United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 19-1009**
	)	**Issued: October 22, 2019**
DEPARTMENT OF THE NAVY, NAVY INSTALLATIONS COMMAND, Portsmouth, VA, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 8, 2019 appellant filed a timely appeal from a March 13, 2019 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.

ISSUE

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

FACTUAL HISTORY

On June 28, 2017 appellant, then a 64-year-old substance abuse counselor, filed a traumatic injury claim (Form CA-1) alleging that he strained his lower back on June 9, 2017 when he reached for objects that were falling off a dolly while in the performance of duty. He reported that he was moving items to his new office. On the reverse side of the claim form, the employing

[1] 5 U.S.C. § 8101 *et seq*.

establishment indicated that the alleged injury occurred in the performance of duty and that appellant had not stopped work.

By decision dated August 2, 2017, OWCP accepted appellant's claim for right-side sciatica.

On July 27, 2017 appellant underwent a lumbar spine magnetic resonance imaging (MRI) scan, interpreted by Dr. Hiten B. Patel, a Board-certified psychiatrist. Dr. Patel noted degenerative disc disease, severe central canal stenosis at L3-4 and L4-5, moderate central canal stenosis at L2-3, mild central canal stenosis at L1-2 and L5-S1, multilevel foraminal stenosis most prominent at L4-5, and grade 1 anterolisthesis at L4-5.

In an August 8, 2017 examination note, Dr. Felix Kirven, a Board-certified orthopedic surgeon, reviewed appellant's history and recounted his complaints of lumbar pain. Sensory examination revealed decreased sensation of L5 dermatomes bilaterally in the lower extremities. Upon examination of appellant's lower lumbar spine, Dr. Kirven observed forward bending of 50 degrees, extension to neutral, and side-bending of 20 degrees. Phalen's spinal test was positive. Dr. Kirven diagnosed right-side sciatica, herniated disc at L4-5 with stenosis at L4-5, and grade 1 spondylolisthesis at L4-5. He recommended a posterior lumbar laminectomy at L4-5, transforaminal interbody fusion at L4-5, posterior bone grafting L4-5, and bilateral lateral instrumented fusion L4-5.

On August 10, 2017 OWCP received Dr. Kirven's request seeking authorization for lumbar spine fusion surgery.

In an October 7, 2017 report, Dr. Nizar Souayah, a Board-certified psychiatrist and neurologist serving as an OWCP district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and noted that appellant's claim was accepted for right side sciatica. He discussed the medical treatment that appellant had received and opined that the requested lumbar spine fusion surgery was not medically necessary to treat appellant's accepted lumbar injury. The DMA explained that the medical evidence of record failed to establish that appellant had failed all conservative therapies, including epidural injections, acupuncture, chiropractic treatment, or other structured pain management strategy.

By decision dated November 2, 2017, OWCP denied authorization for lumbar spine fusion surgery finding that the weight of the medical evidence rested with the October 7, 2017 report of the DMA.

On June 7, 2018 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. He indicated that he was providing medical documentation which showed the medical treatment, including epidural steroid shots and physical therapy, that he had received.

Appellant submitted additional reports dated August 8, 2017 to May 1, 2018 from Dr. Kirven who noted his treatment of appellant for his lumbar conditions.

In a May 2, 2018 letter, Dr. Kirven recounted that appellant continued to experience lower back pain with bilateral leg numbness and tingling. He reported that appellant had failed conservative therapy, including three epidural injections, trigger point injections, physical therapy,

and non-steroid, anti-inflammatory medication. Dr. Kirven requested approval for a lumbar decompressive laminectomy at L4-5 with an instrumented posterior fusion at L4-5 and disc excision at L4-5 with posterior bone grafting at L4-5 with an interbody fusion at L4-5.

By decision dated June 28, 2018, an OWCP hearing representative denied appellant's request for a review of the written record finding that his request had not been made within 30 days of the November 2, 2017 decision.

Appellant subsequently requested reconsideration of the November 2, 2017 decision on July 9, 2018.

On July 19, 2018 OWCP referred appellant, along with the SOAF and a copy of the record, to Dr. James Schwartz, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine if the conditions of lumbar intervertebral disc disorder with radiculopathy, lumbar spondylolisthesis, and lumbar spinal stenosis were causally related to the July 9, 2017 employment injury and if the proposed lumbar decompressive laminectomy at L4/5 with fusion surgery was appropriate and medically necessary for the accepted lumbar injury.

