United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 13-1550**
	)	**Issued: April 14, 2014**
DEPARTMENT OF ENERGY, BONNEVILLE POWER ADMINISTRATION, Portland, OR, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 18, 2013 appellant filed a timely appeal from the May 31, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his request for surgery and claim for disability compensation. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly denied appellant's request for authorization of neck surgery; and (2) whether appellant has established that he was totally disabled commencing August 16, 2012 due to his May 21, 2012 employment injury.

On appeal, appellant contends that his August 16, 2012 neck surgery resulted from his accepted employment-related injury.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

OWCP accepted that on May 21, 2012 appellant, then a 48-year-old realty specialist, sustained a neck sprain when his motor vehicle hit a pothole while pulling off a highway. It authorized steroid injections.

In an August 3, 2012 medical report, Dr. Michael A. Sandquist, a Board-certified neurosurgeon, noted that appellant's medical history included a prior C5-6 anterior cervical discectomy and fusion for stenosis and myelopathy, a C7-T1 posterior cervical foraminotomy and steroid injections. He continued to have radiating neck and arm pain. Dr. Sandquist listed findings on physical examination and reviewed the results of a cervical magnetic resonance imaging (MRI) scan. He diagnosed cervical radiculopathy at C5, C6 and C6-7 and recommended C4-5, C5-6 and C6-7 posterior cervical laminectomies and foraminotomies to treat the condition. On August 16, 2012 Dr. Sandquist performed the stated surgical procedures.

In a September 17, 2012 report, Dr. Benjamin L. Calvert, an attending Board-certified family practitioner, stated that appellant had a history of neck pain with radicular symptoms radiating to his left arm. Appellant's condition had greatly improved following injection therapy during the winter and spring of 2012. During a June 4, 2012 office visit, he reported worsening pain and radicular symptoms following his May 21, 2012 employment injury. Dr. Calvert opined that the May 21, 2012 employment injury worsened his neck issues, causing muscle spasms and worsening pain into his left shoulder and neck. As a result, appellant underwent further evaluation and subsequent surgery performed by Dr. Sandquist on August 16, 2012.[2]

On October 10, 2012 OWCP received a request for authorization of surgery to appellant's cervical spine on August 16, 2012.

On October 22, 2012 appellant filed a claim (Form CA-7) requesting leave buyback for intermittent time lost from work from May 30 to October 1, 2012. A time analysis form (Form CA-7a) dated October 31, 2012 noted that he had medical appointments and received medical treatment, including surgery on August 16, 2012. Appellant submitted additional CA-7 forms claiming compensation for leave without pay from October 21, 2012 through May 18, 2013.

In an October 22, 2012 letter, Dr. Sandquist advised OWCP that, while it had accepted appellant's claim for cervical sprain, his correct diagnoses were radiculopathy, degenerative disc disease and stenosis of the cervical spine for which he underwent surgery.

On November 15, 2012 Dr. William Stewart, an OWCP medical adviser, reviewed the medical record. He noted that the medical record revealed that appellant had undergone two prior neck surgeries, a C5-6 anterior cervical discectomy and fusion for stenosis and myelopathy in 1997 and a C7-T1 posterior cervical foraminotomy in 2007 or 2009.[3] The medical adviser

[2] The record reveals that on August 16, 2012 appellant underwent left C4-5, C5-6 and C6-7 posterior cervical laminectomies and foraminotomies, which were performed by Dr. Sandquist.

[3] The statement of accepted facts and medical reports of record referenced appellant's 1997 and 2007 or 2009 surgical procedures.

also noted appellant's steroid injection at the C5-6 level in January 2012. He stated that these were good indicators of the presence of severe neck disease for 15 years prior to the incident of May 21, 2012. Dr. Stewart reviewed a history and treatment of the May 21, 2012 injury, which included the August 16, 2012 cervical surgery based on the MRI scan. He stated:

> "There is a great deal of information about this case that appears to [be] missing from the record. If the MRI [scan] referenced above was done prior to the May 21, 2012 accident then I would say the pathology that led to the surgery of August 16, 2012 clearly preceded the May 21, 2012 accident and is not related to the May 21, 20112 accident. Even though we do not immediately have that MRI [scan] date, I would still opine that the pathology leading to the neck surgery preceded the May 21, 2012 injury because the pathology described, multilevel foraminal stenosis, is not the pathology of an acute injury and it is simply not conceivably the consequence of what seems to be a minor event just a few weeks previously."

