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

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| **T.C., Appellant** | ) | |
| **and** | ) | **Docket No. 14-878** |
| | ) | **Issued: November 24, 2014** |
| **U.S. POSTAL SERVICE, POST OFFICE, Greensville, SC, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*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 March 25, 2014 appellant filed a timely appeal from a January 15, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 a second cervical fusion.

### ***FACTUAL HISTORY***

On March 17, 2011 appellant, then a 53-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that the repetitive lifting of up to 70 pounds during his career resulted in problems with his neck and arms. OWCP accepted a permanent aggravation of

[1] 5 U.S.C. §§ 8101-8193.

cervical spondylosis at C6-7 with myelopathy, cervical spondylosis without myelopathy, and displacement of a cervical intervertebral disc without myelopathy at right C6-7. It paid benefits, including authorization of an anterior cervical discectomy fusion at C6-7 performed on February 9, 2011.[2]

A June 20, 2012 electromyogram and nerve conduction studies (EMG/NCS) report noted evidence of a moderate bilateral carpal tunnel syndrome affecting sensory and motor components. There was no electrodiagnostic evidence of any bilateral upper extremity radiculopathy, plexopathy, myopathy, or overt peripheral neuropathy.

In a July 19, 2012 treatment note, Dr. Marco A. Rodriguez, an orthopedic surgeon, stated that appellant had pain with Impingement I and II testing and weakness in his deltoid and supraspinatus regions. He also noted weakness in appellant's biceps and triceps on the right side with decreased sensibility in the radial side of the hand bilaterally and a negative Phalen's compression test. Dr. Rodriguez stated that appellant's August 15, 2011 postoperative magnetic resonance imaging (MRI) scan showed right-sided stenosis at C4-C5, C5-C6 which appeared open, and C6-C7 foraminal narrowing on the right side, which was likely scar tissue as distal symptoms in the hand seemed related to carpal tunnel syndrome. The July 9, 2012 computerized tomography (CT) myelogram showed a well-fused C6-C7 level with no bony compression on the nerves. The EMG/NCS showed moderate bilateral carpal tunnel syndrome. Dr. Rodriguez noted that there was no radiculopathy on these studies. He assessed bilateral carpal tunnel syndrome and right shoulder impingement. Dr. Rodriguez also assessed C4-C5 stenosis above a prior well-fused C6-C7, which might require an anterior cervical discectomy and fusion.

In an October 15, 2012 report, Dr. Rodriguez advised that appellant had a nine-day benefit from a C4-C5 transforaminal epidural steroid injection, appellant's shoulder pain with range of motion had improved since shoulder arthrospcopy, but radiating shoulder pain remained.

On October 29, 2012 Dr. Rodriguez requested authorization for a spinal fusion at C4-C5 with insertion of spine fixation and device.

On October 31, 2012 Dr. H.P. Hogshead, an OWCP medical adviser, reviewed the medical evidence of record. He noted that the October 15, 2012 examination by Dr. Rodriguez revealed no motor or sensory loss to the right upper extremity. Dr. Hogshead also noted that the electrodiagnostic study of June 20, 2012 revealed no radiculopathy, myopathy, or neuropathy. Therefore, he recommended that the cervical fusion surgery not be approved.

In a November 20, 2012 narrative, Dr. Rodriguez noted the history of appellant's prior surgeries of C6-C7, left carpal tunnel surgery and right shoulder arthroscopy. He advised that appellant had cervical stenosis at C4-C5 and that the radiating shoulder pain had benefited from a transforaminal epidural steroid injection at C4-C5. Dr. Rodriguez stated that appellant had spinal stenosis with facet hypertrophy and uncovertebral joint hypertrophy on the right side. He

[2] Under claim number xxxxxx568, OWCP accepted bilateral carpal tunnel syndrome and right shoulder impingement. Appellant underwent authorized right shoulder subacromial decompression on September 6, 2012 and authorized left carpal tunnel release on November 1, 2012.

noted that, while appellant had C5-C6 arthropathy and left-sided stenosis, this was not associated with his right-sided symptoms. Dr. Rodriguez stated that the nerve studies did not show any changes and appellant had no significant weakness; however, his pain was distributed in the C5 area. Given the pain relief with the transforaminal injection, he felt that this was the source of appellant's radiating shoulder pain and again recommended a C4-C5 anterior cervical discectomy and fusion with right-sided decompression.

