United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
and	)	**Docket No. 17-0185**
	)	**Issued: October 4, 2017**
U.S. POSTAL SERVICE, POST OFFICE, North Metro, GA, 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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On October 29, 2016 appellant filed a timely appeal from a May 4, 2016[1] merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the Federal

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from OWCP's May 4, 2016 decision was October 31, 2016. Since using November 3, 2016, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights regarding the May 4, 2016 decision, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is October 29, 2016, rendering the appeal of the May 4, 2016 decision timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] Together with his appeal request, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated May 5, 2017, the Board exercised its discretion and denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 17-0185 (issued May 5, 2017).

Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUE

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

FACTUAL HISTORY

On September 2, 1986 appellant, then a 29-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on September 2, 1986 he sustained a low back injury due to casing mail and lifting mail trays weighing 45 pounds. OWCP initially accepted appellant's claim for a herniated disc at L4-5. It later indicated that the accepted conditions included displacement of lumbar intervertebral disc without myelopathy, left side.

On December 15, 1986 appellant underwent OWCP-authorized partial hemilaminectomy at L4-5, on the left, with removal of the L4 disc. On December 14, 1988 he underwent OWCP-authorized intralaminar laminotomy at L4-5 and L5-S1, right and left, with discectomy and posterolateral lumbosacral iliac bone graft fusion. Appellant stopped work prior to each surgery and returned to work in a modified-duty position for the employing establishment after each surgery. He first received disability compensation on the periodic roll beginning November 21, 1986.

On July 7, 1992 appellant began working for the employing establishment in a modified letter carrier position. In an August 23, 1993 decision, OWCP adjusted appellant's wage-loss compensation to reflect that the letter carrier position fairly and reasonably represented his wage-earning capacity. Appellant continued to receive wage-loss compensation for partial disability.[5]

On February 17, 1994 appellant underwent OWCP-authorized bilateral laminectomy at L4-5 with excision of herniated nucleus pulposus at L4-5, exploration and repair of pseudoarthrosis at L4-5 and L5-S1, and bilateral fusion of L4 through S1 with segment fixation and local bone graft.

Effective March 15, 1994, appellant was terminated for cause from the employing establishment due to falsification of a physician's statement.

[3] 5 U.S.C. § 8101 *et seq.*

[4] The record provided to the Board includes evidence received after OWCP issued its May 4, 2016 decision. However, the Board is precluded from reviewing evidence that was not part of the record at the time OWCP issued its final decision. 20 C.F.R. § 501.2(c)(1).

[5] Appellant filed a claim for a schedule award (Form CA-7) due to his accepted work injuries. In a September 22, 1994 decision, OWCP granted him a schedule award for 15 percent permanent impairment of his left lower extremity. On June 8, 1995 it granted appellant a schedule award for an additional two percent permanent impairment of his left lower extremity.

In mid-2011, appellant complained to his medical providers of increased pain in his low back which radiated into his legs.[6] On May 21, 2012 he underwent OWCP-authorized surgical removal of previous instrumentation from L4 through S1, redo bilateral laminectomies and foraminotomies of L3 and L4 with bilateral decompression of the L3 and L4 nerve roots, and posterolateral fusion of L3 and L4 with autogenous bone graft, bone morphogenetic protein, and instrumentation from L3 through L5.

The findings of a September 20, 2012 computerized tomography (CT) scan of appellant's lumbar spine showed no hardware complications and contained an impression of interval postsurgical changes with extension of posterior instrumentation to the L3 level with properly incorporating bone graft. A January 14, 2014 magnetic resonance imaging (MRI) scan of appellant's lumbar spine contained an impression of status post L3 through L5 decompressive laminectomies with posterior fusion resulting in near total osseous fusion of the posterior and elements from L3 through S1, and mild-to-moderate foraminal narrowing, most notably at L4 through S1.

On June 13, 2014 appellant underwent surgical placement of a trial spinal cord stimulator into his lumbar spine. The procedure was authorized by OWCP.

