United States Department of Labor
Employees' Compensation Appeals Board

S.N., Appellant	)	
and	)	**Docket No. 21-0070**
	)	**Issued: March 9, 2022**
U.S. POSTAL SERVICE, DOWNTOWN POST OFFICE, Wichita, KS, 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:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 22, 2020 appellant, through counsel, filed a timely appeal from an August 21, 2020 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 21, 2020 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 OWCP properly denied appellant's request for authorization of additional surgery.

FACTUAL HISTORY

On October 25, 2014 appellant, then a 36-year-old city carrier assistant, filed a traumatic injury claim (Form CA-1) alleging that on that date she twisted her left ankle when she stepped off of a porch onto grass while in the performance of duty.[4] OWCP accepted the claim for left ankle sprain. Appellant returned to limited duty and, as of May 12, 2015, worked full-time regular duty. On June 18, 2015 OWCP accepted an additional condition of left tarsal syndrome. On June 23, 2015 appellant underwent an OWCP-authorized left tarsal tunnel release with neurolysis and an additional nonauthorized left partial plantar fascia release which were performed by Dr. Shawn Morrow, a Board-certified orthopedic foot and ankle surgeon. OWCP paid appropriate benefits and she returned to full-time work in a limited-duty capacity on August 10, 2015.

On October 27, 2015 appellant saw Dr. Steven Howell, a Board-certified orthopedic surgeon, specializing in ankle and foot surgery. On November 20, 2015 Dr. Howell requested authorization for additional surgery involving incision of left foot fascia, decompression of tibial nerve, partial removal of ankle/heel, and partial removal of foot bone. Additional requests were submitted on January 5, March 9, and June 15, 2016.

On September 16, 2016 OWCP forwarded appellant's medical record and a statement of accepted facts (SOAF) to Dr. William Tontz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), to determine whether her requested surgery was medically necessary and causally related to her accepted left ankle sprain and left tarsal tunnel syndrome. In a September 20, 2016 report, Dr. Tontz opined that there was evidence of a temporal relationship between the October 25, 2014 employment injury and the proposed incision of foot fascia, decompression of tibia nerve, partial removal of ankle/heel and partial removal of foot bone, but there was insufficient evidence in the case record of failed conservative management to support plantar fascia release. He thereafter concluded that the proposed incision of foot fascia, decompression of tibia nerve, partial removal of ankle/heel, and partial removal of foot bone were not medically necessary.

On November 17, 2016 OWCP referred appellant, along with the medical record and a SOAF, to Dr. Michael J. Johnson, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a November 22, 2016 report, Dr. Johnson reviewed the medical record and the SOAF and indicated that appellant had received appropriate conservative treatment since her last surgical procedure, which had not improved enough to allow her to return to full duty. He opined that only the decompression of tibia nerve (tarsal tunnel release revision) was medically necessary and causally related to the accepted left tarsal tunnel syndrome. Dr. Johnson opined that the other

[4] At the time of injury, appellant was working with medical restrictions under a traumatic injury under OWCP File No. xxxxxx267. In that claim, OWCP accepted that her fall on August 13, 2016 resulted in right hand contusion, head contusion, chondromalacia patellae, right knee, nondisplaced fracture of base of fifth metacarpal bone, right hand, and carpal tunnel syndrome, right upper limb. It has administratively combined these claims, with OWCP File No. xxxxxx493 serving as the master file.

proposed procedures were not causally related to the employment injury or the accepted conditions. He indicated that the proposed incision of plantar fascia/plantar fascia release was not related to the accepted diagnosis or secondary to mechanism of injury, the removal of bone spur/partial removal of ankle/heel was due degenerative/arthritis and not traumatic injury, and the partial resection of bone/ossicia excision/partial removal of foot bone was a congenital/developmental deformity to navicular bone which preexisted the employment injury.

On January 17, 2017 OWCP provided Dr. Morrow a copy of Dr. Johnson's second opinion report and requested whether he agreed that only the decompression of tibia nerve surgery was causally related to the October 25, 2014 employment injury and the accepted left tarsal tunnel syndrome condition. On February 10, 2017 Dr. Morrow concurred with Dr. Johnson's opinion.

On March 7, 2017 Dr. Howell disagreed with Dr. Johnson's opinion on causal relation. He opined that the increased dorsal impingement of the navicular was due to some loss of arch secondary to the plantar fascial release, which was secondary to employment-related plantar fasciitis. In a March 21, 2017 report, Dr. Howell also opined that appellant's talonavicular spurring was causally related to the accepted conditions. He explained that she had no pain prior to her injury which worsened after her surgery, consistent with an os naviculare secundum that loosened up with her original injury and the subsequent spurring was impinging more following the slight loss of the arch support after the plantar fascial release. Dr. Howell indicated that this preexisting condition was worsened by the employment injury.

