

ISSUE

The issue is whether OWCP abused its discretion in denying appellant's request for authorization of lumbar surgery.

FACTUAL HISTORY

On May 21, 1991 appellant, then a 43-year-old oiler, filed a traumatic injury claim (Form CA-1) alleging that on April 22, 1991 he sustained injuries when he slipped and fell on a manhole cover. He stopped work and did not return. OWCP accepted the claim for a lumbosacral strain and herniated L4-5 disc. On February 15, 1996 appellant underwent authorized surgery performed by Dr. Michael Gratch, an orthopedic surgeon. The procedure included spinal fusion L4-5, bilateral discectomy L4-5, bilateral L5 foraminotomies, left autogenous iliac bone graft and insertion of electrical stimulator. Appellant initially received medical and wage-loss compensation on the supplemental rolls. He received compensation on the periodic rolls as of June 16, 2002.

Dr. Randall Smith, an attending physician and Board-certified orthopedic surgeon, indicated in a November 10, 2000 work restriction evaluation (Form OWCP-5) that appellant could work four hours per day with restrictions. He reported that appellant was limited to 20 pounds lifting. OWCP referred appellant for a second opinion examination with Dr. Anthony Salem, a Board-certified orthopedic surgeon. In a report dated July 25, 2001, Dr. Salem provided a history and results on examination. He reported on an OWCP-5 form dated July 26, 2001 that appellant could work eight hours per day with restrictions that included 30 pounds lifting.

OWCP found that a conflict in the medical evidence and referred appellant for an impartial examination with Dr. E. Balasubramanian, a Board-certified orthopedic surgeon. In a report dated March 26, 2002, Dr. Balasubramanian provided a history and results on examination. He opined that appellant could work full time in a light-duty capacity. In a report dated July 21, 2003, Dr. Balasubramanian opined that appellant would be able to perform the duties of an assembler.

By decision dated October 14, 2003, OWCP reduced appellant's wage-loss compensation based on a wage-earning capacity of \$280.00 per week as an assembler.³

The record indicates that on May 2, 2005 appellant, through counsel, again requested reconsideration of the wage-earning capacity decision. Appellant submitted additional medical

³ On September 19, 2002 a vocational rehabilitation specialist completed a job classification form for the selected position of assembler Department of Labor, *Dictionary of Occupational Titles* No. 723.684-010. The specialist indicated the job was light duty, available full time in appellant's area, with wages from \$280.00 to \$320.00 per week. In a letter dated March 3, 2003, OWCP advised appellant that it proposed to reduce his compensation because he had the capacity to earn wages as an assembler. Following the October 14, 2003 reduction of appellant's compensation benefits, he requested a hearing before an OWCP hearing representative. A hearing was held on June 29, 2004. By decision dated October 18, 2004, an OWCP hearing representative affirmed the October 14, 2003 loss of wage-earning capacity determination. She found that OWCP had properly followed its procedures in reducing appellant's compensation based on the wage-earning capacity in the selected position of assembler.

evidence, including an October 11, 2004 report from Dr. Smith, who provided results on examination. Dr. Smith diagnosed low back syndrome, degenerative disc disease, degenerative joint disease, left-sided sciatica, and peridural adhesions. The record reflects that OWCP took no action on this claim.

On June 30, 2011 appellant also filed a claim for a recurrence of disability (Form CA-2a). Appellant asserted the date of recurrence of disability was August 4, 2008, and he wrote that he had remained under medical care since the original injury. He submitted a May 24, 2011 report from Dr. Lily Voepel, a Board-certified physiatrist. Dr. Voepel opined that appellant's back condition had worsened. She wrote that appellant had adjacent segment disease and more degenerative changes of the lower spine, which were partly due to the aging process but also due to the 1996 surgery.

OWCP denied the claim for a recurrence of disability by decision dated March 22, 2012. It found the evidence was insufficient to warrant modification of the October 14, 2003 loss of wage-earning capacity determination.

Appellant, through counsel, requested a hearing before an OWCP hearing representative on April 16, 2012. By decision dated June 14, 2012, the hearing representative set aside the March 22, 2012 decision. She noted that OWCP had never issued a decision with respect to the May 2, 2005 reconsideration request. In addition, the hearing representative found OWCP had not properly considered all the relevant evidence, including the May 24, 2011 report from Dr. Voepel.