Dr. Stewart related that there was insufficient evidence of record to suggest that the May 21, 2012 employment injury had any significant adverse effect on appellant. There was no question that appellant had a severe preexisting degenerative disease with multiple cervical surgeries and steroid injections prior to May 21, 2012. The available evidence strongly suggested that the August 16, 2012 surgery was recommended and planned for prior to the accepted incident. The medical adviser concluded that appellant's claim of cervical radiculopathy, degenerative disc disease and cervical spinal stenosis should not be accepted. He noted that while the August 16, 2012 surgery was warranted in its own right, it was not necessary or warranted as a result of the May 21, 2012 injury.

In a November 30, 2012 decision, OWCP denied appellant's request for authorization of the August 16, 2012 cervical surgery. It found that the weight of the medical evidence rested with Dr. Stewart, who determined that the surgery was not necessary for treatment of appellant's May 21, 2012 employment injury.

On December 14, 2012 appellant requested reconsideration.

On January 24, 2013 OWCP requested that appellant submit the MRI scan report or other diagnostic studies related to his cervical spine and any medical reports from his physician prior to May 21, 2012.

On January 24, 2013 OWCP found a conflict in the medical opinion between Dr. Calvert and Dr. Stewart as to whether the August 16, 2012 cervical surgery, was necessitated by residuals of appellant's May 21, 2012 employment injury.

On April 22, 2013 OWCP referred appellant, together with the medical record and a statement of accepted facts, to Dr. Michael S. Mason, a Board-certified neurosurgeon, for an impartial medical examination. In a May 21, 2013 report, Dr. Mason reviewed a history of the May 21, 2012 employment injury and appellant's medical treatment. He noted that appellant began working at the employing establishment in January 2000 and that from 2001 to 2008 he sustained several injuries at work, including a neck injury. Dr. Mason noted appellant's

complaint of neck and left upper extremity pain, numbness and tingling. He provided a detailed review of the medical record, noting that it did not include reports regarding appellant's cervical surgery in the 1990s and on May 3, 2007.

Dr. Mason reported essentially normal findings on physical, neurological and sensory examination with the exception of a limited range of motion of the neck, a relative degree of atrophy and nearly absent reflex of the left biceps muscle group. He noted decreased brachioradialis on the left, markedly hyperactive knee reflexes, overactive ankle reflexes, equivocal Babinski reflexes and a patchy area of decreased sensitivity on the lateral aspect of the left thigh rated at -1 and fitting generally with the distribution of the lateral femoral cutaneous nerve. There was a subtle decrease in sensitivity with respect to light touch and pinprick on the medial aspect of the left hand and forearm, but not including the fourth and fifth fingers of the left hand and atrophied left biceps musculature. Dr. Mason advised that appellant had a somewhat perplexing neurological condition. He had longstanding clinical evidence of neck and left upper extremity pain, numbness and tingling. Appellant also had a history of three or possibly four cervical surgical procedures and multiple epidural steroid injections for pain. Multiple cervical contrast and scan studies generally showed a significant degree of mid-cervical spondylosis with cord compression in the midcervical region, but in particular at C4-5, C5-6 and C6-7. There was an area of myelomalacia in the mid-cervical region which represented a chronic cord injury. Dr. Mason stated that this was responsible for appellant's hyperreflexia of the lower and upper extremities. The most recent cervical myelogram showed significant nerve root deficits on both the right and left in the midcervical region.