On March 27, 2017 OWCP found a conflict in medical opinion between Dr. Howell and Dr. Johnson regarding causal relationship and the medical necessity of the specific proposed surgical procedures. It referred appellant to Dr. Sami Framjee, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

However, OWCP found that Dr. Framjee had not answered the questions submitted. On May 18, 2018 it related that appellant would be referred for a new impartial medical evaluation.

On September 13, 2018 OWCP referred appellant, an updated SOAF and a series of questions, to Dr. Dale D. Dalenberg, a Board-certified orthopedic surgeon, for an impartial medical evaluation. The SOAF noted that the accepted conditions were a left ankle sprain and left tarsal tunnel syndrome, and that on June 23, 2015 appellant underwent a left tarsal tunnel release with neurolysis and left partial plantar fascia release. In its series of questions, OWCP specifically inquired as to whether the recommended incision of foot fascia, decompression of tibia nerve, partial removal of ankle/heel, and partial removal of foot bone were medically necessary for, and causally related to, the accepted conditions of the accepted left ankle sprain and left tarsal tunnel syndrome.

In a December 21, 2018 report, Dr. Dalenberg noted that appellant was examined on October 4, 2018. He advised that the proposed procedures were unlikely to improve her condition and that failure to address her dorsal foot pain and popping by not addressing the talonavicular joint problem would leave ongoing complaints. Dr. Dalenberg explained that there was no evidence that performing another tarsal tunnel release would make any difference and the areas of numbness did not support that it was just tarsal tunnel syndrome. He opined that the proposed decompression of the tibial nerve was not medically necessary as it had already been performed, it did not help or had worsened appellant's symptoms, and it would not fully address her

objectively demonstrated numbness. Dr. Dalenberg explained that the proposed excision of the plantar fascia was not for an accepted condition and was not medically necessary with a predominant complaint of dorsal pain and foot/ankle popping and pain. He further opined that the proposed bone removal, particularly removal of the plantar calcaneal spur, was not related to the accepted conditions and, while it was usually done in conjunction with plantar fascia release, he opined that it would not appreciably improve appellant's symptoms. Dr. Dalenberg also advised that the proposed partial resection of bone/ossicle excision/partial removal of foot bone was not medically necessary or causally related to the accepted left ankle sprain and left tarsal tunnel syndrome. He explained that there was evidence of an old dorsal lip avulsion fracture, which was akin to an ankle sprain, but was never diagnosed or treated. This condition was probably subtly unstable given her popping complaint, and management was usually conservative treatment. Dr. Dalenberg also advised that late surgical treatment was not standard and may be considered controversial.

By decision dated February 19, 2019, OWCP denied authorization of the requested surgical procedures. The special weight of the medical evidence was accorded to the opinion of Dr. Dalenberg, the impartial medical examiner (IME).

On February 25, 2019 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held telephonically on June 7, 2019.

OWCP received additional evidence, including x-rays of appellant's left foot dated October 4, 2018, which noted small plantar spur and mild degenerative spurring along the dorsal midfoot.

In an April 2, 2019 report, Dr. Howell indicated that the x-rays taken that day of appellant's left foot showed prominent spurring with a very small surface area for weight bearing on the plantar aspect of her heel directly where she was tender on examination. Appellant also had numbness and tingling on the bottom of her foot consistent with tarsal tunnel syndrome, which he believed that had not been completely decompressed, and spurring at the dorsum of the talonavicular joint. Dr. Howell opined that he could help her with the surgery he previously offered and outlined his proposed approach. He noted that appellant had been evaluated by an orthopedist who was not a foot/ankle expert. Dr. Howell questioned the opinion that her condition would not improve as it was not certain that her tarsal tunnel condition had been adequately released. He noted that appellant would also benefit by a simple removal of the spurring from the talonavicular joint and disagreed with Dr. Dalenberg that the talonavicular ligaments would be involved.

By decision dated June 18, 2019, an Office hearing representative set aside OWCP's February 19, 2019 decision and remanded the case to OWCP for further development and a *de novo* decision. The hearing representative directed OWCP to have Dr. Dalenberg review Dr. Howell's April 2, 2019 report.

In a July 1, 2019 letter, OWCP requested that Dr. Dalenberg review Dr. Howell's April 2, 2019 report and issue a supplemental report.

