United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	**Docket No. 17-1088**
	)	**Issued: December 4, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Pasco, WA, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 24, 2017 appellant filed a timely appeal from an April 10, 2017 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 the claim.

ISSUE

The issue is whether OWCP abused its discretion by denying appellant authorization for cervical spine surgery.

FACTUAL HISTORY

On February 11, 2014 appellant, then a 54-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that, on that same date, he injured his neck and back when he slipped on snow and ice while delivering mail. He indicated that he did not hit the ground, but

[1] 5 U.S.C. § 8101 *et seq.*

felt a pop. Appellant stopped work on the date of injury, but returned to regular duty on February 14, 2014 and began treatment with Dr. Janmeet Sahota, a Board-certified osteopath specializing in orthopedic surgery.

Following OWCP's initial denial of the claim on November 26, 2014, appellant requested reconsideration and submitted additional evidence. In a December 4, 2014 statement, he described the claimed injury, stating that he was walking through a car sales lot when he slipped on snow and ice, and jerked his body about while trying to keep from hitting the ground. Appellant indicated that he felt a snap in his neck and back. He returned to the employing establishment and reported the incident to his supervisor, and then visited a medical center for treatment.

Appellant stopped work on January 15, 2015 and returned on January 20, 2015. On February 4, 2015 he filed a notice of recurrence (Form CA-2a) indicating that on January 15, 2015, while lifting a large parcel, he had severe neck pain which continued.

By decision dated February 6, 2015, OWCP vacated the November 26, 2014 decision and accepted appellant's claim for sprain of neck and back, lumbar region.

Dr. Kenneth Breeden, an osteopath and associate of Dr. Sahota, followed appellant for pain and medication management. On February 23, 2015 he noted a history that appellant first injured his cervical region at home in October 2013 when two dogs jumped into his recliner and threw it back, and that he reinjured his neck at work approximately one year prior when he slipped on ice, but did not fall and jerked his head back. Dr. Breeden diagnosed chronic pain syndrome, cervical disc disease with myelopathy, cervical spondylosis, cervical disc displacement, and cervical sprain and strain. He saw appellant on an approximately monthly basis. Cameron Ritchie, a physician assistant working with Dr. Sahota, also provided monthly treatment notes.

Beginning in June 2015 Dr. Sahota requested authorization for cervical spine surgery. In November 3, 2015 correspondence, OWCP notified appellant that the evidence of record was insufficient to authorize the proposed surgery because it did not appear to be medically necessary for the accepted sprain of neck and sprain of back, lumbar region. It informed him of the medical evidence needed to support the authorization.

In an August 11, 2015 treatment note, Dr. Sahota noted appellant's complaint of cervical paraspinal muscle tenderness. He diagnosed cervical stenosis, cervical spondylosis, cervical disc displacement, cervical disc disease with myelopathy, and degenerative disc disease of the cervical spine. On November 2, 2015 Dr. Sahota advised that appellant was last seen by Mr. Ritchie on October 6, 2015 regarding the February 11, 2014 work injury. He noted appellant's continued complaint of cervical pain, numbness, and tingling in his arms despite conservative care, and advised that appellant wished to proceed with surgery. Dr. Sahota recommended anterior cervical discectomy with fusion from C5 to C7. He maintained that appellant's daily symptoms were the result of a job injury and were consistent with the fall he endured while delivering mail. On December 9, 2015 Dr. Sahota noted seeing appellant for over a year. Examination confirmed left hand numbness, weakness, radiculopathy, and radiating pain. Dr. Sahota opined that all of appellant's symptoms were a result of cervical disc herniation with

cervical stenosis, maintaining that appellant did not have any previous injury, and that the work-related slip and fall onto ice caused the cervical disc herniation with cervical stenosis. He again requested authorization for cervical spine surgery. In a December 10, 2015 treatment note, Dr. Sahota reiterated his findings and conclusions.

In February 2016 OWCP referred appellant to Dr. S. Daniel Seltzer, a Board-certified orthopedic surgeon, for a second opinion evaluation.

On a March 1, 2016 duty status report (Form CA-17), Dr. Sahota advised that appellant could work full-time restricted duty. Appellant continued monthly treatment with Dr. Breeden and Mr. Ritchie.