Upon further review of the evidence, by decision dated March 20, 2013, OWCP denied modification of the loss of wage-earning capacity determination. It found the special weight of the medical evidence rested with the referee physician, Dr. Balasubramanian.

Appellant submitted a July 30, 2016 report from Dr. Richard Hynes, a Board-certified orthopedic surgeon. Dr. Hynes reported that appellant had been injured at work and had undergone surgery 20 or 25 years earlier. He indicated that appellant reported ongoing back pain. Dr. Hynes provided results on examination, and found sagittal imbalance of lumbar spine, significant mismatch of pelvic incidence and lumbar lordosis with a kyphosed fused L4-5 segment, adjacent level severe stenosis L3-4 above and severe neural foraminal stenosis L5-S1 below with retrolisthesis. As to surgery, he wrote that appellant's back condition was complex, and he needed a posterior column osteotomy with an L4-5 fusion. Dr. Hynes noted that there was no guarantee as to what percentage of improvement would result.

On October 18 2016 OWCP noted that a request for authorization had been received for additional spinal fusion, insertion of a spine fixation device, and application of a spine prosthetic device.

OWCP referred the case to an OWCP medical adviser for an opinion as to whether the proposed surgery was medically necessary to treat the employment-related injuries. In a report dated October 31, 2016, Dr. William Tontz, an OWCP medical adviser, opined that the proposed surgery was not medically necessary. He wrote that a low back fusion should be considered in patients with six months of symptoms, with further indicators such as segmental instability.

Dr. Tontz opined that there is a lack of support for fusion surgery for low back pain with failure to participate effectively in postoperative rehabilitation, total disability over six months, active psychiatric diagnosis, and narcotic dependence. He noted that there was no recent magnetic resonance imaging (MRI) or computerized tomography (CT) scan to warrant fusion.

By letter dated November 3, 2016, OWCP requested that appellant submit additional medical evidence. It forwarded the report of Dr. Tontz and advised him to submit a medical report from Dr. Hynes discussing the need for surgery.

On January 30, 2017 appellant submitted a January 16, 2017 lumbar MRI scan report from Dr. Thomas Foster, a Board-certified radiologist. Dr. Foster reported findings that included congenital canal stenosis with multilevel ligament hypertrophy and facet arthropathy.

Appellant also submitted evidence from physician assistants.

On February 2, 2017 OWCP requested a supplemental report from Dr. Tontz. In a report dated February 14, 2017, Dr. Tontz again opined that the proposed surgery was not medically necessary. He noted the results of the January 16, 2017 MRI scan and indicated that there was no instability. Dr. Tontz reiterated that the proposed surgery was not medically necessary.

By decision dated February 16, 2017, OWCP denied the request for authorization of spinal surgery. It found the medical evidence did not establish the proposed surgery was warranted.

Appellant, through counsel, requested reconsideration of OWCP's February 16, 2017 decision on February 21, 2017, and submitted additional evidence from physician assistants. Counsel contended that, since OWCP had determined that the weight of the medical evidence rested with its medical adviser Dr. Tontz, who had not examined appellant, it should refer appellant to a second opinion medical specialist to resolve the issue of authorization for lumbar surgery.

By decision dated May 11, 2017, OWCP denied modification of its February 16, 2017 decision. It found that "[n]o medical evidence was submitted in conjunction with the request for reconsideration or showing that your lumbar spine is no longer stable as a result of your accepted work[-]related injury." Therefore, surgery was not medically warranted.

LEGAL PRECEDENT

5 U.S.C. § 8103(a) provides for the furnishing of services, appliances and supplies prescribed or recommended by a qualified physician which OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.⁴ In interpreting section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in

⁴ 5 U.S.C. § 8103(a).

the shortest amount of time.⁵ OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on OWCP's authority is that of reasonableness.⁶

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.⁷ Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.⁸ Medical rationale is a medically sound explanation for the opinion offered.⁹ 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.¹⁰

ANALYSIS

Appellant seeks authorization for proposed low back fusion surgery. OWCP accepted that appellant sustained lumbosacral strain and herniated L4-5 disc on April 22, 1991 when he slipped and fell on a manhole cover. The record indicates that appellant underwent an initial lumbar fusion surgery on February 15, 1996.

