File Number:
HR11-D-H

RECEIVED DEC 24 2018

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

Date of Injury:
Employee:

Dear

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A preliminary review has been completed, and it has been determined that the case is not in posture for a hearing at this time. The decision of the District Office has been vacated and returned to the district office for further action as explained in the attached Remand Order.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Division of Federal Employees' Compensation

PAUL H. FELSER, ESQ
FELSER LAW FIRM, PC
7393 HODGSON MEMORIAL DR., SUITE 102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, December 19, 2018

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et seq. of , claimant; employed by the case number

Merit Consideration of the case file was completed in Washington, D.C. Based on this review, the decision of the District Office dated is vacated for the reasons set forth below.

The issue is whether the Office abused its discretion in denying the request for authorization for procedure code

The claimant, born is employed as a sales, services/distribution associate by the . On , she filed a traumatic injury claim alleging that on she injured her feet and lower back while trying to avoid a tub that was sticking out under the counter. The Office initially accepted the claim for bilateral ankle contusion and right lumbar sprain. On nurse referral forms dated and , the Office listed accepted conditions as bilateral ankle contusion, right lumbar sprain, bilateral contracture of tendon (sheath), bilateral ankle sprain, and left plantar fibromatosis. The Office expanded the claim to accept "plantar fascia (left)" on and posterior tibial tendinitis of left leg on . CA-1008 letter dated listed all accepted conditions as right plantar fascial fibromatosis, left leg posterior tibial tendinitis, and right lumbar sprain. The Office authorized tenolysis with Topaz procedure, right posterior tibial tendon, flexor digitorum longus tendon transfer with an MBA implant performed on and left endoscopic plantar fasciotomy performed on .

In a letter dated MD stated that the claimant has had a substantial injury to both feet and ankles. He noted that she has had successful surgery performed by him with posterior tibial tendon reconstruction and subtalar arthroereisis on the right side. He recommended reconstruction on the left foot and ankle and noted that if it is as successful as it has been on the right foot and ankle, it is possible that she could return to work full time in a sedentary capacity.

On , the Office received Dr. request for authorization for left FDL tendon transfer (27690) and left subtalar arthroereisis (28585). The Office also received an electronic medical authorization request for procedure codes 27690 (revise lower leg tendon) and 28585 (repair foot dislocation).

Washington DC, December 19, 2018

In a report dated , a District Medical Advisor (DMA), , MD indicated that while arthroereisis in an adult is still considered somewhat controversial, it is becoming more accepted as a treatment option. "When combined with debridement of the posterior tibial tendon and an FDL transfer, it has the potential to improve the clinical situation of this patient." He noted that this procedure was done on the right side and appears to have been successful. He concluded that left FDL tendon transfer and left subtalar arthroereisis should be authorized. However, the DMA indicated that the submitted procedure codes are not accurate, 28585 is open treatment of a talotarsal joint dislocation and 27690 is superficial tendon transfer. He noted that the correct procedure code for an arthroeresis is 28899, and the proper code for an FDL tendon transfer is 27691.

On , the Office authorized procedure code 27690 (left revise lower leg tendon) and advised the claimant that the evidence in file was not sufficient to authorize procedure code 28585 (repair foot dislocation). It asked the claimant to have her physician submit a detailed narrative medical report addressing whether a newly-diagnosed condition is causally related to the accepted work injury.

The Office subsequent received Dr. ; request for authorization for left FDL tendon transfer (27691) and left subtalar arthroeresis (28899)

By letter dated the Office advised the claimant that procedure code (left foot surgery) was outside of the treatment suite for the accepted conditions and requested additional medical evidence addressing causal relationship between the new medical condition(s) and the accepted work injury.

On the Office authorized procedure code 27691 (left revise lower leg tendon).

In a letter date Dr. recommended that the claimant undergo the posterior tibial tendon reconstruction on the left with an FDL tendon transfer and the HyProCure implant subtalar arthroeresis to protect this repair and realign her foot and ankle. He again noted that the surgery on the right foot and ankle has been very successful.

On , the Office received an electronic medical authorization request for procedure code 28555 (repair foot dislocation) for the left side.

By letter dated the Office advised the claimant that procedure code 28555 was outside of the treatment suite for the accepted conditions and requested additional medical evidence addressing causal relationship between the new medical condition(s) and the accepted work injury.

In a report dated Dr. assessed chronic posterior tibial tendinosis, symptomatic and unresponsive to non-operative treatment. He recommended posterior

tibial tendon reconstruction with FDL tendon transfer. He noted that if the tendon was not completely torn, he may be successful in doing the Topaz procedure as well.

In a report dated , Dr. indicated that he was recommending a gastrocnemius lengthening, calcaneal osteotomy as well using the BME step staples.

On the Office received an electronic medical authorization request for procedure codes 28300 (incision of heel bone) and 27687 (revision of calf tendon).

