United States Department of Labor
Employees' Compensation Appeals Board

K.C., Appellant	)	
and	)	**Docket No. 19-0137**
	)	**Issued: May 29, 2020**
U.S. POSTAL SERVICE, POST OFFICE, Kewaunee, WI, 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, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 24, 2018 appellant, through counsel, filed a timely appeal from an August 27, 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 August 27, 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 his burden of proof to establish a left lower extremity condition causally related to the accepted December 23, 2016 employment incident.

FACTUAL HISTORY

On January 9, 2017 appellant, then a 61-year-old rural carrier associate, filed a traumatic injury claim (Form CA-1) alleging that on December 23, 2016 he sprained his left ankle when he slipped on ice and snow while in the performance of duty. He stopped work on January 7, 2017.

In a January 29, 2017 e-mail, a medical management nurse noted that appellant had partial left toe amputation surgery on January 25, 2017 and that he was still hospitalized. She indicated that his surgery was for infected calluses and blisters that he attributed to walking four days on a sprained ankle with an altered gait pattern. The medical management nurse noted that appellant had a history of borderline diabetes.

In a development letter dated February 3, 2017, OWCP notified appellant that when his claim was first received, it appeared to be a minor injury that resulted in minimal or no lost time from work, and that the merits of the claim had not been formally considered. It indicated that his claim had been reopened for consideration because he had not returned to work. OWCP informed appellant of the type of factual and medical evidence needed to establish his claim and attached a questionnaire for his completion. It afforded him 30 days to submit the necessary evidence.

Appellant subsequently submitted a January 9, 2017 x-ray of the left ankle which demonstrated no acute fracture or malalignment with remote posterior matter changes of the medial malleolus, mild degenerative changes of the first metatarsal phalangeal joint, small calcaneal degenerative disease affects, and mild soft tissue swelling of the dorsal forefoot.

In a procedure note dated January 13, 2017, Dr. Stewart Gifford, a Board-certified surgeon, advised that appellant had presented several days earlier with a swollen, blistered left great toe. He advised that appellant's foot examination demonstrated necrotic-appearing skin dorsally, and that the erythema previously seen across the forefoot was no longer present. Dr. Gifford performed incision, drainage, and debridement of the left great toe, diagnosed diabetic foot infection of the toe, and informed appellant that the toe could require amputation. A left ankle x-ray that day demonstrated improvement in dorsal soft tissue swelling.

Katie Lukes, a nurse practitioner, noted seeing appellant in follow-up on January 16, 17, and 18, 2017. She performed dressing changes and diagnosed left foot ulcer and diabetic infection.

On January 19, 2017 Dr. Gifford again debrided necrotic material from appellant's left great toe.

On January 25, 2017 Dr. Gifford noted that appellant was admitted with a left-sided diabetic foot infection. He reported a history that earlier that month appellant noted blister formation over the dorsum of his left great toe, which had been debrided and that he, also had a plantar ulcer, which was also debrided. In a procedure report that day, Dr. Gifford indicated that he performed additional excisional debridement for the diabetic infection of both left foot areas and installed a wound vacuum device. In a January 30, 2017 discharge summary, he noted that

appellant was discharged in good condition that day and was advised not to weight-bear. Discharge diagnoses were type 2 diabetes mellitus and diabetic foot infection.

On February 3, 2017 Dr. Gifford noted that appellant's left foot had continued swelling that affected the left great toe and metatarsal head area. He diagnosed diabetic foot infection and recommended continued use of the wound vacuum device. On February 10, 2017 Dr. Gifford performed excisional debridement of bone fragments secondary to appellant's diabetic foot infection.

By decision dated March 9, 2017, OWCP denied appellant's claim finding that he had not established that the December 23, 2016 incident occurred as described. It explained that he had not provided a detailed description of the factual aspects of his case. OWCP concluded that the requirements had not been met to establish an injury as defined by FECA.

On March 24, 2017 appellant, through counsel, requested a telephonic hearing with OWCP's Branch of Hearings and Review.

Medical evidence submitted subsequent to the March 9, 2017 decision included a January 9, 2017 treatment note in which Ms. Lukes indicated that appellant told her that two weeks prior he had fallen six times on ice, that he had not worked in five days due to pain, and that he thought he had a blister on his left plantar toe. On examination Ms. Lukes observed a large ulcer on his great toe and recommended referral for wound care.

In a January 11, 2017 treatment note, Dr. Gifford reported that appellant was a mail carrier and had recently had several bad days of walking, noting that he fell down six times, wrenched his left knee, and twisted both ankles. He continued that appellant subsequently noted blister formation on the plantar aspect of the first metatarsal head, associated with swelling and erythema of the distal forefoot and great toe. Dr. Gifford described examination findings, noting that the left foot was grossly swollen from the distal third of the calf down to and including the left great toe with ulceration involving the plantar aspect of the distal phalanx, and blistering and erythema of the left foot. He advised that it was somewhat difficult to separate how much of appellant's left foot swelling was secondary to ankle injury and how much could be secondary to a diabetic foot infection. Dr. Gifford noted that, at that time, he had no conclusive evidence of a diabetic foot infection, but that one was suspected.