Attending physician Dr. Hynes opined in his July 30, 2016 report that appellant needed additional lumbar fusion surgery. Dr. Hynes, however, failed to provide a rationalized medical opinion on the issue, failed to provide a complete medical history, and he acknowledged that appellant's back condition was complex. Dr. Hynes wrote that appellant needed fusion surgery but failed to clearly explain how the spinal fusion surgery was medically necessary due to the accepted conditions and failed to provide a detailed medical explanation of the need for surgery.¹¹ Appellant must submit evidence that shows that the requested medical procedure is both due to a condition causally related to an employment injury and that it is medically warranted.¹² Dr. Hynes did not substantiate that the requested procedure was medically warranted. His opinion is therefore of limited probative value.

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

⁶ *Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by OWCP 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).

⁷ *See Debra S. King*, 44 ECAB 203, 209 (1992).

⁸ *Id.*; *see also Bertha L. Arnold*, 38 ECAB 282 (1986).

⁹ *See Ronald D. James, Sr.*, Docket No. 03-1700 (issued August 27, 2003); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (the evidence must convince the adjudicator that the conclusion drawn is rational, sound and logical).

¹⁰ *See Cathy B. Millin*, 51 ECAB 331, 333 (2000).

¹¹ *See C.J.*, Docket No. 16-1693 (issued July 13, 2017).

¹² *See L.C.*, Docket No. 16-1797 (issued March 10, 2017).

Dr. Foster provided findings from a January 16, 2017 MRI scan, but offered no opinion as to whether the request for lumbar surgery should be authorized. A medical opinion which lacks any explanation as to how or why the employment injury contributed to the need for the requested surgery, is of limited probative value.¹³ As such, Dr. Foster's report is of limited probative value.

The only other evidence appellant submitted was from a physician assistant. This evidence is of no probative medical value as a physician assistant is not a physician under 5 U.S.C. § 8101(2).¹⁴

The probative evidence on the issue rests with Dr. Tontz, OWCP's medical adviser. In his October 31, 2016 and February 14, 2017 reports, Dr. Tontz explained that the proposed surgery was not medically necessary. He noted appellant's history and the accepted conditions, and indicated that there was a lack of support for surgery due to the accepted conditions. Moreover, Dr. Tontz noted that results of a January 16, 2017 MRI scan did not show instability, and reiterated in his February 14, 2017 report that the proposed surgery was not medically necessary. His opinion constitutes the weight of the medical evidence.¹⁵

OWCP has discretion with respect to authorization for surgery. Based on the medical evidence of record, the Board finds that it did not abuse its discretion in this case.¹⁶

On appeal counsel argues that OWCP did not follow its procedures and should have referred appellant for a second opinion examination. The record indicates OWCP followed its procedures in this case. When spinal surgery was proposed, the case was routed to OWCP's medical adviser.¹⁷ If the medical adviser's opinion is negative, or there is a need for additional clinical data, the claims examiner may: (1) refer for a second opinion examination; or (2) seek additional information from the attending physician.¹⁸ OWCP attempted to secure an additional report from Dr. Hynes, and received a January 16, 2017 MRI scan. This was sent to OWCP's medical adviser, Dr. Tontz, who reiterated his opinion in the February 14, 2017 report that the proposed surgery was not medically necessary. The Board finds that OWCP properly followed its procedures in this case.

¹³ See *G.G.*, Docket No. 17-0504 (issued August 8, 2017).

¹⁴ *George H. Clark*, 56 ECAB 162 (2004). See also *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a physician as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

¹⁵ *Supra* note 13.

¹⁶ See *L.C.*, Docket No. 16-1797 (issued March 10, 2017).

¹⁷ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.10(d) (October 2010).

¹⁸ *Id.*

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 in denying appellant's request for authorization of lumbar surgery.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 11, 2017 is affirmed.

Issued: November 7, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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