By letter dated the Office advised the claimant that procedure codes 28300 and 27687 were outside of the treatment suite for the accepted conditions and requested additional medical evidence addressing causal relationship between the new medical condition(s) and the accepted work injury.

By decision dated the Office denied the authorization for procedure code 28555 (repair foot dislocation). The claimant's attorney requested an oral hearing.

In a letter dated Dr. stated that the claimant's MRI showed a torn spring ligament and she also had a contracture of the gastrocnemius tendon which was a direct result of her posterior tibial tendon tear which occurred as a work related injury. He recommended FDL tendon transfer, repair of the spring ligament (27698) and gastrocnemius recession (27687).

By decision dated the Office denied authorization for procedure codes 28300 (incision of heel bone) and 27687 (revision of calf tendon).

In a report dated Dr. indicated that the claimant's MRI clearly documented a tear to the posterior tibial tendon and to the spring ligament. He recommended proceeding with repair of the posterior tibial tendon with FDL tendon transfer and repair of the spring ligament. He noted getting approval for the FDL tendon transfer, but not for the spring ligament repair. "To repair the posterior tibial tendon without repairing the spring ligament, particularly when the MRI clearly shows a tear of the spring ligament would not be advised."

Based upon a review of the evidence of record, I find that further development is warranted.

Section 8103 of FECA 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 the degree or the period of disability or aid in lessening the amount of the monthly compensation.[1] In interpreting section 8103, the Board has recognized that OWCP has broad discretion in approving services provided under FECA.[2]

[1] 5 U.S.C. § 8103; *see R.L.*, Docket No. 08-855 (issued October 6, 2008); *Sean O'Connell*, 56 ECAB 195 (2004); *Thomas W. Stevens*, 50 ECAB 288 (1999).

[2] *A.O.*, Docket No. 08-580 (issued January 28, 2009); *Joseph P. Hofmann*, 57 ECAB 456 (2006).

The only limitation on OWCP's authority is that of reasonableness.[3] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[4]

OWCP procedures provide that a statement of accepted facts (SOAF) must contain the date of injury, claimant's age, the job held on the date of injury, the mechanism of injury and the claimed or accepted conditions. OWCP may also include additional elements, including appellant's prior medical history, depending on the nature of the condition claimed and the issues to be resolved.[5] However, the SOAF should not include raw evidence, justifications or reasons for conclusions reached, medical opinions, payment of OWCP compensation and OPM annuities, issues for determination, definitions of terms, discussion of legal issues, and appeals and administrative actions.[6]

In the present case, the Office denied authorization for procedure code 28555. The record indicates that the DMA already reviewed the case file and authorized the surgery recommended by Dr. which included left FDL tendon transfer (27690) and left subtalar arthroereisis (28585). The DMA indicated that procedure codes 28585 is open treatment of a talotarsal joint dislocation and 27690 is superficial tendon transfer. He noted that the correct procedure code for an arthroeresis is 28899, and the proper code for an FDL tendon transfer is 27691. Online search indicates that both procedure codes 28555 and 28585 are used for open treatment of tarsal bone dislocation. It appears that Dr. resubmitted his request for authorization for left subtalar arthroereisis using procedure code 28555. I find that the Office abused its discretion in denying procedure code 28555, because the DMA had determined that left subtalar arthroereisis was necessary for treatment of the claimant's work related condition. However, Dr. recently reported that the claimant's MRI showed a torn spring ligament and she also had a contracture of the gastrocnemius tendon as a direct result of her posterior tibial tendon tear, which occurred as a work related injury. He recommended FDL tendon transfer, repair of the spring ligament (27698) and gastrocnemius recession (27687). As the DMA previously authorized left FDL tendon transfer and left subtalar arthroereisis, the case will be remanded for further review by the DMA.

Upon return of the case file, the District Office should review the record to clarify the conditions that should properly be accepted as the record contains conflicting information regarding accepted conditions. The Office should then prepare an accurate and complete SOAF and refer it with the medical records to the DMA for further review on the

[3] *D.C.*, 58 ECAB 620 (2007); *Mira R. Adams*, 48 ECAB 504 (1997).
[4] *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990)
[5] *Darletha Coleman*, 55 ECAB 143 (2003)
[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.7. Although medical opinions should be excluded from the statement of accepted facts, the procedure manual explains that such opinions should not be confused with the medical history of the claim, which may properly be included. The procedure manual further notes that chronologies of care and nature of treatment received are facts surrounding the medical aspects of the claim, but are not themselves medical opinions. *Id.* at Chapter 2.809.7c.

recommended surgery. The DMA should be asked to provide a rationalized opinion on whether left FDL tendon transfer with repair of the spring ligament and gastrocnemius recession is medically necessary to treat the accepted employment injury. Following this and any further development as deemed necessary, the Office should issue a *de novo* decision.

Accordingly, the decision of the District Office dated is vacated and the case is **remanded** for further actions as outlined above.

Issued:
Washington, D.C.

Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs

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