# United States Department of Labor
# Employees' Compensation Appeals Board

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| **G.H., Appellant** | ) | |
| **and** | ) | **Docket No. 14-721** |
| | ) | **Issued: August 4, 2014** |
| **DEPARTMENT OF THE NAVY, NORFOLK NAVAL SHIPYARD, Portsmouth, VA, Employer** | ) | |

*Appearances:*
*Paul Kalker, Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

### ***JURISDICTION***

On February 11, 2014 appellant, through counsel, filed a timely appeal of a January 7, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied modification of a November 6, 2012 decision, denying authorization for surgery. 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.

### ***ISSUE***

The issue is whether OWCP abused its discretion by denying appellant authorization for back surgery under 5 U.S.C. § 8103(a).

### ***FACTUAL HISTORY***

OWCP accepted that appellant, then a 34-year old pipefitter, sustained an acute lumbar sprain and sprained right thumb as a result of an employment incident on December 6, 1988. It

[1] 5 U.S.C. § 8101 *et seq.*

subsequently accepted a right hand sprain, lumbosacral joint sprain; and sprains of the forearm and elbow. Appellant returned to limited duty as a custodial worker. On October 27, 1995 OWCP adjusted his compensation to reflect his wage-earning capacity in that position.

In a report dated October 11, 2011, Dr. Mark B. Kerner, a Board-certified orthopedic surgeon and treating physician, noted that appellant had complaints of severe and progressive back pain with radiating leg pain, left worse than right. He reviewed a current magnetic resonance imaging (MRI) scan and advised that it was not as impressive as appellant's complaint of pain. Appellant had a degenerative segment at L4-5 with bilateral foraminal stenosis, left worse than right due to foraminal disc protrusion bilaterally. Dr. Kerner also noted some modic changes and some mild degenerative facet changes at L5-S1. He explained that appellant needed more aggressive treatment. Appellant was best suited for an anterior lumbar interbody fusion at L4-5. Dr. Kerner noted that this would allow decompression of the disc space, restore the foraminal stenosis and address appellant's back pain without having to disturb his posterior muscle envelope. He discussed the nature of surgery, the risks, benefits, complications and alternatives. Dr. Kerner explained that the goal for appellant following surgery was to return to functional work activities. Appellant wished to proceed to surgery and Dr. Kerner requested authorization.

An October 14, 2011 lumbar spine MRI scan, read by Dr. Carol Ashman, a Board-certified diagnostic radiologist, revealed a disc bulge redemonstrated at L4-5, facet arthropathy and facet arthropathy at L5-S1 associated with moderate bilateral neural foraminal stenosis.

In a letter dated March 9, 2012, appellant requested authorization for the surgery recommended by Dr. Kerner.

In an April 10, 2012 report, Dr. David E. Lannik, a Board-certified orthopedic surgeon and treating physician, noted that he had treated appellant since the December 16, 1988 injury. He advised that appellant was monitored since that time for a chronic lumbar disc herniation. Despite conservative management, Dr. Lannik suggested surgery for the disc herniation which was chronic and dated back to December 16, 1988.

In an April 27, 2012 report, Dr. Kerner again requested authorization for anterior lumbar interbody fusion.

OWCP requested an opinion from a medical adviser regarding whether the requested surgery was necessary to treat the accepted injury. In a May 5, 2012 report, Dr. Lawrence A. Manning, an OWCP medical adviser, reviewed appellant's history and the accepted conditions of lumbar sprain, right hand sprain, lumbosacral (joint ligament sprain) and elbow/ulnar sprain. He noted that a surgery request was made for arthrodesis, anterior interbody technique including minimal discectomy to prepare interspace, section and spinal instrumentation procedures on the spine (vertebral column) section. Dr. Manning stated that the accepted conditions involving the back were limited to a sprain, a soft tissue injury. He noted that the injury occurred in 1988. Dr. Manning reviewed the diagnostic reports and opined that the requested surgery was not indicated for the accepted conditions.