In a March 26, 2016 report, Dr. Seltzer noted his review of the statement of accepted facts (SOAF), the medical evidence of record including imaging studies, and OWCP questions for resolution. He noted that appellant continued to work full duty, but did not carry a mail satchel. Dr. Seltzer indicated that appellant wanted to go forward with surgery due to his pain. He reported that appellant's injury at home in 2013 caused him to hit his head. Regarding the February 11, 2014 work injury, Dr. Seltzer noted that appellant indicated that when he slipped on ice, he jerked or stretched backwards and felt a pop in his neck. He advised that cervical spine examination was limited by guarding and complaints of pain, but noted that appellant turned his neck and head from side-to-side without difficulty when observed during history taking. Left arm examination revealed subjective weakness with give way throughout the entire extremity that did not conform to any specific dermatomal area. On sensory examination there was entire loss of sensitivity to light touch and pinprick, again not conforming to any specific dermatomal area. Hoffman's test was completely negative with no sign of cervical radiculopathy. Cervical spine range of motion was painful and diminished, and left arm range of motion was diminished.

Dr. Seltzer diagnosed cervical degenerative disc disease with left-sided cervical disc protrusion, as shown on magnetic resonance imaging (MRI) scans. He advised that this was preexisting and likely related to both the natural degenerative process and to appellant's reported injury at home in 2013. Dr. Seltzer further indicated that his examination confirmed evidence of a probable left arm radiculopathy, but opined that this too represented the natural progression of appellant's cervical discogenic disease. He indicated that the mechanism of injury provided by appellant made no sense from a biomechanical standpoint, and that his subjective complaints as demonstrated in the history did not support worsening, other than his increase in symptoms. Dr. Seltzer further advised that the February 11, 2014 employment injury caused sprains of the neck and lumbar region, which had resolved. As to the requested surgery, he indicated that, although appellant was a candidate for surgery, this was due to his underlying preexisting condition and not to the employment injury.

By decision dated April 7, 2016, OWCP denied appellant's request for authorization of cervical spine surgery, finding that the weight of the medical evidence rested with the opinion of Dr. Seltzer.

On May 26, 2016 appellant requested reconsideration, accompanied by additional medical evidence. On March 1, 2016 Dr. Sahota advised that appellant's cervical disc stenosis at C4 to C7 with left upper extremity radiculopathy was a result of a work injury. He repeated this

opinion on April 26, 2016. Dr. Sahota noted that he had reviewed Dr. Seltzer's report and disagreed with his findings, opining that the disc protrusion at C6-7 was an acute change related to the employment and that this injury resulted in exacerbation of appellant's baseline degenerative disc disease. Mr. Ritchie reiterated this opinion on May 26, 2016 and ordered an additional MRI scan and upper extremity electrodiagnostic testing. Dr. Breeden submitted additional treatment notes describing pain management.

By merit decision dated June 13, 2016, OWCP denied modification of the April 7, 2016 decision. It noted that Dr. Breeden provided no opinion regarding the cause of any diagnosed condition, and that Mr. Ritchie's reports were of diminished probative value as a physician assistant was not considered a physician under FECA. OWCP further found Dr. Sahota's opinion insufficient because he did not explain how the requested surgery was necessary to address the effects of the February 11, 2014 employment injury.

Appellant again requested reconsideration on January 10, 2017.

Medical evidence received on reconsideration included monthly treatment notes from Dr. Breeden who reiterated his diagnoses and continued to provide pain and medication management. Dr. Breeden did not provide an opinion on the cause of his diagnoses. Mr. Ritchie also furnished monthly treatment notes reiterating his findings and conclusions.[2]

On October 14, 2016 Dr. Donald Dicken, a Board-certified physiatrist, examined appellant. He noted previously performing a December 6, 2013 upper extremity electromyogram/nerve conduction velocity (EMG/NCV) study that showed mild left carpal tunnel syndrome. The study was normal on the right. Dr. Dicken advised that an October 14, 2016 EMG/NCV study showed possible mild left cervical radiculopathy, mild left carpal tunnel syndrome with no significant changes from the prior study, and a normal study on the right.

On December 13, 2016 Dr. Sahota noted his review of the October 14, 2016 EMG/NCV study. He advised that given the study's findings, appellant had objective signs of cervical radiculopathy, and opined that he would like to proceed with surgery. Dr. Sahota reiterated his opinion that appellant's cervical condition was employment related.

In February 2017 OWCP determined that a conflict in medical evidence had been created between the opinions of Dr. Seltzer and Dr. Sahota regarding whether the accepted February 11, 2014 employment injury caused a new injury and/or exacerbation of appellant's underlying degenerative disc disease of the cervical spine. It referred appellant to Dr. Lowell Anderson, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

Dr. Breeden and Mr. Ritchie continued to treat appellant.