On January 18, 2017 Dr. Gifford performed additional excisional debridement of appellant's left great toe. Both he and Ms. Lukes continued to provide treatment for appellant's left foot condition. This included additional excisional debridement of appellant's left great toe on February 24, 2017. A February 24, 2017 left foot x-ray demonstrated increased soft tissue swelling when compared to the January 13, 2017 x-ray, and a strong suggestion of osteomyelitis involving the first metatarsal distally, sesamoid bones, and the base of the first proximal phalanx, with a small amount of involvement of the distal phalanx.

In progress notes dated March 3 and 10, 2017, Dr. Gifford indicated that appellant's left great toe was massively enlarged when compared to the remainder of the foot. He noted three distinct areas of the wound with tunneling to bone. Great toe amputation was recommended.

On March 14, 2017 Dr. Gifford performed transmetatarsal amputation of appellant's left great toe. The postoperative diagnosis was left-sided diabetic foot infection affecting the left great

toe with underlying osteomyelitis, Wagner's grade three.[4] Appellant was discharged on March 16, 2017.

Dr. Gifford saw appellant in follow-up on March 22 and 29, 2017 and noted a healing of the diabetic left toe infection.

On April 5, 2017 Dr. Rance Hafner, Board-certified in family medicine, saw appellant for wound follow-up. He described examination findings and diagnosed healing diabetic foot infection of the left great toe following amputation.

Dr. Gifford continued to see appellant in follow-up and described continued healing.

In a report dated July 19, 2017, Dr. Barbara Harkness, Board-certified in family medicine, noted that appellant had returned to work and reported no issues with being on his feet for a five- to six-hour shift. She indicated that the left great toe amputation site was improving.

On July 26, 2017 Dr. Gifford advised that inspection of appellant's left great toe demonstrated complete healing. He noted that appellant would be discharged from the wound clinic.

A hearing was held on September 5, 2017. Counsel maintained that appellant had several ankle sprains on or about December 23, 2016. Appellant testified that he had not had diabetic foot care before 2017 and that on December 23, 2016, he had fallen a total of six times after an ice storm the night before, which buckled his left ankle. He indicated that he then worked five shifts before seeking medical attention. Appellant reported that he returned to part-time modified duty work on July 8, 2017.

Counsel subsequently submitted an undated letter in which Dr. Gifford noted appellant's history of injury and initial treatment. Dr. Gifford indicated that his first encounter with appellant was on January 11, 2017 when he noted that the amount of appellant's swelling could not be separated between his prior injury and the development of his great toe ulceration. He also indicated that the blister formation and subsequent ulcer were undoubtedly initiated by an abnormal gait caused by his ankle and knee injuries. Dr. Gifford opined that the presence of the skin injury, in the presence of poorly-controlled diabetes mellitus 2, rapidly progressed to the development of a diabetic foot infection of the left great toe. The resulting treatment, which included amputation, then proceeded as required by appellant's condition.

In correspondence dated September 20, 2017, appellant maintained that working after his ankle sprain worsened his left foot condition.

By decision dated October 19, 2017, the hearing representative accepted that the December 23, 2016 employment incident occurred as alleged, that appellant had provided a diagnosis of left foot ulcer, and that performance of duty was established. She remanded the case, however, for OWCP to obtain a second opinion examination regarding whether the employment incident contributed by direct cause, aggravation, precipitation, or acceleration to any of appellant's diagnosed conditions.

[4] In a report dated March 14, 2017, Dr. Gifford described appellant's left foot treatment to date.

On November 27, 2017 OWCP referred appellant, along with a statement of accepted facts (SOAF) and the medical record, to Dr. Gregory Peyer, a Board-certified orthopedic surgeon.

In a report dated December 11, 2017, Dr. Peyer noted the appellant's claimed history of injury. He described appellant's examination findings and medical treatment from January 9, 2017, including that his left great toe had been amputated, and that he was discharged from the wound clinic in July 2017. Dr. Peyer indicated that, at the time of examination, appellant had a sedentary job at the employing establishment and planned to retire at the end of the year. He noted that examination of the left foot showed that the great toe amputation site was well healed with no open wounds on the foot, good capillary refill, and intact sensation to light touch. No ulcerative lesions were noted. Dr. Peyer acknowledged the accepted December 23, 2016 employment incident. As to whether the accepted incident caused his open wounds and osteomyelitis, he noted his review of Dr. Gifford's undated correspondence and reported that appellant adamantly indicated that he had not sustained a foot ulcer prior to the December 23, 2016 employment incident. After a discussion of the medical evidence of record, Dr. Peyer noted that a significant ankle sprain would be expected to demonstrate significant ecchymosis after two weeks, that it would make the foot difficult to walk on, and that the normal response would be to decrease the pressure on the injured wound, which would not contribute to the formation of a pressure ulcer. He indicated that severe swelling could cause blisters, "but the blisters are usually closer to the injury," as in "an ankle injury they typically occur adjacent to the malleoli and are much more common on the dorsal surface than the plantar surface of the foot." Dr. Peyer opined that he could find no convincing evidence that the accepted employment incident resulted in any of the diagnosed conditions.