By letter dated May 30, 2012, OWCP referred appellant to Dr. Edward Gold, a Board-certified orthopedic surgeon, for a second opinion. In a June 13, 2012 report, Dr. Gold noted appellant's history and diagnosed chronic low back pain and sciatica. He opined that appellant developed pain in his lower back after an injury at work on December 6, 1988. Dr. Gold indicated that appellant continued to be in constant low back pain radiating into both lower extremities. He indicated that no surgery had been performed but a fusion procedure was recently recommended and appellant was currently working. Dr. Gold explained that diagnostic studies of the lumbar spine in 2002 and 2003 did not show any dural or foraminal stenosis or any degenerative changes. He noted an MRI scan study in April 2010 showed foraminal arthrosis and stenosis at L4-5 and L5-S1. Dr. Gold opined that it was possible that appellant could benefit from surgery that would address these findings; but found that, since the diagnostic findings did not appear until more than 11 years after injury, he could not attribute the need for surgery to the injury in 1988.

On September 19, 2012 OWCP referred appellant, together with a statement of accepted facts, and the medical record, to Dr. Bakjit Sidhu, a Board-certified orthopedic surgeon for an impartial medical evaluation to resolve a conflict in medical opinion between Drs. Lannik and Kerner, the treating physicians, and Dr. Gold, the second opinion physician, regarding the need for surgery.

In an October 18, 2012 report, Dr. Sidhu reviewed appellant's history and provided findings on physical examination. Appellant indicated that his pain rated "6/10 in severity" and took away from his normal living. He related that walking, even for a few minutes, made the pain worse. Pain was radiating down appellant's right leg. He completed a pain disability questionnaire and "his self-rated score was 121 out or 150 meaning grade 3 severe disability." On examination appellant could walk on his tiptoes and heels. He could bend forward and touch his toes, which gave him a flexion of 110 degrees at the waist; extension to eight degrees, right flexion to 27 degrees with fingertips going below the knee; left flexion to 28 degrees with the fingertips going below the knee. Appellant had 2+ knee jerks, a sluggish left ankle jerk and an absent right ankle jerk. Dr. Sidhu noted that appellant performed a sitting straight leg raise to test quadriceps strength which was 90 degrees. Appellant was able to turn to the prone position without any problem. Dr. Sidhu found no muscle spasm in the back while appellant had some diffuse tenderness at the lumbosacral area. He did not find much tenderness over the sacroiliac joints or the iliac crest. Dr. Sidhu noted that appellant had grade 5 strength in all the muscle groups tested and that axial pressure on the top of his head while standing up did not produce any lower back pain. Regarding appellant's accepted conditions, he explained that appellant's acute lumbar strain/sprain was primarily a soft tissue injury that usually resolved within 6 to 12 weeks. In some cases, the pain could persist for up to six months, but it almost never went beyond that. Dr. Sidhu stated that appellant had received extensive medical treatment from his attending physicians. He noted that appellant currently developed spinal stenosis and explained that this was the cause of the degenerative disc disease at L4-5 and to a lesser extent at L5-S1. Appellant also had significant arthritis in his facet joints, which further added to his spinal stenosis, and also had degenerative disc bulges in these areas. Dr. Sidhu opined that the findings were the result of normal aging and not caused by his acute lumbar strain/sprain sustained in 1988.

By decision dated November 6, 2012, OWCP denied authorization for lumbar surgery.

An August 29, 2013 MRI scan read by Dr. Charles Hecht-Leavitt, a Board-certified diagnostic radiologist, revealed: L5-S1 mild disc bulging and bilateral facet joint arthrosis with two millimeter retrolisthesis; L4-5 moderate diffuse disc bulging and small central disc extrusion indenting the thecal sac and narrowing of the lateral recesses and neural foramina. It also revealed L3-4, mild annular bulging and right facet joint arthrosis and small left facet joint-related cyst.

On October 28, 2013 appellant's attorney requested reconsideration. He contended that a conflict in medical opinion did not exist. Furthermore, the report of Dr. Sidhu was deficient to the extent that, if relevant at all, it should be considered supportive of continued work-related disability. Counsel submitted new medical evidence.