Appellant came under the care of Dr. Vincente Galan, an attending Board-certified anesthesiologist, who periodically administered facet joint steroid injections in his sacroiliac joint. The injections were authorized by OWCP. In January 2015, appellant began to complain of increased low back and leg pain to Dr. Galan.

The findings of a February 12, 2015 CT scan of appellant's lumbar spine contained an impression of status post laminectomies from L3-4 through L5-S1 with mature fusion from L3 through L5 and the presence of a spinal stimulator. The surgical levels were well compressed without evidence of residual/recurrent spinal canal or foraminal stenosis, and there was minimal discogenic degenerative disease above the fusion without significant stenosis. A July 20, 2015 report of electromyogram (EMG) testing of appellant's lower extremities contained an impression of no findings of acute or ongoing lumbar/lumbosacral radiculopathy, large-fiber polyneuropathy, plexopathy, or focal mononeuropathy.

Appellant began to receive treatment from Dr. Douglas B. Kasow, a Board-certified orthopedic surgeon and osteopath. On September 1, 2015 Dr. Kasow diagnosed degeneration of lumbar intervertebral disc and indicated that appellant could stand or walk for 30 minutes each hour and lift, push, or pull up to 20 pounds.

In a September 3, 2015 report, Dr. Kasow discussed findings on physical examination and diagnostic testing and characterized the February 12, 2015 CT scan as showing severe facet arthropathy at L2-3 with significant osteophytes, but no significant stenosis. He indicated that x-rays of appellant's lumbar spine taken on an unspecified date showed normal alignment and solid arthrodesis at L3 through S1 with haloing around the L3 screws, that a September 20, 2012 CT scan of his lumbar spine revealed no haloing, and that a March 26, 2013 MRI scan of his lumbar spine showed screws in good position. Dr. Kasow noted that appellant had failed a reasonable

[6] The Board notes that the record does not contain any medical reports dated between June 1995 and May 2011 and the extent to which appellant received medical treatment during this period remains unclear.

course of nonoperative care and diagnosed low back pain, lumbago (ICD-9 Code 724.2), degeneration of lumbar or lumbosacral intervertebral disc (722.52), arthropathy of lumbar facet joint, and unspecified arthropathy of other specified sites (716.98). He recommended that appellant undergo revision posterior fusion surgery at L2-3 with removal of his hardware "since he has a sound arthrodesis [at] L3-S1." Dr. Kasow opined that appellant needed a decompression and stabilization procedure to address the adjacent level disease and severe facet arthropathy at L2-3. He indicated that the main goal of the surgery was to remove the facet joints which could cause iatrogenic instability, a procedure which would require stabilization with possible instrumentation. Dr. Kasow noted that he hoped the surgery would allow appellant to be more functional to the point that he could walk further and stand for longer periods.

On September 4, 2015 Dr. Kasow submitted, on behalf of appellant, a request for authorization of lumbar spine fusion surgery, including removal of posterior segmental instrumentation, morselized allograft, bone marrow aspiration, removal of lumbar spine lamina, microsurgery add-on, and insertion of a spine fixation device. In connection with the surgery request, Dr. Kasow listed the ICD-9 codes for displacement of thoracic or lumbar intervertebral disc without myelopathy (722.1) and lumbago (724.2).

In a September 8, 2015 letter, OWCP advised Dr. Kasow that the requested authorization for surgery could not be approved at that time, but that it would carry out further development with respect to the matter. In a separate September 8, 2015 letter, it advised appellant that the request for authorization of lumbar spine fusion surgery was insufficiently specific and informed him that his physician needed to provide a medical report with current findings which provided medical rationale for the proposed surgery. OWCP provided appellant 30 days to submit the requested evidence, but appellant did not submit additional medical evidence addressing the proposed surgery.

In late-September 2015, OWCP approved appellant's request for authorization of additional low back facet joint injections and Dr. Galan continued to administer such injections.

In an October 23, 2015 decision, OWCP denied appellant's request for authorization of lumbar spine fusion surgery, noting that the request received on September 4, 2015 did not specify the levels and that the diagnosis codes provided were not accepted in his case. It noted that the submitted evidence was insufficient to establish that the surgery was necessary to address effects of appellant's accepted work-related injuries because Dr. Kasow did not specify the levels for the surgery or explain why he requested authorization under the provided diagnoses.

