U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROBERT L. MONTGOMERY and DEPARTMENT OF THE NAVY, NAVAL SEA SYSTEMS COMMAND, PUGET SOUND NAVAL SHIPYARD Bremerton, WA

Docket No. 99-497; Submitted on the Record;
Issued December 8, 2000

DECISION and ORDER

Before DAVID S. GERSON, A. PETER KANJORSKI,
VALERIE D. EVANS-HARRELL

The issue is whether the Office of Workers' Compensation Programs properly refused to authorize surgery of the cervical spine at C5-6 as necessary to treat appellant's work-related condition.

The Board has duly reviewed the case record and finds that the Office did not abuse its discretion in denying the medical treatment requested by appellant's treating physician.

On October 28, 1992 appellant, then a 41-year-old police officer, was directing traffic at an entrance/exit gate to the employing establishment when he was struck on the rear of his left shoulder by a side mirror of a van that was moving approximately five miles per hour.[1] Appellant has not worked since his injury. The Office accepted appellant's traumatic injury claim for aggravation of cervical and lumbar strain, left shoulder contusion, right elbow contusion and aggravation of cervical degenerative disc disease. The record indicates that following a series of steroid epidural injections appellant developed septic discitis (an infection), which further complicated his back condition and required him to be hospitalized for eight months.[2] The Office subsequently authorized an anterior discectomy with fusion at C4-5 on November 28, 1994 and a graft on February 16, 1996.

[1] Appellant was injured in 1979 during a motor vehicle accident and sustained injuries to the cervical spine and his left leg. He underwent left knee surgery at the time of the accident and was hospitalized for six months. On August 17, 1992 appellant fell in the performance of duty and complained of neck pain with numbness extending to both the right arm and leg. The Office accepted his traumatic injury claim for a trapezius strain. He was placed on light duty from August 18 to October 25, 1992.

[2] On May 5, 1993 an electromyogram (EMG) was performed and showed no signs of cervical radiculopathy, although it did show signs of right carpal tunnel syndrome.

On September 5, 1996 an EMG was obtained that showed right ulnar entrapment neuropathy across appellant's right elbow with no signs of carpal tunnel syndrome or cervical radiculopathy.

On October 3, 1997 a magnetic resonance imaging (MRI) revealed:

> "Status post anterior discectomy and cervical vertebral body fusions at C4-5 and C5-6. Circumferential disc bulge at C3-4 without evidence of spinal stenosis. Posterior osteophytic ridges at C4-5 and C5-6 with borderline spinal stenosis at each of these levels. Bilateral severe neuroforaminal stenosis at C5-6."

In an October 17, 1997 treatment note, appellant's treating physician, Dr. H.R. Johnson, has stated the following with regard to appellant's continuing cervical condition:

> "[I]t was the hope of all concerned that with surgical stabilization of C4-5 and C5-6 with the anterior discectomies and fusions, that the degenerative changes would basically arrest themselves with regards to foraminal stenosis. Unfortunately, such is not the case and in spite of stabilization the degenerative changes have progressed from moderate to now severe at the C5-6 level, creating the severe neural foraminal stenosis."

Dr. Johnson opined that appellant's back condition was due to the "rapid degeneration of the C4-5 and C5-6 disc spaces," which he concluded "are directly" causally related to his work injury. He recommended that appellant undergo further surgical consultation to alleviate the back and arm complaints and to correct the progression of his degenerative disease due to the work injury.

Dr. Johnson apparently referred appellant to Dr. Joseph D. Sueno, a Board-certified physician in physical medicine and rehabilitation, for a neurological evaluation. In a report dated October 21, 1997, Dr. Sueno advised that electrodiagnostic studies suggested a right C6 irritative root lesion with no acute degeneration at that time.[3]

In a report dated December 10, 1997, Dr. Richard N.W. Wohns, a Board-certified neurologist, indicated that he examined appellant at the request of Dr. Johnson. Dr. Wohns noted that appellant had just finished four weeks of physical therapy and continued to wear a Philadelphia collar. He related that three months ago appellant began to develop severe pain on the right side of his neck -- "this comes with jolts like an electrical shock feeling," and extends to his right shoulder, right arm and tingling in the palm. The physician reported that a cervical MRI scan obtained on October 3, 1997 showed severe bilateral C5-6 neuroforaminal stenosis, with a solid fusion across C4-5 but a bony bridge anteriorly at C5-6. Dr. Wohns noted his belief that appellant required surgery given the MRI results and recommended a right C5-6 laminotomy and foraminotomy.

[3] Nerve conduction studies performed on October 21, 1997 were within normal ranges.

The Office referred appellant to Dr. Robert C. Winegar, a Board-certified orthopedic surgeon, for assessment of his work-related injury and an opinion on the proper course of treatment for appellant's back condition. In a March 9, 1998 report, Dr. Winegar noted physical findings and diagnosed cervical strain, lumbar strain, aggravation of cervical degenerative disc disease requiring C5-6 fusion, C4-5 disc space infection attributed to epidural injection with resultant degenerative disc disease requiring anterior fusion. He stated that surgery was not recommended.

