

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOSEPH A. EMMONS and DEPARTMENT OF THE INTERIOR, NATIONAL
PARK SERVICE, LAVA BEDS NATIONAL MONUMENT, Tullake, CA

*Docket No. 01-1151; Submitted on the Record;
Issued January 23, 2002*

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs abused its discretion in denying appellant's request for authorization for additional back surgery.

On July 7, 1999 appellant, then a 54-year-old maintenance worker, pushed to stop a motorized wheelbarrow from turning over and developed severe low back pain. He received continuation of pay from July 8 through August 21, 1999. The Office accepted appellant's claim for a herniated nucleus pulposus at L3-4 and radiculopathy, L4-5. On October 15, 1999 appellant underwent a microlumbar discectomy at L3-4 on the right side.

In an October 29, 1999 report, Dr. Mark Belza, a neurosurgeon, indicated that appellant had persistent pain along the iliac crest and down the right leg in the L4 nerve root distribution to the groin following surgery. In an October 30, 1999 report, Dr. Robert E. Andrews, a specialist in preventive medicine, stated that appellant had right leg pain that was consistent with L4 or L5 nerve root irritation of the sciatic nerve. In a March 1, 2000 report, Dr. Jeffrey Drutman, a Board-certified radiologist, reported that a lumbar magnetic resonance imaging (MRI) scan showed settling of the L3-4 disc since surgery and a post surgery MRI scan with an enhancing epidural scar in the right lateral recess extending into the right neural foramen but with no evidence for significant recurrent disc extrusion. He noted that there was a central extrusion of the L2-3 intervertebral disc creating a moderate left lateral recess narrowing. Dr. Drutman also reported that appellant had degenerative anterolisthesis of L5 on S1 bilaterally, which created mild neuroforaminal stenosis.

In a March 13, 2000 report, Dr. Belza stated that appellant should undergo a two level surgical procedure at L2-3 and L3-4 with fusion at L3-4, posterolateral screw fixation at L2-3 and L3-4 with bone grafting. He commented that the question of whether appellant needed decompression at L3-4 would be dependent on the findings in surgery. In a March 21, 2000 report, Dr. Belza requested authorization for the surgery. He indicated that the possibility of fusion at L3-4 was dependent on the amount of scarring at that level. Dr. Beltz noted that

appellant had a large central protrusion at L2-3 and stated that he was unclear whether stabilization would be sufficient or whether a radical discectomy and fusion would be necessary.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Paul Williams, a neurosurgeon, for an examination and second opinion on appellant's employment-related condition and the need for surgery. In a May 3, 2000 report, Dr. Williams diagnosed preexisting degenerative disc disease at multiple levels, postoperative discectomy at L3-4 on the right and continued subjective pain in the lumbosacral spine and right leg after surgery. He commented that the postoperative electromyogram (EMG) showed no abnormalities while the postoperative MRI scans revealed postoperative changes, including severe scarring, but no recurrent disc. Dr. Williams related appellant's current condition to the July 7, 1999 employment injury and the subsequent surgery. He concluded appellant's postoperative pain was the result of postoperative scarring and the preexisting degenerative changes at multiple levels. Dr. Williams noted that the postoperative x-rays showed extensive postoperative scarring and entrapment of the L4 nerve root in the scarring, as well as a continuation of the severe preexisting degenerative changes. He stated that, in view of a diagnosis of spinal instability, a simple discectomy would not produce instability and appellant did not require a fusion at L2-3 or L3-4. Dr. Williams indicated that, in time, appellant's right leg pain would decrease. He commented that appellant's back pain was likely due to preexisting degenerative changes, aggravated by postoperative scarring. Dr. Williams concluded that appellant could return to full duty without restrictions.