In a November 20, 2019 addendum, Dr. Dalenberg reviewed Dr. Howell's April 2, 2019 report and indicated that his concern was that the results of the tarsal tunnel release were uncertain. He noted that literature documented worse results with revision release, and that results could be compromised by adhesive neuritis and intraneural damage, which could be the reason for appellant's ongoing symptoms. Dr. Dalenberg explained that appellant had a predominance of dorsal foot pain and popping during his examination, which was not anatomically related to a tarsal tunnel syndrome diagnosis, and he believed that performing the same surgery would not be warranted, as the prior procedure had not been successful, and her current symptoms were not due to tarsal tunnel syndrome. He noted that he had performed various procedures about the foot and ankle and indicated that he had similar credentials to Dr. Howell. Dr. Dalenberg also noted that he was called upon by OWCP to weigh in on whether the proposed surgery was for conditions specified in the SOAF and whether such treatments were likely to be successful. He reiterated his concern that, while distal release was an indication for revision tarsal tunnel release, it may not be successful. Dr. Dalenberg also explained that the basis of his medical opinion was the fact that a large part of appellant's symptomatology (dorsal foot pain and popping) had nothing to do with the accepted tarsal tunnel syndrome. He agreed with Dr. Howell that ligament reconstruction around the talonavicular joint or fusion was not standard with this clinical presentation and explained that this was mentioned in his prior report as ideas on how to address the dorsal foot pain and popping. Dr. Dalenberg agreed with dorsal fragment excision but explained that the procedure was unrelated to the accepted ankle sprain, and tarsal tunnel syndrome.

By decision dated February 25, 2020, OWCP again denied authorization of the requested surgical procedures. It accorded the special weight of the medical to the opinion of Dr. Dalenberg, the IME.

On March 4, 2020 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held telephonically on June 11, 2020.

In a July 2, 2020 report, Dr. Howell indicated that he did not understand Dr. Dalenberg's opinion that appellant's symptoms on the dorsum of the foot were unsubstantiated by her other complaints. He explained that her dorsal foot pain was consistent with talonavicular spurring and the numbness on the bottom of her foot was consistent with an incompletely released tarsal tunnel. Dr. Howell opined that appellant had a reasonable chance of responding satisfactorily to the proposed surgical procedure.

By decision dated August 21, 2020, OWCP's hearing representative affirmed the February 25, 2020 decision.

LEGAL PRECEDENT

Section 8103 of FECA[5] provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which OWCP considers likely to cure, give relief, reduce

[5] *Supra* note 2 at § 8103.

the degree, or the period of disability, or aid in lessening the amount of monthly compensation.[6] In interpreting section 8103 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[7]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[8] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[9] In order to prove that the procedure is warranted, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[10]

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[11] For a conflict to arise the opposing physicians' viewpoints must be of virtually equal weight and rationale.[12] Where OWCP has referred the case to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[13] If the IME is unable to clarify or elaborate on his original report, or if his supplemental report is vague, speculative, or lacking in rationale, OWCP shall refer appellant to a new IME.[14]

ANALYSIS

The Board finds that OWCP properly denied appellant's request for authorization of additional surgery.

OWCP properly found that a conflict in medical opinion existed between Dr. Howell, appellant's attending physician, who recommended incision of foot fascia, decompression of tibia nerve, partial removal of ankle/heel and partial removal of foot bone, and Dr. Johnson, the second

[6] *Id.*, *see also N.G.*, Docket No. 18-1340 (issued March 6, 2019).

[7] *D.S.*, Docket No. 19-1698 (issued June 18, 2020); *D.W.*, Docket No. 19-0402 (issued November 13, 2019); *see also Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or administrative actions which are contrary to both logic, and probable deductions from established facts).

[8] *See R.M.*, Docket No. 19-1319 (issued December 10, 2019); *Debra S. King*, 44 ECAB 203, 209 (1992).

[9] *Id.*; *see also K.W.*, Docket No. 18-1523 (issued May 22, 2019); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[10] *See T.A.*, Docket No. 19-1030 (issued November 22, 2019); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[11] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *K.C.*, Docket No. 18-0378 (issued June 18, 2019).

[12] *Id.*

[13] *J.H.*, Docket No. 19-0513 (issued September 24, 2019).

[14] *See C.E.*, Docket No. 19-1923 (issued March 30, 2021); *M.S.*, Docket No. 18-1228 (issued March 8, 2019); *R.H.*, Docket No. 17-1903 (issued July 5, 2018).

opinion physician, who opined that only the recommended decompression of the tibia nerve was medically necessary and causally related to the accepted left tarsal tunnel syndrome. Consequently, it referred her to Dr. Framjee, an IME, to resolve the conflict in medical opinion pursuant to 5 U.S.C. § 8123(a). However, Dr. Framjee was unable to clarify or elaborate on his original report in response to OWCP's questions and it was unlikely that he would respond to an additional request for clarification. OWCP, therefore, properly referred appellant to a new IME.[15] It referred her to Dr. Dalenberg, serving as the new IME, to resolve the conflict in medical opinion.

