

FACTUAL HISTORY

On October 8, 2014 appellant, then a 62-year-old mail handler technician, filed an occupational disease claim (Form CA-2) alleging that repetitive job duties at work for over 30 years caused multiple disorders. OWCP accepted other affections of the shoulder region, not elsewhere classified, right, and brachial neuritis or radiculitis not otherwise specified, right.

An April 8, 2014 magnetic resonance imaging (MRI) scan of the cervical spine demonstrated disc protrusions at C3-4, C4-5, C5-6, and C6-7, moderate foraminal stenosis at C5-6, and degenerative facet joint hypertrophy at C3-4, C4-5, and C5-6. An April 1, 2015 cervical spine MRI scan showed no significant change from the April 8, 2014 study.

In reports dated April 2, 2015, Dr. Jeffrey Fritz, a Board-certified anesthesiologist, noted appellant's 18-month history of shoulder and neck pain. He reviewed cervical and right shoulder MRI scans and found decreased neck and right shoulder range of motion on physical examination. Dr. Fritz noted the accepted conditions, advised that appellant had a worsening neck injury, and provided physical restrictions.

On April 7, 2015 Dr. John C. Milani, a Board-certified orthopedic surgeon, noted that appellant had worked at the employing establishment since 1983. He described complaints of neck pain and reviewed the April 1, 2015 cervical spine MRI scan. Following physical examination, Dr. Milani diagnosed cervical radiculopathy. He recommended anterior decompression at C4-5 and C5-6.

On April 13, 2015 Dr. Jack E. Zigler, Board-certified in orthopedic surgery, noted appellant's complaint of radiating neck pain. On examination he found abnormal pinprick and light touch at C6 and C7 dermatomes. Dr. Zigler noted that appellant's MRI scan demonstrated multilevel spondylosis with disc and lesions causing central foraminal compression at C5-6 and C6-7. He recommended an anterior cervical discectomy and fusion (ACDF) procedure at C5-6, and an arthroplasty at C6-7. Dr. Zigler requested authorization for the recommended procedure.

OWCP paid appellant wage-loss compensation for the period April 6 through 29, 2015 because the employing establishment had no work available within his restrictions.

OWCP requested that its medical adviser review the request for surgery authorization. In a May 14, 2015 report, Dr. Michael M. Katz, a Board-certified orthopedist and OWCP medical adviser, reviewed the medical record including MRI scans. He noted the different recommendations by Dr. Milani and Dr. Zigler and recommended that appellant undergo a second opinion evaluation by a neurosurgeon with expertise in surgery of the spine.

Dr. Fritz saw appellant in follow-up on May 13, 2015. He recommended electrodiagnostic testing, consisting of an electromyogram (EMG) and nerve conduction velocity (NCV) study.

OWCP referred appellant to Dr. Marvin E. Van Hal, a Board-certified orthopedic surgeon, for a second opinion evaluation.

In a May 27, 2015 report, Dr. Alan Scott Hamilton, a Board-certified physiatrist, described appellant's employment history and job duties and his complaint of neck pain. He noted the accepted conditions and described physical examination findings. Dr. Hamilton performed an EMG/NCV study which demonstrated evidence of mild-to-moderate right-sided sensorimotor ulnar neuropathy at the elbow. He noted that the study did not demonstrate overt findings of radiculopathy, although appellant presented multiple signs and symptoms clinically that were consistent with cervical radiculopathy, as demonstrated on his MRI scans.

Cervical spine x-rays on August 6, 2015 demonstrated degenerative changes at C5-6 with degenerative facet joint hypertrophy at C3-4, C4-5, and C5-6. A right shoulder x-ray that day was normal.

A functional capacity evaluation (FCE) on August 10, 2015, ordered by Dr. Van Hal, demonstrated symptoms that involved the neck region radiating into the right upper extremity with a decrease in range of motion of the neck and right upper extremity. Lifting more than five pounds caused neck and shoulder pain.