The Office asked Dr. Belza to provide a further explanation of the need for additional surgery. In a June 28, 2000 report, he noted that the most recent MRI scan showed a significant amount of settling of the disc space at L3-4 and a central disc herniation at L2-3. Dr. Belza commented that while the postoperative scarring may be contributing to appellant's radicular pain, it was also likely that the settling of the disc space and the narrowing of the neuroforamen accompanied by movement contributed to appellant's low back pain and increasing radicular pain. He stated that the only possibility of restoring appellant's preinjury disc height and opening the neuroforamen would be to go forward with a posterior lumbar interbody fusion procedure at the L3-4 level. Dr. Belza noted, however, that it was possible that this operation might be difficult given the scarring that would be apparent at the operative site. He, therefore, recommended a posterolateral fusion with pedicle screws and rods, which would avoid working around the nerve root. Dr. Belza indicated that at the L2-3 level appellant had degenerative changes and a bulging disc. He stated that a stabilization procedure at L3-4 with the L2-3 disc pathology would predispose appellant for further degradation and might lead to increasing back pain or radicular symptoms in the future. Dr. Belza recommended stabilization at that level as well. He commented that a simple decompression at L2-3 should be sufficient but, if a significant pathology was found, a radical discectomy and fusion might be necessary.

In a July 5, 2000 report, Dr. Williams clarified his report. He stated that surgery was not indicated for postoperative scarring and, after 90 days post surgery, further formal therapy was of unproven benefit. Dr. Williams concluded that appellant was medically stationary. He commented that every person who has surgery has postoperative scarring. Dr. Williams stated that the amount of postoperative scarring did not directly correlate with persistent postoperative pain. He indicated that the majority of people who had a simple discectomy, like appellant, were able to return to full duty.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Deborah R. Syna, a Board-certified neurologist, to resolve the conflict in the medical evidence between Drs. Belza and Williams on appellant's ability to return to work and the need for additional surgery. In a September 20, 2000 report, Dr. Syna diagnosed a history of L3-4 herniated disc with reported right L4 nerve root entrapment post micro discectomy, resultant epidural fibrosis and failed back syndrome. She noted that the examination was difficult due to functional overlay and much reporting of pain during her examination. Dr. Syna stated that it was likely appellant was suffering a right L4 radiculitis, which was ongoing and more likely related to postoperative epidural fibrosis rather than degenerative disc disease. She concluded that it was more likely than not that appellant's condition was due to the employment injury and the subsequent back surgery. Dr. Syna concurred with Dr. Williams' assessment on the need for surgery. She expressed doubt that Dr. Belza's proposed surgery would provide appellant significant relief. Dr. Syna stated that further surgery tended to make epidural fibrosis worse and might worsen appellant's condition. She stated that appellant's current radicular pain, complaints of numbness and tingling and complaints of pain radiating to the groin were in fact related to the spondylolisthesis or his L2-3 disc bulge. Dr. Syna related appellant's radiculitis to the employment injury and postoperative scarring. She concluded that appellant would not return to his preinjury status.

In a December 21, 2000 decision, the Office denied appellant's request for authorization for additional surgery on the grounds that the medical evidence of record did not support further surgical intervention.

The Board finds that the Office did not abuse its discretion in denying appellant's request for authorization for additional surgery.

Section 8103(a) of the Federal Employees' Compensation Act provides as follows:

"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 period of disability, or aid in lessening the amount of monthly compensation."¹

In interpreting section 8103, the Board has long recognized that the Office, acting as the delegated representative of the Secretary of Labor, had broad discretion in approving services under the Act.² The Office has the general objective of ensuring that an employee recovers from his injury to the fullest extent possible in the shortest period of time. The Office, therefore, has broad administrative discretion in choosing means to achieve this objective. The only limitation on the Office's authority is reasonableness. Abuse of discretion is generally shown through

¹ 5 U.S.C. § 8103(a).

² *James R. Bell*, 49 ECAB 642 (1998).

proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from known facts.³

In this case, Drs. Belza and Williams disagreed on whether additional surgery would reduce appellant's pain, which arose from the employment injury and the postoperative scarring from the first operation. To resolve this conflict, the Office referred appellant to Dr. Syna who stated that she agreed with Dr. Williams' assessment. Dr. Syna stated that the additional back surgery was unlikely to give the relief that Dr. Belza believed. She indicated that the surgery was just as likely to make appellant's condition worse by increasing the amount of postoperative scarring. The Office, therefore, acted reasonably in denying appellant's request for authorization of additional surgery based on the report of the impartial medical specialist, Dr. Syna.

The decision of the Office of Workers' Compensation Programs, dated December 21, 2000, is hereby affirmed.

Dated, Washington, DC
January 23, 2002

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

³ *Daniel J. Perea*, 42 ECAB 214 (1990).