In a November 6, 2015 letter, appellant requested reconsideration of OWCP's October 23, 2015 decision. He argued that the proposed lumbar spine fusion surgery was necessitated by the OWCP-authorized surgery he underwent on May 21, 2012 which included fusion of L3 and L4. Appellant indicated that Dr. Kasow had reported that screws were haloing at the L3 disc level.

Appellant submitted October 23, 2015 and January 19, 2016 reports from Dr. Kasow who discussed findings on physical examination and diagnostic testing, and diagnosed low back pain, unspecified inflammatory spondylopathy of the lumbar region, and unspecified thoracic, thoracolumbar, and lumbosacral intervertebral disc disorder. In both reports, Dr. Kasow

repeated the discussion of the proposed lumbar spine fusion surgery that he provided in his September 3, 2015 report.[7]

Appellant also submitted reports from late-2015 and early-2016 in which Dr. Galan discussed his periodic administering of low back facet joint injections. In December 15, 2015 and February 23, 2016 reports, Dr. David Webb, an attending Board-certified anesthesiologist, diagnosed several conditions including spondylosis of the lumbar region without myelopathy or radiculopathy, chronic pain syndrome, and long-term use of opiate analgesics, and discussed his medical management of appellant's pain symptoms.

In December 2015, OWCP referred appellant's case to Dr. Neil Saldua, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, and asked him to review the evidence of record and answer various questions regarding the necessity of the lumbar spine fusion surgery for which appellant requested authorization.

On December 28, 2015 Dr. Saldua indicated that the proposed lumbar spine fusion surgery at L2-3 was not causally related to the accepted medical conditions at L4-5. He discussed the North American Spine Society criteria for lumbar spine fusion surgery and noted that, because appellant did not meet these criteria, the proposed lumbar spine fusion surgery was not medically necessary.[8] Dr. Saldua opined that an adequate trial of conservative treatment was not attempted, noting that appellant's nonoperative treatment consisted of facet injections and radiofrequency ablations, but that there was no mention in the record of nonsteroidal anti-inflammatory drugs, activity modification, or physical therapy. He indicated that the diagnosed condition did not warrant surgical intervention according to current medical concepts and that the proposed surgical procedure was not within the realm of accepted medical practice.

In late-January 2016, OWCP referred appellant to Dr. Sarveswar I. Naidu, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion regarding whether the proposed lumbar spine fusion surgery was necessitated by an accepted work-related condition. It asked Dr. Naidu to review the relevant medical evidence of record with respect to this matter, including the reports of Dr. Kasow.

In a March 4, 2016 report, Dr. Naidu discussed appellant's factual and medical history and reported the findings of the physical examination. He noted that appellant currently complained of severe low back pain radiating into both hips, worse on the left side, and numbness around the left ankle. Dr. Naidu indicated that his physical examination findings showed that most of appellant's tenderness and spasm was at the lower lumbosacral level and that he had minimal tenderness above the L3 level. He found that appellant did not have any neurological deficit at the L2 or L3 level. Appellant did not exhibit any pain radiation down

[7] Dr. Kasow recommended that appellant undergo revision posterior fusion surgery at L2-3 with removal of his hardware because he had a sound arthrodesis at L3-S1. He posited that appellant needed a decompression and stabilization procedure to address the adjacent level disease and severe facet arthropathy at L2-3. Dr. Kasow indicated that the main goal of the surgery was to remove the facet joints which could cause iatrogenic instability, a procedure which would require stabilization with possible instrumentation. He noted that he hoped the surgery would allow appellant to be more functional to the point that he could walk further and stand for longer periods.