The Board finds that the special weight of the medical evidence rests with the opinion of Dr. Dalenberg, who examined appellant, reviewed the medical evidence, and found that the authorization of additional surgery regarding decompression of tibial nerve was not medically necessary and additional surgery involving incision of left foot fascia, partial removal of ankle/heel, and partial removal of foot bone were not medically necessary, or causally related to, the accepted left ankle sprain and left tarsal tunnel syndrome.

The record reflects that Dr. Dalenberg was provided with a SOAF, which listed the accepted conditions and noted appellant's June 23, 2015 surgery involved a left tarsal tunnel release with neurolysis and left partial plantar fascia release. The left partial plantar fascia release was not authorized by OWCP and was for a condition which OWCP had not accepted.[16] Dr. Dalenberg also provided a series of questions which specifically requested that he provide medical rationale to support his opinion on the medical necessity for the proposed surgery involving incision of foot fascia, decompression of tibia nerve, partial removal of ankle/heel, and partial removal of foot bone.

In his December 21, 2018 report, Dr. Dalenberg opined that the proposed decompression of the tibial nerve was not medically necessary as it had already been performed, it did not help or had worsened appellant's symptoms, and it would not fully address her objectively demonstrated numbness. He opined, however, that the proposed incision of the plantar fascia, and the partial removal of ankle/heel, and foot bone were not medically necessary or causally related to the accepted left ankle sprain and left tarsal tunnel syndrome. Dr. Dalenberg explained that incision of the plantar fascia was not medically necessary for a predominant complaint of dorsal pain and foot/ankle popping and pain and, while removal of plantar calcaneal spurs was usually done in conjunction with plantar fascia release, it would not appreciably improve appellant's symptoms. With regard to the proposed partial resection of bone/ossicle excision/partial removal of foot bone, he explained that it was not medically necessary as appellant had a dorsal foot sprain which was probably subtly unstable given her popping complaint and management was usually closed.

In response to Dr. Howell's April 2, 2019 report, Dr. Dalenberg, in his November 21, 2019 report, reiterated that it was not medically warranted to repeat the tarsal tunnel release. He explained that the results of the tarsal tunnel release was uncertain, noting literature documented worse results with revision release, that the original surgery had not been successful, and that the

[15] *Id*.

[16] When an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury. *See T.E.*, Docket No. 18-1595 (issued March 13, 2019); *T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

results could be compromised by adhesive neuritis and intraneural damage. Dr. Dalenberg further indicated that appellant's symptomatology (dorsal foot pain and popping) were from something other than tarsal tunnel syndrome and was not anatomically related to the accepted tarsal tunnel syndrome. The Board further notes that, while he agreed with the dorsal fragment excision and that such removal was usually done in conjunction with plantar fascia release, he opined that the procedure was not for a diagnosis in the SOAF and was unrelated to the accepted ankle sprain and tarsal tunnel syndrome. As previously discussed, OWCP has not accepted an employment-related plantar fasciitis condition and appellant has failed to meet her burden of proof to establish her burden of proof.

In situations where the case is referred to an IME for the purpose of resolving a medical conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[17] The Board finds that Dr. Dalenberg provided a well-rationalized opinion based on a complete background, his review of the SOAF, the medical record, and his examination findings. Thus, Dr. Dalenberg's opinion that the requested procedures were not medically warranted for the accepted conditions is entitled to the special weight of the evidence.[18]

The Board further finds that Dr. Howell's reports, are insufficient to overcome the special weight accorded to Dr. Dalenberg because reports from a physician who was on one side of a medical conflict resolved by an IME are insufficient to overcome the special weight accorded the report of the IME or create a new conflict.[19]

The only limitation on OWCP's authority in approving or denying service under FECA is one of reasonableness.[20] OWCP obtained an impartial medical examination by Dr. Dalenberg who opined that the requested surgical procedures were not medically warranted for the accepted conditions. It, therefore, had sufficient evidence upon to deny surgery and did not abuse its discretion.

CONCLUSION

The Board finds that OWCP properly denied appellant's request for authorization of additional surgery.

[17] *See D.S.*, Docket No. 19-1698 (issued June 18, 2020); *C.W.*, Docket No. 17-0918 (issued January 5, 2018); *Patricia J. Glenn*, 53 ECAB 159 (2001).

[18] *See D.S.*, *id.*, *P.F.*, Docket No. 16-0693 (issued October 24, 2016).

[19] *J.M.*, Docket No. 18-1387 (issued February 1, 2019); *D.M.*, Docket No. 17-1992 (issued September 12, 2018); *S.F.*, Docket No. 17-1427 (issued May 16, 2018).

[20] *See T.A.*, Docket No. 19-1030 (issued November 22, 2019); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

ORDER

IT IS HEREBY ORDERED THAT the August 21, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 9, 2022
Washington, DC

Alec J. Koromilas, 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