By decision dated February 1, 2018, OWCP denied appellant's claim. It found that the evidence submitted was insufficient to establish causal relationship between his diagnosed conditions and the accepted December 23, 2016 employment incident.

On February 12, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

During the hearing, held on July 2, 2018, counsel asserted that OWCP unfairly gave the weight of the evidence to the second opinion examiner. He explained that appellant was not claiming that his position caused him to have diabetes or diabetic neuropathy, but that his employment incident caused aggravation of his preexisting conditions and, therefore, causal relationship was established. Appellant testified that on the date of injury, he was on no diabetic medication, and that he had not found out that he was diabetic until the work-up for his foot. The hearing representative held the record open for 30 days for the submission of additional evidence. No additional evidence was received.

By decision dated August 27, 2018, the hearing representative affirmed OWCP's February 1, 2018 decision, finding that Dr. Peyer's second opinion report constituted the weight of medical evidence.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] 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 of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability or specific condition for which compensation in claimed is causally related to the employment injury.[6] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[7]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established.[8] Fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[9] The second component is whether the employment incident caused a personal injury.[10] Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[11] Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and compensable employment factors.[12] 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.[13]

Section 8123(a) of FECA 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.[14] The implementing regulation provides that, if a conflict exists between the medical opinion of the employee's physician and the

[5] *Supra* note 2.

[6] *D.J.*, Docket No. 19-1301 (issued January 29, 2020); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *Id*.

[8] *D.B.*, Docket No. 18-1348 (issued January 4, 2019); *T.H.*, 59 ECAB 388, 393-94 (2008).

[9] *See M.F.*, Docket No. 18-1162 (issued April 9, 2019); *D.S.*, Docket No. 17-1422 (issued November 9, 2017); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[10] *B.M.*, Docket No. 17-0796 (issued July 5, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

[11] *T.H.*, Docket No. 19-0599 (issued January 28, 2020).

[12] *K.C.*, Docket No. 18-0529 (issued January 21, 2020).

[13] *D.J.*, *supra* note 6.

[14] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

medical opinion of either a second opinion physician or a district medical adviser (DMA), OWCP shall appoint a third physician to make an impartial examination.[15]

ANALYSIS

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

In reports dated January 13, 2017 to an undated report received by OWCP on September 29, 2017, Dr. Gifford, appellant's treating surgeon, recounted appellant's history of diabetic foot infection that necessitated amputation of his left great toe. He described appellant's examination findings and treatment. Dr. Gifford diagnosed left-sided diabetic foot infection affecting the left great toe with underlying osteomyelitis. In the undated report, he explained that when he first saw appellant on January 11, 2017, the amount of appellant's swelling of appellant's left foot could not be separated between his prior injury and the development of his great toe ulceration. Dr. Gifford indicated that the blister formation and subsequent ulcer were undoubtedly initiated by an abnormal gait caused by appellant's ankle and knee injuries. He opined that the presence of the skin injury, in the presence of poorly-controlled diabetes mellitus, rapidly progressed to the development of a diabetic foot infection of the left great toe, with resulting treatment that included amputation.

Dr. Peyer, OWCP's referral physician, provided a December 11, 2017 report in which he fully discussed the medical evidence of record and described examination findings. In contrast, he opined that he could find no convincing evidence that appellant's diagnosed conditions were causally related to the accepted December 23, 2016 employment incident.

Both Dr. Gifford and Dr. Peyer provided a description of appellant's employment incident and both provided rationale for their respective opinions based on their review of the medical evidence and physical findings. The Board, therefore, finds that a conflict in medical opinion exists regarding whether appellant's diagnosed conditions were causally related to the accepted December 23, 2016 employment incident.[16]

As noted, OWCP's 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 its DMA, OWCP shall appoint a third physician to resolve the conflict in the medical opinion.[17] The Board will thus remand the case to OWCP for referral to an impartial medical examiner regarding whether appellant has met his burden of proof to establish that his diagnosed conditions are causally related to the accepted December 23, 2016 employment incident. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.[18]

[15] 20 C.F.R. § 10.321.

[16] *See M.W.*, Docket No. 19-1347 (issued December 5, 2019).

[17] *Id*.

[18] *M.N.*, Docket No. 19-1421 (issued March 5, 2020); *M.W.*, *supra* note 16.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 27, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 29, 2020
Washington, DC

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

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

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