[8] The North American Spine Society criteria, as delineated by Dr. Saldua in his report, require *inter alia* that objective evidence of disc instability be present to justify the performance of lumbar spine fusion surgery.

below the knee, although he had some questionable nonsegmental dysesthesias in the left ankle region. Dr. Naidu noted that appellant exhibited full strength in the quadriceps and hamstring muscles bilaterally, and that reflexes were equal bilaterally. He diagnosed status post laminectomies from L3-4 through L5-S1 and mature fusion from L3 through L5 with well-decompressed surgical levels and no evidence of residual recurrent spinal canal or foraminal stenosis, and minimal discogenic degenerative disease above the fusion without significant stenosis. Dr. Naidu noted that MRI and CT scans of record showed that the internal fixation from the prior surgery was intact. He indicated that he had reviewed Dr. Kasow's reports and advised that he did not agree that another surgery to fuse L2 and L3 and remove the previous hardware was necessary because there was very minimal tenderness or other symptoms at L2-3 and most of appellant's tenderness and spasm, as well as limited range of motion, was in the lower lumbar region. Dr. Naidu indicated that the findings of record showed no neurologic deficit corresponding to the L1, L2, and L3 discs. He noted that appellant's claim was accepted for lumbar intervertebral disc herniation at L4-5 and that the fusion of L2 and L3 was not causally related to the accepted condition at L4-5. Dr. Naidu indicated that that there was no evidence of any spinal canal stenosis or foraminal stenosis at L2-3 as noted in the February 2015 CT scan and advised that the September 2012 CT scan showed solid fusion from L3 through S1 with the L2-3 facet arthropathy. He opined that none of his findings of record showed evidence of any spinal instability/slippage, or spondylolisthesis. Dr. Naidu indicated that there was no evidence of any pseudarthrosis in the lumbar spine region or any failure of the previous procedures. He noted that the proposed lumbar spine fusion surgery was not within the realm of the accepted medical practice under the North American Spine Society criteria for lumbar fusion.

In a May 4, 2016 decision, OWCP denied appellant's request for authorization of additional lumbar spine surgery. It determined that the weight of the medical opinion evidence with respect to this matter rested with the well-rationalized March 4, 2016 report of Dr. Naidu, which showed that the requested surgery was not medically necessary and that it would not provide treatment for the accepted work conditions. OWCP indicated that the reports of Dr. Kasow were of limited probative value with respect to the matter.

LEGAL PRECEDENT

Section 8103(a) of FECA states in pertinent part: "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 the monthly compensation."[9]

The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[10] The only limitation on the OWCP's authority is that of reasonableness.[11] Abuse of discretion is generally shown through proof of manifest

[9] 5 U.S.C. § 8103(a).

[10] *Vicky C. Randall*, 51 ECAB 357 (2000).

[11] *Lecil E. Stevens*, 49 ECAB 673, 675 (1998).

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.[12]

In order to be entitled to reimbursement of medical expenses, it must be shown that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.[13] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[14]

ANALYSIS

OWCP accepted that on September 2, 1986 appellant sustained a herniated disc and displacement of lumbar intervertebral disc without myelopathy at L4-5 (left side) due to casing mail and lifting mail trays weighing 45 pounds. On December 15, 1986, December 14, 1988, and February 17, 1994 appellant underwent OWCP-authorized surgeries at the L4 through S1 disc levels, including fusion surgery. On May 21, 2012 he underwent OWCP-authorized surgical removal of previous instrumentation from L4 through S1, redo bilateral laminectomies and foraminotomies of L3 and L4 with bilateral decompression of the L3 and L4 nerve roots, and posterolateral fusion of L3 and L4 with autogenous bone graft, bone morphogenetic protein, and instrumentation from L3 through L5.[15]

On September 4, 2015 appellant's attending physician, Dr. Kasow, submitted a request for authorization of lumbar spine fusion surgery on behalf of appellant. The surgery was to include removal of posterior segmental instrumentation, morselized allograft, bone marrow aspiration, removal of lumbar spine lamina, microsurgery add-on, and insertion of a spine fixation device. In October 23, 2015 and May 4, 2016 decisions, OWCP denied appellant's request for authorization of the proposed lumbar spine fusion surgery, noting that the medical evidence of record did not show that it was necessitated by the accepted work-related conditions.