In a March 30, 2017 report, Dr. Anderson noted his review of the SOAF and the medical evidence of record and noted appellant's complaints of left hand numbness and aching pain

[2] Appellant also submitted a February 14, 2017 treatment note and duty status report in which Michael Corey Woolf, a second physician assistant with Dr. Sahota, noted findings and diagnoses as a result of a work injury, and occipital neuralgia. Mr. Woolf advised that appellant could work eight hours a day with no satchel.

down the left arm. He reported that on February 11, 2014 appellant slipped, but did not fall and thereafter continued to work as a letter carrier, but no longer carried a satchel. Dr. Anderson described a past medical history of cervical injuries in 2013 and 2014, and that appellant related that in August 2017 he bumped his head and had a concussion, noting there was no medical evidence regarding this injury. Physical examination demonstrated that during the history portion, appellant appeared to move his neck and upper extremities comfortably without symptoms. Active cervical motion was minimal, and gentle passive cervical motion was resisted. Nonspecific pericervical soft tissue tenderness and mild left trapezius tenderness were present. Gross sensory examination of the left upper extremity was considered nondiagnostic. Dr. Anderson advised that appellant had no present lumbar condition. He diagnosed preexisting cervical spondylosis, opining that appellant's present condition was a natural progression of this condition, noting that after full record review he was unable to document any evidence that appellant's left upper extremity complaints were due to the February 11, 2014 work injury which did not cause a disc protrusion at C6-7 or accelerate the natural progression of appellant's preexisting degenerative condition. Dr. Anderson concluded that no employment-related condition remained, and any surgical procedure was not indicated due to the accepted conditions.

In a merit decision dated April 10, 2017, OWCP denied modification of the prior decisions, finding that the special weight of the medical evidence rested with the impartial medical opinion of Dr. Anderson.

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 monthly compensation.[3] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of proof to establish that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[4]

In interpreting section 8103 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[5] 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. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[6] To be entitled to reimbursement of medical expenses, a claimant has the burden of proof to establish 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

[3] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

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

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

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

medical evidence.[7] 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.[8]

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.[9] The implementing regulation states 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 an OWCP 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.[10] When there exist 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 upon a proper factual background, must be given special weight.[11]

ANALYSIS

The Board finds that OWCP did not abuse its discretion by denying authorization for cervical spine surgery. OWCP accepted neck and lumbar sprains caused by a February 11, 2014 employment injury in which appellant slipped on ice, but did not fall. Beginning in June 2015 Dr. Sahota, an attending orthopedic surgeon, requested authorization for cervical spine surgery. OWCP determined that a conflict in medical opinion existed between Dr. Sahota and Dr. Seltzer, OWCP's referral physician, with regard to whether the accepted February 11, 2014 work injury caused a new injury and/or exacerbation of appellant's underlying degenerative disc disease of the cervical spine. Consequently, it referred appellant to Dr. Anderson, a Board-certified orthopedic surgeon, to resolve the conflict.

The Board finds that the special weight of the medical evidence rests with the opinion of Dr. Anderson, the impartial medical specialist, who examined appellant, reviewed the medical evidence, and found that no surgical procedure was recommended for the accepted conditions, which had resolved. In his comprehensive March 30, 2017 report, Dr. Anderson noted his review of the SOAF and medical record and discussed appellant's complaints of left hand numbness with aching pain down the left arm. After a thorough examination, he advised that appellant had no present lumbar condition. Dr. Anderson diagnosed preexisting cervical spondylosis, opining that appellant's present condition was a natural progression of this condition, noting that after full record review he was unable to document any evidence that

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

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

[9] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

[10] 20 C.F.R. § 10.321.

[11] *V.G.*, 59 ECAB 635 (2008).

appellant's left upper extremity complaints were due to the February 11, 2014 work injury which did not cause a disc protrusion at C6-7 or accelerate the natural progression of appellant's preexisting degenerative condition. He concluded that no employment-related condition remained, and a surgical procedure was not indicated for the accepted conditions.

In situations where the case is referred to an impartial medical specialist for the purpose of resolving a medical conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12] The Board finds that Dr. Anderson provided a well-rationalized opinion based on a complete background, his review of the accepted facts, the medical record, and his examination findings. Dr. Anderson's opinion that the requested cervical spine procedure was not medically warranted for the accepted cervical and lumbar sprains is entitled to special weight and represents the weight of the evidence.[13]

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[14] In the instant case, OWCP obtained an impartial medical examination by Dr. Anderson who clearly opined that the requested surgery was not warranted for the accepted conditions. It, therefore, had sufficient evidence upon which it based its decision to deny surgery and did not abuse its discretion.

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 did not abuse its discretion when it denied appellant's request for authorization of cervical spine surgery.

[12] *Id*.

[13] *P.F.*, Docket No. 16-0693 (issued October 24, 2016).

[14] *D.K*, *supra* note 5.

ORDER

IT IS HEREBY ORDERED THAT the April 10, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 4, 2017
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board