United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 15-1162**
	)	**Issued: November 12, 2015**
DEPARTMENT OF JUSTICE, U.S. MARSHALS SERVICE, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 27, 2015 appellant filed a timely appeal from a February 3, 2015 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.[2]

ISSUE

The issue is whether OWCP abused its discretion by denying appellant authorization for lumbar decompression and spinal fusion surgery.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the issuance of the February 3, 2015 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

On appeal appellant contends that OWCP's hearing representative ignored or disregarded the medical reports from his treating physician and argues that the decision was based on the OWCP medical adviser's bias against surgery.

FACTUAL HISTORY

On May 15, 2000 appellant, a 40-year-old inspector, filed a traumatic injury claim (Form CA-1) alleging that he sustained a lower back injury on May 8, 2000 due to a slip and fall while walking to an office in the performance of duty. OWCP accepted the claim for permanent aggravation of lumbar intervertebral disc without myelopathy at L4-5, lumbar intervertebral disc degeneration, and thoracic intervertebral disc degeneration.[3] It retroactively authorized a right L4-5 lumbar microdiscectomy, which appellant underwent on December 21, 2000 and later authorized an L4-5 prosthetic disc replacement on August 27, 2007 and a left T7-8 hemilaminectomy and medial facetectomy on February 21, 2012.

Appellant was placed on the periodic rolls on March 11, 2012.

OWCP referred appellant to Dr. James Schwartz, an orthopedic surgeon, for a second opinion evaluation to determine the nature and extent of appellant's employment-related conditions and work capacity. In an August 26, 2013 report, Dr. Schwartz found that appellant had reached maximum medical improvement and was capable of full-time, sedentary work as long as he was allowed frequent change of position. He advised that appellant should be weaned from his narcotic medication and "[n]o directed treatment [was] recommended."

A bone scan dated August 14, 2013 revealed L4-5 disc photogenic defect consistent with disc prosthesis.

An x-ray dated August 26, 2013 showed stable position with no significant change at the artificial disc at L4-5, minimal foraminal/extra foraminal bulge without impingement at L3-4 and L1-2 and L2-3.

An August 20, 2013 computerized tomography (CT) scan of the lumbar spine demonstrated artifacts from an artificial disc at L4-5 with no apparent subluxation or displacement of the artificial disc.

On September 3, 2013 Dr. John Demakas, a neurosurgeon, found that appellant's lumbosacral spondylosis without myelopathy remained unchanged. He noted that there were facet inflammatory changes at right-sided L5-S1 and left-sided L3-4 and L4-5. Dr. Demakas further indicated that the August 20, 2013 CT myelogram other than demonstrating artifact at L4-5 "does not demonstrate any significant central or foraminal narrowing at any of the levels but clearly has evidence of facet arthropathy in the above[-]mentioned levels." He stated that there had been no changes in appellant's symptoms as previously described.

[3] Appellant also has accepted claims for a left ankle sprain, left Achilles tendinitis, and left contracture of tendon under OWCP File No. xxxxxx479 and a left ankle sprain under File No. xxxxxx501.

In a December 18, 2013 report, Dr. Trent Tredway, a Board-certified neurosurgeon and appellant's attending physician, "recommended considering an L4-5 posterior decompression and instrumented fusion." He noted that, after careful review of his medical history and findings of his physical examination, as well as reviewing the pertinent imaging studies, it appeared that appellant was presenting with signs and symptoms of lumbago and lumbar radiculopathy (right L5 into buttock). Imaging revealed an artificial disc at L4-5 which was intact, but showed degenerative changes with stenosis. Dr. Tredway found that the spinous processes were abutting each other. He discussed the possible risks and benefits of surgical intervention and appellant decided to proceed with the surgery.

A December 20, 2013 x-ray showed status post prosthetic disc placement at L4-5 without complication and moderate bilateral L3-4 through L5-S1 apophyseal spondylosis.

On December 30, 2013 and January 23, 2014 appellant requested authorization for lumbar spinal surgery.

On January 30, 2014 Dr. William Stewart, an OWCP medical adviser, reviewed the medical evidence and determined that the L4-5 posterior decompression and fusion surgery was not appropriate or medically necessary. It was later determined that the medical adviser had not received all of the medical reports. The record was corrected and the case was sent to another medical adviser.