In an August 18, 2018 second opinion report, Dr. Schwartz reviewed appellant's history, including the SOAF, and noted that the claim was accepted for right-side sciatica. He recounted appellant's complaints of burning pain in the back of his right leg down to the back of the knee. Upon examination of appellant's lumbar spine, Dr. Schwartz observed essentially no lumbar extension, right and left lateral bending to 5 degrees, and rotation to 5 to 10 degrees with pain. Straight leg raise testing on the right at 45 degrees with burning down his right leg and on the left to 60 degrees with pain. Dr. Schwartz diagnosed right-side sciatica and permanent aggravation of lumbar spinal stenosis with claudication as causally related to the June 9, 2017 employment injury and lumbar spinal stenosis with claudication L4-5, not related to the June 9, 2017 employment injury. He reported that appellant needed an L4-5 lumbar decompression, but he was unclear, given appellant's age and activity level, whether lumbar fusion surgery was necessary. Dr. Schwartz explained that a lumbar decompression surgery may produce significant lumbar instability, but there was no evidence of lumbar instability at the present time. He concluded that lumbar decompression surgery was an accepted medical practice to treat appellant's lumbar injury, but he explained that fusion surgery was not yet necessary unless instability was caused by the decompression surgery.

In a September 8, 2018 letter, Dr. Kirven noted his disagreement with Dr. Schwartz's opinion that lumbar fusion surgery was not required to treat appellant's accepted lumbar injury. He indicated that appellant's severe central canal stenosis would require a wide laminectomy. Dr. Kirven explained that, without an instrumented posterior spinal fusion, appellant's spine would be unstable, considering the amount of decompression that was needed. He reported that, although his proposed surgery was more extensive than a simple decompressive surgery, the surgery would benefit appellant.

OWCP determined that there was a conflict in medical opinion between the treating physician, Dr. Kirven, and OWCP's second opinion physician, Dr. Schwartz, regarding whether the conditions of lumbar intervertebral disc disorder with radiculopathy, lumbar spondylolisthesis, and lumbar spinal stenosis were causally related to the June 9, 2017 employment injury and whether the proposed lumbar decompressive laminectomy at L4-5 with fusion was appropriate and necessary for the accepted employment injury. It referred appellant to Dr. Mohammad H.

Zamani, a Board-certified orthopedic surgeon, for an impartial medical examination in order to resolve the conflict in medical opinion.

In a November 20, 2018 report, Dr. Zamani described the June 9, 2017 employment injury and reviewed appellant's medical records. He noted that diagnostic testing did not support a diagnosis of herniated disc at L4-5. Upon examination of appellant's lumbar spine, Dr. Zamani observed pain on palpation of the lower lumbar area. Straight leg raise testing in the sitting position revealed some tightness of the hamstring without pain. Dr. Zamani indicated that appellant no longer suffered from radiculopathy due to his June 9, 2017 employment injury and, therefore, the requested surgery was not required. He further reported that appellant suffered from an exacerbation of a preexisting spinal stenosis condition, which existed by natural history and that there would come a time that required some surgery.

By decision dated January 11, 2019, OWCP denied modification of the November 2, 2017 decision. It found that the special weight of the medical evidence rested with the November 20, 2018 decision of Dr. Zamani, the impartial medical examiner.

On February 13, 2019 appellant requested reconsideration.

In a January 22, 2019 letter, Dr. Kirven recounted that appellant continued to have symptomatic back and left lower extremity weakness due to his June 9, 2017 employment injury. He noted his disagreement with Dr. Zamani's opinion regarding causation and appellant's treatment. Dr. Kirven reported that as Dr. Schwartz, OWCP's second-opinion examiner, had agreed that appellant was in need for a simple decompression lumbar surgery, OWCP should authorize a simple decompression surgery.

By decision dated March 13, 2019, OWCP denied modification of the January 11, 2019 decision. It found that the special weight of the medical evidence rested with the November 20, 2018 decision of Dr. Zamani, the impartial medical examiner, who opined that the requested lumbar decompressive laminectomy and with fusion surgery was not appropriate and necessary to treat appellant's accepted June 9, 2017 employment injury.

LEGAL PRECEDENT

Section 8103(a) of FECA[2] 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 by 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.[3] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in determining whether a particular type of treatment is likely to cure or give relief.[4] The only limitation on OWCP's authority is that of reasonableness.[5]

[2] *Id*.

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

[4] *R.C.*, Docket No. 18-0612 (issued October 19, 2018); *W.T.*, Docket No. 08-812 (issued April 3, 2009).

[5] *D.C.*, Docket No. 18-0080 (issued May 22, 2018); *Mira R. Adams*, 48 ECAB 504 (1997).

