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

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| **R.R., Appellant** | ) | |
| **and** | ) | **Docket No. 14-1368** |
| | ) | **Issued: December 17, 2014** |
| **DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Philadelphia, PA, Employer** | ) | |

*Appearances:*
*Jeffrey P. Zeelander, Esq.,* for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

### *JURISDICTION*

On May 28, 2014 appellant, through his attorney, filed a timely appeal of a February 12, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) denying approval of 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 to consider the merits of the case.

### *ISSUE*

The issue is whether OWCP abused its discretion by declining to authorize a percutaneous sacroiliac fusion.

### *FACTUAL HISTORY*

On March 10, 2011 appellant, then a 60-year-old customs and border protection officer, filed a traumatic injury claim alleging injury to his left hip and leg, left hand, lower back, and ribs when he tripped and fell down steps on March 7, 2011. He was attempting to avoid a

[1] 5 U.S.C. § 8101 *et seq.*

collision with another officer and canine. On April 8, 2011 OWCP accepted appellant's claim for sprain of the thoracic spine, contusion of the chest wall, closed fractures of fingers on the left hand, and contusion of the left hip.

Appellant underwent surgery for nonunion of proximal phalanx with secondary laxity in the left fifth finger on August 31, 2011. On December 27, 2011 he underwent a thoracic laminectomy at T11-12. Appellant underwent a left total hip arthroplasty on May 28, 2012.

Dr. Marcellino P. Oliveri, an osteopath, examined appellant on August 22, 2012 and noted that appellant reported increasing lumbar pain. On August 23, 2012 appellant reported increasing stress of his back due to perceived limb length discrepancies following his hip replacement. He underwent a computerized tomography (CT) scan of his lumbar spine which demonstrated multilevel disc bulging with evidence of mild spinal stenosis at L2-3 and small disc protrusion at L5-S1 on August 29, 2012. In a note dated September 5, 2012, Dr. Oliveri stated that appellant reported a lot of back pain and tailbone pain with numbness and paresthesias in the right anterior thigh and left anterior shin. He reviewed appellant's CT scan and found areas of facet arthropathy with no nerve root impingement. Dr. Oliveri stated that there were areas of mild bulging, but no need for surgery.

On September 27, 2012 appellant informed Dr. Thomas J. Renz, an osteopath, that he had no ongoing hip symptoms. Dr. Oliveri examined appellant on November 14, 2012 and appellant reported chronic pain in his back, hips, and knee. He noted he had difficulties rising from a seated position and pain with lumbar extension. Appellant also exhibited an absence of reflexes of the patella and Achilles. Dr. Oliveri did not recommend surgery. On December 5, 2012 Dr. Renz noted that appellant reported pain over the lateral aspect of his left hip. He found that appellant walked with a satisfactory gait and had tenderness over the trochanteric bursa area with full range of motion of the left hip.

In a note dated March 6, 2013, Dr. Oliveri reported appellant's listing of pain in his back, left sacroiliac area, left buttock, left groin and anterior thigh. He reviewed appellant's diagnostic studies and opined that he had some facet arthropathy without disc disease or stenosis. Dr. Oliveri stated, "I would hold off on doing any kind of spinal surgery on the patient but certainly on examination and history, there is something going on in his back or left-sided sacroiliac area that could be causing him to have discomfort and debility. He has tried different treatments including spinal cord stimulation, transdermal therapy, shots, extended release oral pain medication, all of which have been minimally helpful, but the pain is persistent and debilitating." He diagnosed mechanical low back pain, chronic lumbar sprain/strain, lumbar facet disease, myalgia, and possible sacroiliitis.