In a March 10, 2014 report, Dr. Kenneth Sawyer, an orthopedic surgeon and OWCP medical adviser, reviewed the complete medical record and concurred with Dr. Stewart that the L4-5 posterior decompression and fusion surgery was not appropriate or medically necessary. He found that the requested surgery was for an accepted condition of L4-5 disc pathology, but it was not clear that appellant had discontinued narcotic medication or begun a regular aerobic exercise program as recommended. Appellant had undergone prior nonoperative treatment, including activity modification, stopping work, physical therapy, chiropractic treatment, massage therapy, acupuncture, use of a cane, and multiple medications. Dr. Sawyer concluded that physical examination of appellant neither supported the proposed surgery, nor contradicted it. Appellant did not have any significant and reproducible radiculopathy or a neurologic deficit. Dr. Sawyer opined that the recently noted diffuse weakness in both legs was inconsistent with prior examiners and most likely volitional or due to pain inhibition rather than a neurologic deficit. He found no diagnostic support for the surgery as flexion-extension x-rays and CT myelogram over the past year had shown no failure or loosening of the prosthesis at L4-5 and no instability at that level. Facet changes at L4-5 were described as mild and unchanged from prior studies. No neurologic compression was noted at the L4-5 level.

Dr. Sawyer found that appellant's accepted conditions were not more likely to improve with the surgery than without it. He further opined that an improvement in function or ability to work would not be more likely with surgery than without it. Dr. Sawyer concluded that the requested surgery should not be authorized because appellant's condition and symptoms had not changed substantially since Dr. Schwartz's second opinion evaluation on August 26, 2013. He noted that there had been multiple emergency room visits for pain medication due to back pain, typically brought on by activity such as working in the yard, lifting trash, working on farm equipment, or painting overhead all day. Dr. Sawyer opined that in addition to poor indications

for this procedure, appellant was a poor candidate for surgery in general due to chronic habituation to narcotics, deconditioning, obesity, a history of deep vein thrombosis (DVT) and pulmonary embolism, cardiac arrhythmia, and a history of anxiety and depression.

On April 2, 2014 appellant reiterated his request for lumbar spinal surgery and submitted an April 2, 2014 report from Dr. Tredway who diagnosed lumbar radiculitis neuritis, lumbar stenosis, low back pain, and lumbar degenerative disc disease. He found that appellant had a L5 radiculopathy secondary to foraminal stenosis. Dr. Tredway stated that appellant underwent a lumbar disc arthroplasty, but still had significant radicular pain and lumbago. He recommended an open decompression of the nerve roots with fusion across the level using posterior lateral fusion techniques. Dr. Tredway strongly encouraged appellant "to follow up with OWCP since he [had] severe lumbar radiculopathy and lumbago after undergoing a decompression with fusion across the L4-5 level."

In an April 3, 2014 letter, OWCP notified appellant that it had received his request for surgery. It advised him that the evidence was insufficient to establish medical necessity and afforded him 30 days to submit additional evidence and respond to its inquiries.

Appellant submitted another report dated April 2, 2014 from Dr. Tredway reiterating his recommendation for decompression and fusion surgery at L4-5.

On May 5, 2014 Dr. Sawyer reviewed Dr. Tredway's April 2, 2014 reports and found that it did not provide any new history or a new explanation or reasoning as to why the proposed surgery was medically appropriate or necessary.

By decision dated May 8, 2014, an OWCP denied authorization for lumbar decompression and spinal fusion surgery.

On May 13, 2014 appellant requested an oral hearing before an OWCP hearing representative and submitted a June 13, 2014 report from Dr. Jeffrey O'Connor, a family practitioner, who diagnosed anticoagulation, chronic back pain, and ulnar neuropathy with surgery anticipated.

A telephonic hearing was held before an OWCP hearing representative on December 3, 2014.

By decision dated February 3, 2015, OWCP hearing representative affirmed the prior decision denying authorization for surgery.

LEGAL PRECEDENT

Section 8103 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] In interpreting this section of FECA, the Board has recognized that OWCP has

[4] 5 U.S.C. § 8103.

broad discretion in approving services provided under FECA.[5] 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. The only limitation on OWCP's authority is that of reasonableness.[6] 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] It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[8]

ANALYSIS

The Board finds that OWCP did not abuse its discretion and properly denied appellant authorization for lumbar decompression and spinal fusion surgery.

OWCP accepted that appellant sustained a permanent aggravation of lumbar intervertebral disc without myelopathy at L4-5, lumbar intervertebral disc degeneration, and thoracic intervertebral disc degeneration due to a slip and fall on May 8, 2000. OWCP has authorized three surgical procedures: a right L4-5 lumbar microdiscectomy on December 21, 2000, an L4-5 prosthetic disc replacement on August 27, 2007, and a left T7-8 hemilaminectomy and medial facetectomy on February 21, 2012.

OWCP referred appellant to Dr. Schwartz for a second opinion evaluation to determine the nature and extent of appellant's employment-related conditions. In his August 26, 2013 report, Dr. Schwartz found that appellant had reached maximum medical improvement and was capable of full-time, sedentary work as long as he was allowed frequent change of position. He advised that appellant should be weaned off of his narcotic medication and "[n]o directed treatment [was] recommended."