In an October 22, 2013 report, Dr. Lannik noted that he disagreed with the denial of the requested back surgery. He stated that there was no doubt that appellant had a low back injury and, on more recent MRI scans, a lumbar disc protrusion at L4-5. Dr. Lannik explained that the initial injury was an annular tear at L4-5 disc as documented by a 1988 MRI scan and Dr. Kerner's notes. He also noted that the medical literature also supported that a delay between a low back injury, an annular tear and the development of MRI scan changes was consistent with traumatic arthritis, disc protrusions and degenerative disc changes. The fact that appellant had continued pain was consistent with an annular tear from the time of injury to the present time without resolution, especially in the absence of preexisting problems. This was evidence that there was a direct relationship between the lifting injury of 1988 and the development of a later disc protrusion and facet joint changes. Dr. Lannik advised there was no dispute that appellant lifted materials in 1988 causing this injury.

Dr. Lannik explained that the primary relevant factor was age and that when considering whether appellant's present condition was caused by age-related degeneration or traumatic progressive disc disease, it was important to review appellant's history. He indicated that the natural history of degenerative disc disease was the slow onset of stiffness and aching progressing to more serious pain over years. However, Dr. Lannik advised that this was not appellant's presentation. He explained that appellant's presentation was immediate pain radiating down the legs that continued since his 1988 injury. Dr. Lannik opined that this was not the natural history of age-related degenerative disc disease. He explained that "the likelihood that [appellant's] presentation today is due to age[-]related degenerative wear and tear is markedly less than the likelihood that this is a natural progression of traumatic changes as delineated in the literature and consistent with [appellant's] history of an annular tear. Therefore, to a reasonable degree of medical certainty, the opinion of the defense medical experts is wrong." Dr. Lannik opined that "to a reasonable degree of medical certainty, [appellant's] current symptoms are similar to his symptoms of 1988 and represent a progression of these symptoms as a result of the traumatic changes that are consistent with the MRI [scan] findings." He advised that the data and his assessment supported the conclusion of a causal relationship between appellant's present lumbar disc MRI scan findings, his traumatic injury involving lifting materials in 1988 and the symptoms which he had presented since 1988. Dr. Lannik stated that appellant had an annular tear at L4-5 that progressed to a lumbar disc protrusion and traumatic arthritis. He reiterated his surgery recommendation.

In a November 18, 2013 report, Dr. Lannik noted that the current objective findings included an MRI scan that showed a posterior disc protrusion at L4-5. He noted that appellant also had facet arthropathy at L5-S1, with positive straight leg raising on the left, and weakness on flexion on the left. Dr. Lannik diagnosed L4 degenerative disc disease which was noted since 1989 following his work injury. He opined that the work injury had not ceased and appellant still had chronic back pain and leg pain requiring intermittent injections for the last 20 years. Dr. Lannik advised that appellant could only ambulate less than one city block due to back pain radiating to the left lower extremity. He noted that appellant's work performance was spotty due to intermittent pain requiring treatment and that appellant worked in a light-duty job. Dr. Lannik noted that Dr. Kerner opined in 1997 that a lumbar laminectomy and fusion was the only option offered to provide increased ability to ambulate as well as hopefully some sort of pain control.

By decision dated January 7, 2014, OWCP denied authorization of the lumbar surgery. It found the weight of the medical evidence did not establish that surgery was medically necessary for the accepted work injury.

## ***LEGAL PRECEDENT***

Section 8103(a) 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.[2] OWCP has the general objective of ensuring that an employee recovers from his injury to the fullest extent possible in the shortest amount of time. It therefore has broad administrative discretion in choosing means to achieve this goal.[3] The only limitation on OWCP's authority is that of reasonableness.[4]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[5] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[6] Therefore, in order to prove that the surgical procedure is warranted, appellant must submit evidence to show that the procedure was for a condition causally related to the employment injury and that the surgery was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[7]

[2] 5 U.S.C. § 8103(a).

[3] *Dale E. Jones*, 48 ECAB 648, 649 (1997).

[4] *Daniel J. Perea*, 42 ECAB 214 (1990) (holding that 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).

[5] *See Kennett O. Collins, Jr*., 55 ECAB 648 (2004); *Debra S. King*, 44 ECAB 203, 209 (1992).

