he failed to rely upon the SOAF and thus his report is not based upon an accurate history.[19] For these reasons the Board finds that his report is insufficient to resolve the existing conflict in the medical opinion evidence.[20]

The Board has held that, when OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the IME's opinion requires clarification or elaboration, it must secure a supplemental report to correct the defect in his or her original report.[21] If the IME is unable to clarify or elaborate on his or her original report, or if the supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to another IME for the purpose of obtaining a rationalized medical opinion on the issue.[22]

Upon return of the case record, OWCP should provide Dr. Abate with an updated SOAF and case record, including the report of Dr. Freedman, and obtain a supplemental report clarifying whether appellant sustained CRPS of the right foot or bilateral hands as a consequence of her accepted employment injury. Following this and any further development deemed necessary, it shall issue a *de novo* decision.[23]

CONCLUSION

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

[17] *J.S.*, Docket No. 17-0626 (issued January 22, 2019); *M.D.*, Docket No. 18-0468 (issued September 4, 2018).

[18] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990) (when OWCP's medical adviser, second opinion specialist or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether).

[19] *V.H.*, Docket No. 17-0439 (issued December 13, 2017); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[20] *K.C.*, Docket No. 19-1251 (issued January 24, 2020).

[21] *R.O.*, Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996); *see also supra* note 18 at Chapter 2.810.11(c)(1)-(2) (September 2010).

[22] *Id*.

[23] *See S.R.*

ORDER

IT IS HEREBY ORDERED THAT the December 10, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: June 10, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board