Dr. Mason advised that appellant's clinical symptoms were due to an ongoing cervical cord injury and cervical nerve root involvement especially on the left, resulting in biceps atrophy due to persistent canal narrowing and foraminal stenosis resulting in a nerve root injury, muscle atrophy, pain, numbness and tingling of the left hand. He related that the current clinical impression of chronic cervical sprain and strain was not accurate based on clinical and radiographic findings and did not explain appellant's clinical conditions at any time since early 2000 when he began to have a significant increase in cervical symptoms. Dr. Mason advised that appellant's prior cervical conditions for which he underwent surgery resulted in no permanent improvement of his clinical condition as he had significant cervical degenerative changes. Based on a January 2013 cervical myelogram and postmyelogram scan, appellant had persistent and significant multilevel cervical nerve root abnormalities. Dr. Mason related that appellant's spinal cord injury was due to the changes at C5-6 for which an initial fusion was performed and resulted in a permanent neurological impairment of function. He advised that appellant had an advanced cervical spondylosis producing injury to the spinal column proper resulting in a good deal of local neck pain. Dr. Mason also had a spinal cord and spinal nerve injury bilaterally. The diagnosis of soft tissue injury or cervical sprain or strain was simply an inappropriate diagnosis given appellant's clinical and radiographic findings. Dr. Mason stated that, under these conditions, it was difficult to sort out the statement of accepted facts since it was not correct.

Dr. Mason related that appellant had a cervical spine injured over the years by heavy-duty work activity and simultaneously sustained injuries during frequent falls while carrying out his normal work activity. The objective studies showed degenerative arthritic changes of appellant's cervical spine prior to the additional surgery in May 2007. The fusion that was

performed caused an acceleration of degeneration of the joint above and below and there had been an injury to the spinal cord at the C5-6 level, the level of the fusion. Appellant had very significant nerve root defects bilaterally and an injured spinal cord that resulted in abnormal reflexes. He also had a new finding of increased slippage C4 on C5. Dr. Mason advised that all of these conditions were generally progressive and it was entirely likely that further major surgical procedures would be required to stabilize his neck and hopefully provide relief. He noted that, at the time of the May 21, 2012 employment injury, appellant's spine was not normal as he had three surgeries. Dr. Mason noted that if a person with a normal cervical spine had hit the same pothole as appellant, the person would probably have an accurate diagnosis of cervical sprain/strain, but since appellant had undergone three cervical surgeries his spine was not normal at the time of injury. He advised that the May 21, 2012 employment injury was another incident that added injury to a physically abnormal cervical spine complex and resulted in increasing pain. Dr. Mason stated that this was the primary reason for appellant's August 16, 2012 surgery. He concluded that, "I have requested copies and reports of the earlier scans that were not provided initially. Apparently, this is taking longer than expected so I have concluded this report and will send an addendum once I have had a chance to see them."

In a May 31, 2013 decision, OWCP denied modification of the November 30, 2012 decision. It found that Dr. Mason's report was incomplete as he was unable to review diagnostic studies obtained prior to the May 12, 2012 employment injury and before the August 16, 2012 surgery. OWCP noted that it was appellant's responsibility to provide these critical reports. Without these reports, it could not be determined whether his preexisting cervical condition worsened due to his accepted injury or necessitated surgery. OWCP denied appellant's claim for wage-loss compensation commencing August 16, 2012 as he did not establish that the surgery was related to his accepted injury.

LEGAL PRECEDENT -- ISSUE 1

Section 8103 of FECA[4] 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 monthly compensation.[5] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[6]

In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under section 8103, with the only limitation on OWCP's authority being that of reasonableness.[7] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken

[4] *See supra* note 1.

[5] *Id.* at § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[6] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

[7] *See D.K.*, 59 ECAB 141 (2007).

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] To be entitled to reimbursement of medical expenses, a claimant has the burden of establishing that the expenditures were incurred for treatment of the effects of an employment-related injury or condition. Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[9] In order for a surgical procedure to be authorized, a claimant must submit evidence to show that the surgery is for a condition causally related to an employment injury and that it is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[10]

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.[11] The implementing regulations state 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 OWCP's medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[12]

ANALYSIS -- ISSUE 1

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

OWCP accepted that on May 21, 2012 appellant sustained a neck sprain while in the performance of duty. On August 16, 2012 Dr. Sandquist, a Board-certified neurosurgeon, performed surgery for left C4-5, C5-6, C6-7 posterior cervical laminectomies and foraminotomies. On October 10, 2012 appellant requested authorization of the August 16, 2012 cervical surgery. OWCP determined that the September 17, 2012 report from Dr. Calvert, an attending Board-certified family practitioner, created a conflict with the a November 15, 2012 report of Dr. Stewart, on whether the August 16, 2012 cervical surgery was necessitated by the May 21, 2012 employment injury. It referred appellant to Dr. Mason, a Board-certified neurosurgeon, for an impartial medical examination.[13]