The Board finds that OWCP properly denied appellant's request for authorization of additional lumbar spine surgery in that the weight of medical opinion evidence with respect to this matter rests with the well-rationalized opinion of Dr. Naidu, OWCP's referral physician who found that the proposed surgery was unnecessary. OWCP properly exercised its discretion in finding that the evidence of record did not show that the proposed surgery was likely to cure or give relief for appellant's accepted work-related conditions.[16]

[12] *Rosa Lee Jones*, 36 ECAB 679 (1985).

[13] *Bertha L. Arnold*, 38 ECAB 282, 284 (1986).

[14] *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

[15] On June 13, 2014 appellant underwent OWCP-authorized surgical placement of a trial spinal cord stimulator into his lumbar spine.

[16] *See supra* note 10.

In his March 4, 2016 report, Dr. Naidu, after examining appellant and reviewing Dr. Kasow's reports, determined that the proposed lumbar spine fusion surgery at L2-3 was not medically necessary. He provided extensive medical rationale for his opinion by explaining that the objective findings of record did not support the performance of the surgery. Dr. Naidu noted that the findings of record showed no neurologic deficit corresponding to appellant's L1, L2, and L3 discs, and that he exhibited full strength in the quadriceps and hamstring muscles bilaterally. He noted that diagnostic testing of record showed that the internal fixation from the prior surgeries was intact. In particular, Dr. Naidu indicated that there was no evidence of any spinal canal stenosis or foraminal stenosis at L2-3 as noted in the February 2015 CT scan and advised that the September 2012 CT scan showed solid fusion from L3 through S1 with the L2-3 facet arthropathy.[17] He further opined that none of the findings of record showed evidence of any spinal instability/slippage, or spondylolisthesis. Dr. Naidu noted that he had reviewed Dr. Kasow's reports and advised that he did not agree that another surgery to fuse L2 and L3 and remove the previous hardware was necessary because there was very minimal tenderness or other symptoms at L2-3 and most of appellant's tenderness and spasm, as well as limited range of motion, was in the lower lumbar region. Dr. Naidu noted that appellant's claim was accepted for lumbar intervertebral disc herniation at L4-5 and indicated that the proposed fusion of L2 and L3 was not causally related to an accepted work-related condition. The Board has held that the weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[18] The opinion of Dr. Naidu contains such probative value with respect to the matter of the proposed lumbar spinal fusion surgery given the medical rationale he presented in support of his opinion that the surgery was not medically warranted.[19]

On appeal appellant argues that his attending physician, Dr. Kasow, had provided an opinion that the requested lumbar spine surgery was medically necessary to treat his accepted work injuries. In reports dated September 3 and October 23, 2015, and January 19, 2016, Dr. Kasow recommended that appellant undergo revision posterior fusion surgery at L2-3 with removal of his hardware because he had a sound arthrodesis at L3-S1. He opined that appellant needed a decompression and stabilization procedure to address the severe facet arthropathy at L2-3. Dr. Kasow indicated that the main goal of the surgery was to remove the facet joints which could cause iatrogenic instability, a procedure which would require stabilization with possible instrumentation. He noted that he hoped the surgery would allow appellant to be more functional to the point that he could walk further and stand for longer periods.

[17] Dr. Naidu diagnosed status post laminectomies from L3-4 through L5-S1 and mature fusion from L3 through L5 with well-decompressed surgical levels and no evidence for residual recurrent spinal canal or foraminal stenosis, and minimal discogenic degenerative disease above the fusion without significant stenosis.

[18] *See M.D.*, Docket No. 17-0028 (issued March 13, 2017).

[19] The Board notes that Dr. Naidu's opinion is supported by the opinion of Dr. Saldua, an OWCP medical adviser. In a December 28, 2015 report, Dr. Saldua indicated that the proposed lumbar spine fusion surgery at L2-3 was not causally related to the accepted medical conditions at L4-5. He opined that the diagnosed condition did not warrant surgical intervention according to current medical concepts and that the proposed surgical procedure was not within the realm of accepted medical practice.