Because a conflict existed in the record as to whether or not to authorize surgery, the Office referred appellant for an examination with an impartial medical specialist. In a report dated June 18, 1998, Dr. Donald D. Hubbard, a Board-certified orthopedic surgeon, outlined appellant's medical history and reported physical and objective findings. Dr. Hubbard noted that appellant was post C5-6 discectomy as the result of a cervical spine injury in 1979, a work-related cervical injury in 1992 and preexisting degenerative disc disease. He opined that appellant still suffered from residuals of his work injury, namely his pain behavior and subjective complaints of pain. Dr. Hubbard stated:

> "Although surgery is technically do able the images portray a picture more severe than what is found on clinical examination. And in particular as demonstrated by objective physical findings. In my experience as an orthopedic surgeon for over a quarter of a century, once a motion segment or intervertebral disc level has been fused it is highly unlikely further encroachment will occur of the neural foramen or stenosis of the central canal will worsen at the fused levels. Hence any neurological deficit present now will probably remain stable (or improve according to the literature dealing with the subject matter). Besides, this gentleman has no major neurologic deficit 'to fix' according to my examination. To operate, in my opinion, would be a crucial mistake of major importance and consequence in this individual who already has pain behavior and a history of chronic pain at least since 1979. It is highly unlikely or not probable that surgery will be successful in alleviating his chronic pain. I would strongly vote for 'no surgery' from a surgeon and musculoskeletal physician perspective."

Dr. Hubbard also noted that if it became necessary at a later date to perform surgery for "abnormality of the disc at the top or bottom of the fused intervertebral bodies, I do not think it will return him to work. Certainly the 11 mm central canal AP distance is adequate, in my view, since stenosis is typically felt to be present when 9 mm is reached."

In a decision dated August 5, 1998, the Office refused to grant authorization for the surgery, right C5-6 laminotomy and foraminotomy. The Office erroneously stated that prior authorization for medical expenses was terminated, but the Office corrected that error on August 10, 1998 with an amended decision.

The Board finds that the Office properly denied authorization for surgery.

Once the Office found that appellant sustained an injury in the performance of duty on October 28, 1992, appellant became entitled to treatment of these conditions under the provisions of the Federal Employees' Compensation Act.

Section 8103 of the Act states in pertinent part:

> "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 the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation."[4]

In interpreting this section of the Act, the Board has recognized that the Office has broad discretion in approving services provided under the Act.[5] The Office has the general objective of ensuring that an employee recovers from his injury to the fullest extent possible in the shortest amount of time. The Office, therefore, has broad administrative discretion in choosing means to achieve this goal.[6] The only limitation on the Office's authority is that of reasonableness.[7] 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.[8]

In the present case, the Office's rejection of appellant's request for surgery rests on the evaluation and opinion of Dr. Hubbard, the selected impartial medical specialist. Because a conflict was properly found by the Office to exist in the record as to whether appellant required surgery at C5-6 for treatment of his work-related injury, the Office correctly referred appellant for an impartial medical evaluation.[9] The Board has held that the report of the impartial medical specialist, if sufficiently well rationalized and based on a proper medical background, must be given special weight.[10] The Board finds that the report of Dr. Hubbard is based on a complete and thorough review of appellant's history of medical treatment and diagnostic testing. Dr. Hubbard explained in detail why surgical intervention was not medically necessary. In light of the report from Dr. Hubbard, the Board finds that the Office did not abuse its discretion by refusing to authorize surgery as it has not been established by the impartial medical specialist's report that surgery is "likely to cure or give relief" to appellant's back condition or subjective

[4] 5 U.S.C. § 8103(a). While the Office is obligated to pay for treatment of employment-related conditions, appellant has the burden to establish that expenditures are incurred for treatment of the effects of an employment-related condition. *Carolyn F. Allen*, 47 ECAB 240 (1995); *Peggy F. Reed*, 46 ECAB 139 (1994); *Mamie L. Morgan*, 41 ECAB 214 (1990).

[5] *Daniel J. Perea*, 42 ECAB 214 (1990).

[6] *Id.*

[7] *Daniel J. Perea, supra* note 5.

[8] *Id.*

[9] Section 8123(a) of the Act provides that, "If there is a disagreement between the physician making the examination for the Unites States and the physician of the employee, the Secretary shall appoint a third physician who will make an examination." 5 U.S.C. § 8123(a).

[10] *Louis G. Psyras*, 39 ECAB 264 (1987).

complaints of pain. Thus, the Board credits the opinion of the impartial medical specialist under 5 U.S.C. § 8123(a) and finds that the Office properly denied authorization for medical treatment.

The decision of the Office of Workers' Compensation Programs dated August 5, 1998 is hereby affirmed.

Dated, Washington, DC
December 8, 2000

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

Valerie D. Evans-Harrell
Alternate Member