By report dated August 11, 2015, Dr. Van Hal noted that he examined appellant on August 6, 2015. He described a 32-year employment history and appellant's complaint of neck discomfort with repetitive use. Dr. Van Hal noted his review of the statement of accepted facts and medical record. Examination revealed a positive right shoulder impingement sign, painful neck range of motion, positive Tinel's and Phalen's signs on the right, and dysesthesia at C5. Dr. Van Hal reviewed the August 6, 2015 x-rays and April 8, 2014 cervical MRI scan. He diagnosed cervical sprain/strain and right shoulder strain with repetitive use type activity, and multilevel degenerative disc disorder of the cervical spine that was unrelated to work activity. Dr. Van Hal advised that he did not concur with the surgery recommendations of Dr. Milani and Dr. Zigler, and did not agree that any surgery was warranted as there was no correlation between the proposed surgery and appellant's symptoms. In an addendum dated August 19, 2015, Dr. Van Hal noted his review of the August 10, 2015 FCE.

In a report dated August 12, 2015, Dr. Venkat Sethuraman, a Board-certified orthopedic surgeon, noted appellant's complaint of radiating neck pain. Following his review of the April 1, 2015 cervical spine MRI scan and physical examination, the physician diagnosed cervical spondylosis with myelopathy and radiculopathy, spondylopathy, traumatic, and cervical herniated nucleus pulposus. Dr. Sethuraman recommended an ACDF procedure from C5 to C7. Surgical authorization was requested.

On August 24, 2015 OWCP referred appellant to Dr. Sofia M. Weigel, a Board-certified physiatrist.³ Dr. Weigel performed an EMG/NCV study on September 14, 2015. She advised that there was no evidence of diffuse or entrapment peripheral neuropathy, carpal tunnel syndrome, ulnar neuropathy, or radiculopathy on the examination. On September 29, 2015

³ In a September 25, 2015 decision OWCP denied appellant's claim for compensation for the period July 29 to 31, 2015 because he submitted no evidence to support this claim. Appellant had submitted a Form CA-7, claim for compensation, on August 7, 2015. On August 18, 2015 OWCP informed him of the evidence needed to establish disability. In a November 5, 2015 decision, OWCP denied appellant's August 24, 2015 claim for compensation for the period August 10 to 12, 2015. Appellant appealed these decisions to the Board.

Dr. Van Hal noted reviewing Dr. Weigel's report. Dr. Van Hal opined that, based on the EMG/NCV study, he was unable to support that appellant had a radiculopathy that would warrant any operative intervention.

In a September 30, 2015 treatment note, Dr. Sethuraman reiterated his recommendation that appellant have cervical spine surgery. He requested authorization.

Dr. Fritz saw appellant in follow-up on October 7, 2015 and January 27, 2016. He noted that Dr. Milani, Dr. Zigler, and Dr. Sethuraman all recommended surgery, and urged that it be authorized. On the January 27, 2016 report Dr. Fritz indicated that appellant's injuries were affecting his activities of daily living, noting that if he sat for an extended period, his head got heavy.

OWCP determined that a conflict in medical evidence had been created between the opinions of appellant's attending surgeons and Dr. Van Hal regarding the need for surgery. On April 1, 2016 it referred appellant to Dr. Dale R. Allen, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

In an April 29, 2016 report, Dr. Allen noted a history that on October 1, 2013 appellant had a neck spasm while at work and had neck problems which he attributed to constantly lifting and pulling over his shoulder for many years. He related that appellant was presently working full-time, modified duty. Dr. Allen described his review of the medical record, including MRI scans and EMG studies. Physical examination demonstrated neck pain with range of motion, no radicular pain, and some numbness in the C5 area from the back of the thumb into the forearm on the radial side. Sensory function was otherwise intact, and motor function was 5/5. Dr. Allen diagnosed preexisting chronic multilevel facet hypertrophy and degenerative disc disease of the cervical spine from C3-4 to C6-7. He indicated that he agreed with appellant's attending physician's assessment of cervical radiculopathy as it was objectively documented on his examination. Dr. Allen noted that, as appellant had been able to retain full-time modified employment, he did not think appellant was a candidate for cervical surgery because he was stable. He recommended follow-up with Dr. Fritz for pain management. Dr. Allen also concluded that the recommended surgery was not employment related as it was for appellant's preexisting degenerative disc disease of the cervical spine.