On March 21, 2013 appellant underwent a sacroiliac joint injection due to left sacroiliitis. On April 3, 2013 Dr. Oliveri stated that appellant underwent a left-sided fluorscopically-assisted sacroiliac injection which gave him four to five days of excellent pain relief. He opined that appellant's was a complex situation and noted that he had lumbar facet disease, a hip replacement, and sacroiliac osteoarthropathy. Dr. Oliveri stated, "I do think that this fall that he took at work certainly could have caused a sacroiliitis or aggravation of sacroiliac arthropathy. I have seen that occur very commonly and the literature states that even just minor injuries to the sacroiliac joint and trauma to that area can certainly cause significant pain into that area…. At

this point we are going to try to schedule him for a percutaneous sacroiliac fusion." He noted that appellant's daughter had undergone a similar procedure. On April 15, 2013 Dr. Oliveri requested authorization for fusion of appellant's sacroiliac joint.

In a letter dated April 18, 2013, counsel requested that OWCP provide the status of the surgery request. OWCP informed appellant on April 25, 2013 that his accepted conditions included enthesopathy of the hip region, contusion of the chest wall, closed fracture of his finger, contusion of the left hip, lumbar spine sprain, aggravation of osteoarthritis of the left hip, aggravation of sacroiliitis on the left, closed fracture of three ribs, aggravated of preexisting degeneration of the thoracic, lumbar and sacral spines. It informed him that any surgery or procedure must be approved in advance.

OWCP referred a statement of accepted facts and appellant's request for surgery to a medical adviser on May 10, 2013. It inquired whether a percutaneous sacroiliac fusion was necessary to give pain relief.

Dr. Oliveri performed a left sacroiliac percutaneous fusion on May 14, 2013 due to left sacroiliac osteoarthritis and left sacroiliac dysfunction.

On May 10, 2013 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and medical adviser, reviewed appellant's claim. He stated that the request for a percutaneous sacroiliac fusion was highly inappropriate and should not be approved. Dr. Berman stated that there was no specific demonstrable pathology in the sacroiliac joint and opined that appellant's complaints were clearly secondary to lumbar spine pathology. He stated that there was no basis for a percutaneous sacroiliac fusion and that there was no pathology to justify it. Dr. Berman stated that such surgery would create extreme pain and disability with resultant marked reduction in appellant's function. He opined that there had been little to no rehabilitation and, due to appellant's combination of hip and lumbar spine pathology, he would greatly benefit from aquatic exercise.

By decision dated June 5, 2013, OWCP denied authorization for percutaneous sacroiliac fusion on the grounds that there was no evidence of pathology to the sacroiliac. Appellant requested a review of the written record by an OWCP hearing representative on July 1, 2013.

Appellant underwent additional surgery on November 11, 2013 approved by OWCP for left hip trochanteric bursectomy with tensor fascia release and removal of hardware.

By decision dated February 12, 2014, an OWCP hearing representative found that the medical evidence failed to establish that the requested medical procedure, percutaneous sacroiliac fusion, was necessary for treatment of the accepted work injury or would be likely to cure, give relief, reduce the degree or period of disability or aid in lessening the amount of monthly compensation. He found that the weight of the medical opinion evidence rested with the medical adviser.

## *LEGAL PRECEDENT*

Section 8103(a) of FECA states:

> "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 monthly compensation."[2]

OWCP has broad discretion in reviewing requests for medical services under 5 U.S.C. § 8103(a), with the only limitation on its authority being that of reasonableness.[3] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or administrative actions which are contrary to both logic and probable deductions from established facts.[4]

While OWCP is obligated to pay for treatment of work-related conditions, appellant has the burden of establishing that the medical expenditure was incurred for treatment of the effects of a work-related injury or condition.[5] Proof of causal relationship must include rationalized medical evidence. In addition to demonstrating causal relationship, the injured employee must show that the requested services, appliances or supplies are medically warranted.[6]

## *ANALYSIS*

OWCP accepted that appellant sustained enthesopathy of the hip region, contusion of the chest wall, closed fracture of his finger, contusion of the left hip, lumbar spine sprain, aggravation of osteoarthritis of the left hip, aggravation of sacroiliitis on the left, closed fracture of three ribs, aggravated of preexisting degeneration of the thoracic, lumbar and sacral spines as a result of his March 7, 2011 employment injury. Appellant underwent surgery on his finger and thoracic spine and two hip surgeries which were approved by OWCP.