The Board finds, however, that there was no conflict in medical opinion between Dr. Calvert and Dr. Stewart on the issue of whether the cervical surgery performed on August 16, 2012 was due to the May 12, 2012 employment injury. Dr. Calvert opined that the May 21, 2012 employment injury worsened appellant's neck and left shoulder symptoms and

[8] *Minnie B. Lewis*, 53 ECAB 606 (2002).

[9] *M.B.*, 58 ECAB 588 (2007).

[10] *R.C.*, 58 ECAB 238 (2006).

[11] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[12] 20 C.F.R. § 10.321.

[13] *See supra* notes 10 and 11 and accompanying text.

resulted in the August 16, 2012 surgery performed by Dr. Sandquist. Dr. Stewart did not provide a definitive opinion on whether the August 16, 2012 surgery was necessary to treat residuals of the accepted employment injury.[14] While he opined that appellant's current cervical conditions warranted the August 16, 2012 surgery, he specifically noted that the record was missing a "great deal of information." Dr. Stewart advised that the date of the MRI scan on which Dr. Sandquist based his August 16, 2012 surgery was unknown, yet he concluded that "even though we do not immediately have the MRI [scan] date, the pathology leading to the August 16, 2012 surgery clearly preceded the accepted employment injury." The Board notes that while Dr. Sandquist referenced appellant's 1997 C5-6 anterior cervical discectomy and fusion for stenosis and myelopathy, May 2007 C7-T1 posterior cervical foraminotomy and January 2012 cervical steroid injection at the C5-6 level, he did have for review the diagnostic studies or surgical reports as they are not contained in the case record. The Board has held that medical reports must be based on a complete and accurate factual and medical background. Medical opinions based on an incomplete or inaccurate history are of limited probative value.[15] Absent the relevant medical reports pertaining to appellant's preexisting cervical condition, the medical opinions of record are of reduced probative value. The Board finds that Dr. Mason served as an OWCP referral physician rather than an impartial medical specialist.

Statement of facts indicated OWCP's acceptance of appellant's claim for work-related neck sprain. Dr. Mason, stated, however, that the statement of accepted facts was not correct. He found that appellant had cervical spondylosis and stated that the diagnosis of cervical sprain and strain was inappropriate based on the objective findings of record. Dr. Mason opined that the accepted injury was the primary reason for the surgery, but noted that he had not received a response to his request for "copies and reports of the earlier scans that were not provided initially" and stated that he would "send an addendum once I have had a chance to see them." The Board notes that absent these reports he did not submit a supplemental report prior to the issuance of OWCP's May 31, 2013 decision. Dr. Mason did not have an accurate medical background on which to evaluate whether the accepted employment injury aggravated or contributed to appellant's cervical condition and necessitated surgery on August 16, 2012.

Since OWCP attempted to develop the medical evidence and referred the case for a second opinion evaluation, it has the responsibility to secure a medical report that adequately addresses the pending issues.[16] The case will be remanded for OWCP to request that appellant submit all medical records relevant to his preexisting cervical conditions, treatment and surgeries. Thereafter, it should prepare an updated statement of accepted facts and refer him for a second opinion examination to determine whether the May 21, 2012 employment injury aggravated or contributed to his cervical condition and necessitated the August 16, 2012 surgery. After such further development as deemed necessary, OWCP should issue a *de novo* decision.

[14] *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal; the opinion should be expressed in terms of a reasonable degree of medical certainty).

[15] *J.R.*, Docket No. 12-1099 (issued November 7, 2012); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[16] *See Robert Kirby*, 51 ECAB 474, 476 (2000); *Mae Z. Hackett*, 34 ECAB 1421 (1983); *Richard W. Kinder*, 32 ECAB 863 (1981).

In view of the Board's disposition of the first issue the question of whether appellant was totally disabled commencing the date of this surgery is not in posture for decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 31, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: April 14, 2014
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board