On December 12, 2012 Dr. Hogshead reviewed Dr. Rodriguez's November 20, 2012 report and noted that he did not provide any new objective findings. He noted that there was a pain problem but there was no documentation of record of any radiculopathy. Dr. Hogshead recommended that the cervical disc fusion surgery at C4-C5 not be approved.

On December 18, 2012 OWCP referred appellant, the medical record and a statement of accepted facts to Dr. James Bethea, a Board-certified orthopedic surgeon, for a second opinion examination. In a January 23, 2013 report, Dr. Bethea stated that he did not recommend the proposed surgical procedure as there was a discrepancy on interpretation of the July 9, 2012 CT myleogram. Dr. Rodriguez believed that stenosis of the cervical spine was responsible for appellant's continuing pain while the radiologist stated that there was no significant stenosis demonstrated. Dr. Bethea stated that he could not make a recommendation as the CT myleogram was not made available for his review. On April 3, 2013 he reviewed the July 9, 2012 CT myleogram and stated that there was no indication for surgical intervention at this time.

On April 8, 2013 OWCP again received a request from Dr. Rodriguez for cervical fusion at C4-C5.

On April 10, 2013 Dr. James W. Dyer, an OWCP medical adviser, concurred with Dr. Bethea, who found no objective evidence of radiculopathy in the right upper extremity and recommended that surgery not be authorized.

In an April 24, 2013 letter, OWCP informed Dr. Rodriguez of the deficiencies in his request to approve the recommended surgery at C4-C5. It requested that he respond within 30 days with a reasoned medical opinion as to how the C4-C5 facet disease and stenosis was related to the accepted conditions as work related.

In a May 7, 2013 report, Dr. Rodriguez stated that appellant's diagnosis was C4-C5 spinal stenosis with right arm radiculopathy, which dated back to his recovery from the C6-C7 fusion from his original injury. He noted that appellant went back to light-duty work during that recovery doing repetitive lifting and the pain came back in his neck and arms. Appellant underwent left carpal tunnel release and right shoulder arthroscopy which helped with his symptoms, but his neck pain and right shoulder and arm pain continued with weakness in his deltoid. Dr. Rodriguez stated that the MRI scan showed C4-C5 stenosis on right side and some C5-C6 narrowing on the left side. A CAT scan myleogram also showed some stenosis on the right side at C4-C5. Dr. Rodriguez noted that appellant obtained some relief from a C4-C5 transforaminal epidural steriod injection of his right shoulder but continued to have problems with radiating pain into his right shoulder and arm after his right shoulder and left wrist surgery. He stated that the best option was a C4-C5 fusion with instrumentation as there was significant osteophyte formation that needed decompression. Dr. Rodriguez opined that appellant's

condition arose from his recovery from his cervical fusion which OWCP had accepted as it occurred during the recovery phase of that surgery.

In a June 13, 2013 letter, OWCP informed appellant of the deficiencies in Dr. Rodriguez's May 7, 2013 report regarding the surgical request and requested that he provide a medical narrative with medical rationale to support that the requested surgery was warranted due to the November 30, 2010 work injury. Appellant was provided 30 days to provide the information to OWCP.

Dr. Rodriguez resubmitted his May 7, 2013 report. No new medical reports were received.

By decision dated August 14, 2013, OWCP denied authorization of the spinal surgery at C4-C5 as it did not appear to be medically necessary for or treatment causally related to the accepted conditions. The weight of the medical evidence rested with Dr. Bethea, the second opinion specialist, and Dr. Dyer who concurred with Dr. Bethea.

On December 2, 2013 OWCP received a request for reconsideration. In a November 14, 2013 letter, appellant stated that he was scheduled for a cervical fusion of C4-C5. He did not understand why surgery was denied when his claim had been approved for a permanent aggravation of a preexisting cervical injury and he had underwent an approved surgical fusion at C6-C7 in 2011. Appellant submitted physical therapy notes from a certified physician's assistant and a September 11, 2013 MRI scan of the cervical spine. In treatment records Dr. Rodriguez diagnosed C4-C5 stenosis with right arm radiculopathy. In an October 7, 2013 report, he stated that the C4-C5 cervical disc fusion with instrumentation could help appellant's radicular pain. Dr. Rodriguez indicated that appellant was getting worse and more severely limited. Appellant was scheduled for surgery on November 19, 2013.[3]

By decision dated January 15, 2014, OWCP denied modification of its April 14, 2013 decision denying authorization of surgery.