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.[7] Proof of causal relationship 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 procedure was for a condition related to the employment injury and that the surgery was medically warranted.[9] Both of these criteria must be met in order for OWCP to authorize payment.[10]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[11] 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.[12] For a conflict to arise, the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[13] When 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.[14]

ANALYSIS

The Board finds that this case is not in posture for decision.

The Board finds that OWCP improperly determined that a conflict in medical opinion evidence existed between Dr. Kirven, appellant's treating physician, and Dr. Schwartz, OWCP's

[6] *E.L.*, Docket No. 17-1445 (issued December 18, 2018); *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990).

[7] *J.T.*, Docket No. 18-0503 (issued October 16, 2018); *Debra S. King*, 44 ECAB 203, 209 (1992).

[8] *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[9] *J.R.*, Docket No. 18-0603 (issued November 13, 2018); *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

[10] *J.L.*, Docket No. 18-0990 (issued March 5, 2019); *R.C.*, 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[11] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[12] 20 C.F.R. § 10.321.

[13] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[14] *Id.*; *Gloria J. Godfrey*, 52 ECAB 486 (2001).

second-opinion examiner, regarding whether the proposed lumbar decompressive and fusion surgery were medically necessary to treat appellant's accepted lumbar injury. In an August 8, 2017 and May 2, 2018 letter, Dr. Kirven recommended a posterior lumbar laminectomy at L4-5 and bilateral lateral instrumented fusion at L4-5. He explained that appellant had failed conservative treatment and still experienced lower back pain. In an August 18, 2018 report, Dr. Schwartz determined that lumbar decompressive surgery was an appropriate course of treatment for appellant's accepted lumbar injury, but he was not sure if fusion surgery was necessary unless instability was caused by the decompression surgery. He also noted that appellant would need an evaluation of his hips in order to determine if lumbar decompression surgery may produce significant lumbar instability.

The Board finds that Dr. Schwartz's August 18 2018 report lacked sufficient medical rationale and is not of equal weight to Dr. Kirven's reports as OWCP had determined. In determining the probative value of medical evidence, the Board considers such factors as the opportunity for and thoroughness of examination performed by the physician, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[15] In this case, Dr. Schwartz agreed that appellant needed lumbar decompressive surgery. He disagreed on whether lumbar fusion surgery was necessary.

The Board finds that Dr. Schwartz did not provide a conflicting opinion on whether lumbar decompressive surgery was medically necessary and appropriate to treat appellant's accepted lumbar injury. The Board also notes that Dr. Schwartz did not provide an unequivocal opinion that the proposed lumbar fusion surgery was not medically necessary. Dr. Schwartz noted that it was unclear from the record if lumbar fusion surgery was necessary and indicated that additional evaluation was needed. Medical opinions that are speculative or equivocal in character are of diminished probative value.[16] The Board finds, therefore, that this report is of diminished probative value and is insufficient to create a conflict in medical opinion with Dr. Kirven.[17] As there was no conflict in medical evidence between Dr. Kirven and Dr. Schwartz pursuant to 5 U.S.C. § 8128(a), the referral to Dr. Zamani was for a second opinion examination.[18]

In a November 20, 2018 report, Dr. Zamani reviewed the medical evidence of record and provided examination findings related to appellant's lumbar spine. He determined that appellant's lumbar radiculopathy had resolved and, therefore, the proposed lumbar decompressive and fusion surgery was not medically necessary to treat appellant's accepted lumbar injury. The Board finds

[15] *C.D.*, Docket No. 17-1623 (issued February 20, 2018); *James T. Johnson*, 39 ECAB 1252, 1256 (1988).

[16] *D.B.*, Docket No. 18-1359 (issued May 14, 2019); *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty).

[17] *See supra* note 11.

[18] *See S.M.*, Docket No. 19-0397 (issued August 7, 2019) (the Board found that at the time of the referral for an impartial medical examination there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination); *see also Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996) (the Board found that, as there was no conflict in medical opinion evidence, the report of the physician designated as the impartial medical examiner was not afforded the special weight of the evidence, but instead considered for its own intrinsic value as he was a second opinion specialist).

that there is now a conflict in medical evidence between Dr. Kirven and Dr. Zamani regarding whether the proposed lumbar decompressive and fusion surgery was medically necessary and appropriate to treat his accepted June 9, 2017 employment injury.

Because there is an unresolved conflict in medical opinion regarding whether the requested lumbar decompressive and fusion surgery was medically necessary to treat appellant's accepted June 9, 2017 employment injury, the case shall be remanded to OWCP for referral to an impartial medical examiner pursuant to section 8123(a) of FECA.[19] After this and such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the March 13, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: October 22, 2019
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[19] *Supra* notes 11 and 13.