Appellant's attending physician, Dr. Oliveri, examined appellant on March 6, 2013 and listed appellant's symptoms of pain in his back, left sacroiliac area, left buttock, left groin and anterior thigh. He found that on examination and history appellant was experiencing an issue in his back or left-sided sacroiliac area causing him to have discomfort and debility. Dr. Oliveri stated that appellant had tried spinal cord stimulation, transdermal therapy, shots, and extended release oral pain medication which had not relieved his persistent and debilitating pain. He diagnosed mechanical low back pain, chronic lumbar sprain/strain, lumbar facet disease,

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[2] 5 U.S.C. § 8103(a); 20 C.F.R. § 10.310(a).

[3] *B.L.,* Docket No. 14-894 (issued August 15, 2014); *Joseph E. Hofmann*, 57 ECAB 456, 460 (2006).

[4] *Id.*

[5] *Id.*

[6] *Id.*

myalgia, and possible sacroiliitis. On March 21, 2013 appellant underwent a sacroiliac joint injection due to left sacroiliitis. Dr. Oliveri examined appellant on April 3, 2013 and stated that the sacroiliac injection which gave appellant four to five days of excellent pain relief. He diagnosed sacroiliac osteoarthropathy and opined that appellant's fall at work "certainly could have caused a sacroiliitis or aggravation of sacroiliac arthropathy. I have seen that occur very commonly and the literature states that even just minor injuries to the sacroiliac joint and trauma to that area can certainly cause significant pain into that area." Dr. Oliveri subsequently recommended a percutaneous sacroiliac fusion which he performed on May 14, 2013.

The Board finds that Dr. Oliveri did not present sufficient explanation to OWCP based on appellant's complete history of treatment, the diagnostic tests, or why conservative treatment had been found to have failed. Dr. Oliveri did not explain how the proposed surgery would aid in curing appellant, in providing relief, in reducing the degree or period of disability or in lessening the amount of monthly compensation. Based on the evidence of record, the Board finds that OWCP did not abuse its discretion by denying surgery.

OWCP referred appellant's request for spinal fusion to its medical adviser. Dr. Berman reviewed appellant's claim on May 10, 2013. He concluded that the request for percutaneous sacroiliac fusion was highly inappropriate and should not be approved. Dr. Berman stated that there was no specific demonstrable pathology in the sacroiliac joint and that therefore there was no basis for a percutaneous sacroiliac fusion. He opined that appellant's complaints were clearly secondary to lumbar spine pathology. Dr. Berman noted that the surgery would create extreme pain and disability with resultant marked reduction in appellant's function. He concluded that due to appellant's combination of hip and lumbar spine pathology he would greatly benefit from aquatic exercise.

The Board finds that Dr. Berman's report represents the weight of the medical evidence. He provided sufficient explanation to deny appellant's requested surgery. Dr. Berman clearly opined that the requested surgery would not cure or give relief or reduce the period of disability for appellant, but instead would result in additional pain and disability with a marked reduction in appellant's function. The Board notes that the additional pain and disability would likely increase the amount of monthly compensation rather than meet the goal of medical treatment in caring, giving relief or lessening the degree of disability. Dr. Berman provided a detailed report based on the statement of accepted facts and concluded that the proposed medical treatment was likely to defeat the goals of FECA. The Board finds that OWCP did not abuse its discretion in relying on this report to deny the request for surgery.

## ***CONCLUSION***

The Board finds that OWCP properly denied appellant's requested percutaneous sacroiliac fusion as the medical evidence establishes that the requested surgery would not likely cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation for appellant.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the February 12, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 17, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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