## ***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.[4] OWCP has the general objective of ensuring that an employee recovers from his or her 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.[5] The only limitation on

[3] Medical reports from Dr. Mark D. Visk, a Board-certified orthopedic surgeon, referred to appellant's bilateral carpal tunnel syndrome and right shoulder impingement syndrome with AC joint arthritis conditions.

[4] 5 U.S.C. § 8103(a).

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

OWCP's authority is that of reasonableness.[6] To be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury. This burden of proof includes providing supporting rationalized medical evidence.[7]

To establish that a medical procedure is warranted, a claimant must submit evidence to show that the procedure is for a condition causally related to the employment injury and that the procedure is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[8]

## ***ANALYSIS***

OWCP accepted that appellant sustained a permanent aggravation of cervical spondylosis at C6-C7 with myelopathy, cervical spondylosis without myelopathy, and displacement of cervical intervertebral disc without myelopathy at right C6-C7. It paid appropriate benefits, including benefits pertaining to a February 9, 2011 cervical disc fusion at C6-C7.[9] Dr. Rodriguez requested authorization for a cervical disc fusion at C4-C5, which OWCP denied.

On October 29, 2012 Dr. Rodriguez, requested authorization for a neck/spine fusion at C4-C5 with insertion of spine fixation and device. However, his October 15, 2012 report did not specifically explain how the requested procedure was medically necessary for treatment of the effects of an employment-related condition. In his October 15, 2012 examination, Dr. Rodriguez reported only pain and no motor or sensory loss in the right upper extremity. The June 20, 2012 electrodiagnostic study also revealed no radiculopathy, myopathy, or neuropathy. In his November 20, 2012 narrative, Dr. Rodriguez did not offer any new objective findings or any rationale as to how the requested surgery was causally related. He stated that appellant has cervical stenosis at C4-C5. Dr. Rodriguez indicated that the nerve studies did not show any changes and appellant had no significant weakness; however, given the pain relief with the transforaminal epidural steroid injection at C4-C5, he opined that this was the source of appellant's radiating shoulder pain and recommended a C4-C5 anterior cervical discectomy and fusion with right-sided decompression.

In his May 7, 2013 report, Dr. Rodriguez did not specifically explain why the requested surgery was medically warranted for treatment of an accepted condition. In his May 7, 2013 report, he stated that appellant's diagnosis was C4-C5 spinal stenosis with right arm radiculopathy. Dr. Rodriguez opined that appellant's problems started during his recovery from the C6-C7 fusion from his original injury as he was doing repetitive lifting and the pain came

[6] *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).

[7] *F.T.*, Docket No. 09-919 (issued December 7, 2009).

[8] *See R.L.*, Docket No. 08-855 (issued October 6, 2008).

[9] Under claim number xxxxxx568, OWCP accepted bilateral carpal tunnel syndrome and right shoulder impingement and authorized right shoulder subacromial decompression and left carpal tunnel release.

back in the neck and arms. However, he offered no rationale as to how or why the diagnosed condition or proposed surgery was causally related to the accepted C6-C7 condition other than the condition occurred during the recovery phase of the accepted C6-C7 surgery. Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish a causal relationship.[10] Consequently, Dr. Rodriguez's reports are of limited probative value regarding whether the requested C4-C5 cervical disc fusion surgery was medically needed for the treatment of an accepted work-related condition.

OWCP referred appellant for a second opinion examination with Dr. Bethea, a Board-certified orthopedic surgeon. In a January 23, 2013 report, Dr. Bethea noted his review of the medical record, the statement of accepted facts and his examination of appellant. After reviewing on April 3, 2013 the July 9, 2012 CT myelogram, which he indicated Dr. Rodriguez and the radiologist disagreed on the interpretation of whether a significant stenosis was present, Dr. Bethea advised that there was no indication for surgical intervention at this time. While Dr. Bethea and the medical adviser agreed appellant suffered from pain, both physicians found there were no objective findings to support any radiculopathy in the right upper extremity to necessitate the proposed surgery.

Based on the evidence of record, the Board finds that OWCP did not abuse its discretion by denying the proposed surgical procedure for a cervical fusion at C4-C5. While appellant contends on appeal that the C4-C5 cervical surgery offered relief for his symptoms, the evidence of record failed to establish the necessity for surgery was causally related to the accepted employment injury or that the procedure was medically warranted.

## ***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 cervical surgery at C4-C5.

[10] *P.K.*, Docket No. 08-2551 (issued June 2, 2009); *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the January 15, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 24, 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