The Board finds, however, that Dr. Kasow's reports in support of the proposed lumbar spine fusion surgery at L2-3 are of limited probative value because Dr. Kasow did not provide adequate medical rationale in support of his opinion that the proposed surgery was necessary to treat an accepted work-related condition. The Board has held that a medical report is of limited probative value on a given medical matter if it contains a conclusion regarding that matter which is unsupported by medical rationale.[20] Dr. Kasow did not adequately explain why he felt that the fusion surgery at L2-3 was medically necessary. He indicated that appellant had severe facet arthropathy at L2-3, but he did not adequately discuss the objective medical evidence of record and explain why appellant's condition at L2-3 was serious enough to require fusion surgery. Importantly, he failed to provide any discussion of why surgery at L2-3 would be related to a work condition given that the accepted work conditions, herniated disc and displacement of lumbar intervertebral disc without myelopathy at L4-5, are at a different spinal level. As noted above, in order to be entitled to reimbursement of medical expenses, it must be shown that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.[21]

On appeal appellant further contends that, even though OWCP did not accept a work-related condition at any level other than L4-5, the proposed lumbar spinal fusion surgery at L2-3 should have been authorized because the surgery was necessary to address the effects of his OWCP-authorized May 21, 2012 surgery which involved the L3 level, *i.e.*, redo bilateral laminectomies and foraminotomies of L3 and L4 with bilateral decompression of the L3 and L4 nerve roots, and posterolateral fusion of L3 and L4 with autogenous bone graft, bone morphogenetic protein, and instrumentation from L3 through L5.[22] The Board has held that authorization by OWCP for medical examination and/or treatment constitutes a contractual agreement to pay for the services if the services are rendered, regardless of whether a compensable injury/condition exists, and that any medical condition resulting from authorized examination or treatment (such as residuals from surgery) may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury.[23] However, Dr. Kasow's reports are of limited probative value with respect to this matter because he did not provide a clear opinion that the proposed spinal fusion surgery at L2-3 was necessary to address the effects of appellant's May 21, 2012 surgery or any other OWCP-authorized surgery. The Board has held that medical evidence which does not offer a clear opinion on a given medical matter is of limited probative value with respect to that matter.[24] Appellant has argued that the need for the proposed lumbar spine fusion surgery was supported by Dr. Kasow's mentioning of haloing around the L3 screws as seen on x-rays of his lumbar spine taken on an unspecified date. The Board notes, however, that Dr. Kasow did not identify the specific diagnostic test to which he referred or provide any comment on the significance, if any, of this

[20] *C.M.*, Docket No. 14-88 (issued April 18, 2014).

[21] *See supra* note 13.

[22] The procedure also included surgical removal of previous instrumentation from L4 through S1.

[23] *See G.C.*, Docket No. 15-0370 (issued December 2, 2015); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Authorizing Examination and Treatment*, Chapter 3.300.2b (February 2012).

[24] *See Charles H. Tomaszewski*, 39 ECAB 461 (1988).

ostensible finding. Moreover, as noted by Dr. Naidu, the diagnostic testing of record showed that the screws and other internal fixation devices from appellant's prior OWCP-authorized surgeries were intact. For these reasons, the reports of Dr. Kasow are of diminished probative value on the matter of the proposed lumbar spine fusion surgery and are insufficient to overcome the weight of Dr. Naidu's opinion or to create a conflict in the medical opinion evidence.[25]

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.[26]

CONCLUSION

The Board finds that OWCP did not abuse its discretion in denying appellant's request for authorization of additional lumbar spine surgery.

[25] *See S.P.*, Docket No. 16-1349 (issued May 10, 2017).

[26] On appeal appellant argues that OWCP did not pay him monies due from 1994 and 1995 schedule awards for permanent impairment of his left lower extremity and that it improperly adjusted his compensation in 2013 for failure to participate in vocational rehabilitation efforts. However, the record does not contain final decisions of OWCP regarding these matters that are within the jurisdiction of the Board. *See* 20 C.F.R. §§ 501.2(c), 501.3.

ORDER

IT IS HEREBY ORDERED THAT the May 4, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 4, 2017
Washington, DC

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

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

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