Appellant requested authorization for lumbar spinal surgery based on a December 18, 2013 report from Dr. Tredway, his treating physician, who "recommended considering an L4-5 posterior decompression and instrumented fusion." Dr. Tredway noted that after careful history and physical examination, as well as reviewing the pertinent imaging studies, it appeared that appellant was presenting with signs and symptoms of lumbago and lumbar radiculopathy (right L5 into buttock). Imaging revealed an artificial disc at L4-5 which was intact, but showed degenerative changes with stenosis. Dr. Tredway found that the spinous processes were abutting each other. On April 2, 2014 he diagnosed lumbar radiculitis neuritis, lumbar stenosis, low back pain, and lumbar degenerative disc disease. Dr. Tredway found that appellant had an L5 radiculopathy secondary to foraminal stenosis. He noted that appellant had undergone a lumbar disc arthroplasty, but still had significant radicular pain and lumbago. Dr. Tredway recommended an open decompression of the nerve roots with fusion across that level, using

[5] *See J.B.*, Docket No. 11-1301 (issued March 22, 2012).

[6] *Id.*

[7] *Id.*

[8] *See Dale E. Jones*, 48 ECAB 648 (1997); *Daniel J. Perea*, 42 ECAB 214 (1990).

posterior lateral fusion techniques. He strongly encouraged appellant "to follow up with OWCP since he [had] severe lumbar radiculopathy and lumbago after undergoing a decompression with fusion across the L4-5 level."

On March 10, 2014 Dr. Sawyer, an orthopedic surgeon and OWCP medical adviser, reviewed the medical evidence and determined that the L4-5 posterior decompression and fusion surgery was not appropriate or medically necessary. He found that the requested surgery was for an accepted condition of L4-5 disc pathology, but it was not clear that appellant had discontinued narcotic medication as recommended. Appellant did not have any significant and reproducible radiculopathy or neurologic deficit. Dr. Sawyer opined that the recently noted diffuse weakness in both legs was inconsistent with prior examiners and most likely volitional or due to pain inhibition rather than neurologic deficit. He found no diagnostic support for the surgery as flexion-extension x-rays and CT myelogram over the past year had shown no failure or loosening of the prosthesis at L4-5 and no instability at that level. Facet changes at L4-5 were described as mild and unchanged from prior studies. No neurologic compression was noted at the L4-5 level. Dr. Sawyer found that appellant's accepted conditions were not more likely to improve with the surgery than without it. He further opined that an improvement in function or ability to work would not be more likely with surgery than without it. Dr. Sawyer concluded that the requested surgery should not be authorized because appellant's condition and symptoms had not changed substantially since Dr. Schwartz's second opinion evaluation on August 26, 2013. He noted that there had been multiple emergency room visits for pain medication due to back pain, typically brought on by activity such as working in the yard, lifting trash, working on farm equipment, or painting overhead all day. Dr. Sawyer opined that in addition to poor indications for this procedure, appellant was a poor candidate for surgery in general due to chronic habituation to narcotics, decondition, obesity, a history of deep vein thrombosis (DVT) and pulmonary embolism, cardiac arrhythmia, and a history of anxiety and depression. On May 5, 2014 he reviewed Dr. Tredway's new April 2, 2014 report and found it did not provide any new history or a new explanation or reasoning as to why the proposed surgery was medically appropriate or necessary.

As noted above, the only restriction on OWCP's authority to authorize medical treatment is one of reasonableness.[9] Dr. Sawyer's opinion constituted sufficient medical rationale to support OWCP hearing representative's February 3, 2015 decision. He stated unequivocally, based on a thorough review of the medical evidence, that the requested surgical procedure was not appropriate or necessary for appellant's accepted conditions and that he was generally not a good candidate for surgery due to other nonwork-related conditions. Dr. Sawyer's report is sufficiently probative, rationalized, and based upon a proper factual background. The Board finds that OWCP did not abuse its discretion by relying on the opinion of Dr. Sawyer to deny approval for the elective spinal surgery.

The Board further finds that the reports from Drs. Demakas and O'Connor do not constitute competent medical evidence as they do not provide an opinion regarding appellant's need for surgery.

[9] *See supra* note 6; *see also A.W.*, Docket No. 14-0708 (issued January 2, 2015) (where the Board found that OWCP did not abuse its discretion by relying on the opinion of its second opinion examiner as the weight of evidence to deny approval for elective spinal surgery).

On appeal appellant contends that an OWCP hearing representative ignored or disregarded the medical reports from his treating physician and argues that the decision was based on the OWCP medical adviser's bias against surgery. However, appellant's arguments are not substantiated with any evidence.

CONCLUSION

The Board finds that OWCP did not abuse its discretion by denying authorization for lumbar decompression and spinal fusion surgery.

ORDER

IT IS HEREBY ORDERED THAT the February 3, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 12, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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