[6] *Id.; see also M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[7] *See R.C*., 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

## ***ANALYSIS***

OWCP accepted the claim for an acute lumbar sprain and sprained right thumb as a result of an employment incident on December 6, 1988. It expanded the claim to include: right hand sprain, lumbosacral joint sprain; sprain of forearm and elbow. OWCP determined that a conflict in medical opinion evidence occurred between the treating physicians, Drs. Lannik and Kerner, and Dr. Gold, the second opinion physician, regarding appellant's need for back surgery due to his accepted conditions. It referred him to Dr. Sidhu for an impartial medical evaluation to resolve the conflict.

Section 8123(a) of FECA provides, 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.[8]

In an October 18, 2012 report, Dr. Sidhu noted appellant's history and examined appellant. He noted examination findings, including that appellant could turn to the prone position without problem, there was no muscle spasm in his back but some diffuse tenderness at the lumbosacral area. Dr. Sidhu found that appellant had grade 5 strength in all the muscle groups. He explained that appellant had an acute lumbar strain/sprain, which was primarily a soft tissue injury, which usually resolved within 6 to 12 weeks but, in some cases, could persist for up to six months. Dr. Sidhu noted that appellant had developed spinal stenosis which was the cause of his degenerative disc disease at L4-5 and to a lesser extent at L5-S1. Additionally, he explained that appellant had significant arthritis in his facet joints, which further added to his spinal stenosis along with degenerative disc bulges in these areas. Dr. Sidhu opined that the findings were the result of normal aging and were not caused by his acute lumbar strain/sprain that he sustained in the 1988 work injury.

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[9] The Board finds that the opinion of Dr. Sidhu is well rationalized and based on a proper factual and medical history. Dr. Sidhu accurately summarized the relevant medical evidence, provided detailed findings on examination and reached conclusions about appellant's condition which comported with his findings.[10] In his October 18, 2012 report, he reviewed the medical evidence, including the results of diagnostic studies and examined appellant and provided rationale for his opinion with regard to the requested surgery. As Dr. Sidhu's report is detailed, well rationalized and based on a proper factual background, his opinion is entitled to the special weight accorded an impartial medical

[8] 5 U.S.C. § 8123(a).

[9] *Barbara J. Warren*, 51 ECAB 413 (2000).

[10] *See Manuel Gill*, 52 ECAB 282 (2001).

examiner.[11] OWCP properly relied upon his report to find that the requested surgical procedure was not related to the accepted conditions.

OWCP received additional reports from Dr. Lannik. They included an October 22, 2013 report in which he disagreed with the prior medical reports and a November 18, 2013 report, in which he indicated that the lumbar laminectomy and fusion was the only option offered to provide increased ability to ambulate as well as hopefully some sort of pain control. However, Dr. Lannik's reports essentially reiterated his previously stated findings and conclusions regarding appellant's condition. As he had been on one side of the conflict in the medical opinion that the impartial specialist resolved, the treating physician's reports were insufficient to overcome the special weight accorded the impartial specialist or to create a new medical conflict.[12] Other reports merely provided findings and did not offer a current opinion regarding whether the need for the requested surgery was due to the accepted conditions.

Based on the evidence of record, OWCP reasonably concluded that the proposed surgery was not warranted. It did not abuse its discretion in denying authorization for the proposed back surgery in this case.

On appeal, appellant's attorney argued that the evidence supported the need for surgery and that OWCP had taken an adversarial position. As noted, the impartial medical examiner's determined that appellant's need for surgery was not attributable to the accepted lumbar sprain. OWCP did not abuse its discretion in denying authorization for the proposed lumbar surgery.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

## ***CONCLUSION***

The Board finds that OWCP properly exercised its discretion pursuant to 5 U.S.C. § 8103(a) in refusing to authorize appellant's request for back surgery.

[11] *See J.M.*, 58 ECAB 478 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[12] *Barbara J. Warren*, 51 ECAB 413 (2000); *Alice J. Tysinger*, 51 ECAB 638 (2000).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the January 7, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 4, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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