By decision dated November 16, 2016, OWCP denied authorization for the proposed ACDF at C5-6 with arthroplasty at C6-7. It noted that Dr. Allen, the impartial medical specialist, had indicated that the requested surgery was for a preexisting condition that was not employment related.

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.⁴

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

While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.⁵

In interpreting section 8193 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.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. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.⁷ To be entitled to reimbursement of medical expenses, a claimant has the burden of establishing 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 medical evidence.⁸ 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.⁹

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.¹⁰ The implementing regulation provides 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.¹¹ 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.¹²

⁵ *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

⁶ *See D.K.*, 59 ECAB 141 (2007).

⁷ *Minnie B. Lewis*, 53 ECAB 606 (2002).

⁸ *M.B.*, 58 ECAB 588 (2007).

⁹ *R.C.*, 58 ECAB 238 (2006).

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

¹¹ 20 C.F.R. § 10.321.

¹² *V.G.*, 59 ECAB 635 (2008).

ANALYSIS

The Board finds that OWCP did not abuse its discretion by denying authorization for cervical spine surgery. OWCP accepted appellant's occupational disease claim for other affections of the shoulder region, not elsewhere classified, right, and brachial neuritis or radiculitis not otherwise specified, right. On April 7, 2015 Dr. Milani recommended surgical anterior decompression at C4-5 and C5-6. On April 13, 2015 Dr. Zigler recommended an ACDF procedure at C5-6 and an arthroplasty at C6-7. Dr. Van Hal, an OWCP referral physician, opined that appellant's multilevel degenerative disc disease was not related to work activity. He advised that the recommended surgery was not warranted, based on appellant's symptoms and a negative EMG study. Consequently, OWCP referred appellant to Dr. Allen, to resolve the conflict.

The Board finds that the weight of the medical evidence rests with the opinion of Dr. Allen, the impartial medical specialist, who examined appellant, reviewed the medical evidence, and found that the surgical procedure was not recommended for the accepted conditions, but for preexisting degenerative disc disease of the cervical spine. In his comprehensive report dated April 29, 2016, Dr. Allen noted his review of the SOAF and medical record and appellant's complaints of radiating neck pain. Dr. Allen diagnosed chronic multi-level facet hypertrophy and preexisting degenerative disc disease of cervical spine from C3-4 to C6-7. He indicated that he agreed with appellant's attending physician's assessment of cervical radiculopathy as it was objectively documented on his examination. Dr. Allen advised that, since appellant had been able to retain full-time modified employment and was stable, he was not a candidate for surgery, further noting that it was recommended for preexisting cervical degenerative disc disease that was not employment related. He recommended follow-up with Dr. Fritz for pain management.

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.¹³ The Board finds that Dr. Allen provided a well-rationalized opinion based on a complete background, his review of the SOAF, the medical record, and his examination findings. Dr. Allen's opinion that the requested cervical spine procedure was not medically warranted for the accepted condition is entitled to special weight and represents the weight of the evidence.¹⁴

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.¹⁵ In the instant case, appellant requested surgery. OWCP obtained an impartial medical examination by Dr. Allen who clearly opined that the requested surgery was not warranted for the accepted conditions. OWCP, therefore, had sufficient evidence upon which it made its decision to deny surgery and did not abuse its discretion.

¹³ *Patricia J. Glenn*, 53 ECAB 159 (2001).

¹⁴ *P.F.*, Docket No. 16-0693 (issued October 24, 2016).

¹⁵ *Supra* note 6.

CONCLUSION

The Board finds that OWCP did not abuse its discretion when it denied appellant authorization for cervical spine surgery.

ORDER

IT IS HEREBY ORDERED THAT the November 16, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 5, 2018
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