United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 19-1698**
	)	**Issued: June 18, 2020**
U.S. POSTAL SERVICE, PHILADELPHIA LOGISTICS & DISTRIBUTION CENTER, Swedesboro, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 8, 2019 appellant, through counsel, filed a timely appeal from a March 14, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the March 14, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

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

FACTUAL HISTORY

On August 1, 2002 appellant, then a 46-year-old clerk, filed an occupational disease claim (Form CA-2) alleging that she developed a low back condition due to factors of her federal employment including lifting tubs at work. On February 14, 2003 OWCP accepted her claim for herniated disc at L5-S1 with sciatica and lumbosacral sprain/strain.

On February 15, 2003 appellant underwent an OWCP-authorized posterior laminectomy, lateral recess decompression, and excision of a herniated disc at L5-S1.

On June 29, 2004 appellant underwent an OWCP-authorized anterior lumbar antibody fusion with posterior second pedicle screws and midline left L5-S1 nerve root decompression.

On February 6, 2007 appellant underwent OWCP-authorized removal of spinal instrumentation, laminectomy, and left hemi-laminectomy with decompression of the left L5 and S1 nerve roots.

On December 13, 2013 appellant underwent OWCP-authorized total laminectomies of L3 and L4 and medial facetectomy and foraminotomies with a lumbar interbody cage.

An electromyography and nerve conduction velocity (EMG/NCV) testing dated January 11, 2016 demonstrated an abnormal study, left greater than right chronic polyradiculopathy with no acute features, and no evidence to suggest peripheral polyneuropathy of the bilateral lower extremities.

A magnetic resonance imaging (MRI) scan of appellant's lumbar spine dated February 10, 2016 demonstrated lumbosacral transitional vertebrae with lumbarization of S1 resulting in six lumbar vertebrae and an immobile disc at L6-S1, satisfactory postsurgical changes of posterolateral spinal fusion from L3-4 with hardware in good position with no loosening, satisfactory intervertebral fusion at L3-4 and L5-6 with no sign of nonunion and postsurgical changes of laminectomy from L3-5, minimal posterior placement of L2 on L3 related to facet arthrosis, and disc protrusion and osteophyte at L4-5 surrounded by contracted and enhancing granulation tissue indenting on the dural sac and mildly narrowing the bilateral intervertebral foramina, with clinical correlation recommended.

In a report dated February 18, 2016, Dr. P. Tymour Boulos, a Board-certified neurosurgeon, indicated that appellant was status post L4 fusion with a previous L5-S1 fusion. He noted that she had significant progression of pathology at this intervening segment. Dr. Boulos recommended a "re-do" decompression and subsequent stabilization of the rods.

On October 24, 2016 appellant requested authorization for lumbar decompression of the spinal cord, lumbar spine fusion, insertion of a spinal fixation device, and application of a spinal prosthetic device. With her request, she attached an October 14, 2016 report from Dr. Boulos. In this report, Dr. Boulos noted appellant's previous surgical procedures and indicated that she had

developed worsening problems at the L4-5 segment. He recommended a final procedure of L4-5 decompression and stabilization with transforaminal lumbar interbody fusion and pedicular screw instrumentation connecting the constructs to the pelvis.

On November 2, 2016 OWCP forwarded appellant's medical record and a statement of accepted facts (SOAF) to a district medical adviser, Dr. Todd Fellars, a Board-certified orthopedic surgeon, in order to determine whether appellant's requested lumbar surgery was medically necessary.

In a report dated November 22, 2016, Dr. Fellars indicated that he could not agree or disagree with appellant's treating provider's recommendation for additional lumbar surgery. He explained that the only recent clinical note he was given to review did not contain appellant's physical examination findings. Dr. Fellars noted that while appellant's treating physician reported she had pain and weakness in her legs and her EMG demonstrated chronic L4 to S1 radiculopathy, her MRI scan from February 2016 showed no surgical indication, and there was no correlation with the L4-5 level documented. He noted that appellant's EMG showed chronic radiculopathy despite no evidence of nerve root impingement at L4-5, L5-6, and L6-S1.[4] Dr. Fellars explained that she needed to have verified imaging findings that correlated with physical examination, as nonverifiable radicular complaints did not improve with surgery. He concluded that as the requested surgery would not treat documented symptoms, but rather only imaging findings, he could not recommend the surgery as medically necessary.

On March 22, 2017 OWCP referred appellant, along with the medical record and a SOAF, to Dr. Stanley Askin, a Board-certified orthopedic surgeon, for a second opinion evaluation.

In a report dated April 10, 2017, Dr. Askin reviewed the medical record and SOAF. He noted that appellant had undergone three surgical procedures at the L5-S1 level, as well as an additional surgical procedure in 2007 to remove hardware that had been implanted. Appellant perceived that particular disc levels had been responsible for particular groupings of symptoms, but injection treatments and surgical procedures had failed to provide any symptomatic benefit. Dr. Askin noted that having completely failed to be symptomatically managed by any of the surgical treatments to date, appellant was absolutely convinced that she needed another surgical procedure to be performed by the same surgeon who failed to address her complaints in her most recent surgery. He documented appellant's physical examination findings and reported the diagnosis found on examination was age-appropriate degenerative disc disease, now status post multiple surgical procedures. Dr. Askin noted that while there was no reason to doubt that appellant had back pain associated with her degenerative disc disease, the original diagnosis of mechanical back pain had been distorted by the manner in which she interacted with health care providers, and it was difficult to explain how her employment injury would have resulted in so many surgical procedures. He found that the only disabling residuals of appellant's accepted conditions were those imposed by inappropriate surgical procedures. Dr. Askin opined that it would be highly inappropriate for appellant to undergo further surgical treatment. He concluded that the proposed surgical procedure was not medically necessary and there was about zero likelihood that she would be improved by any further surgery, but rather appellant would be placed at significant potential for harm if she was subjected to another surgery.

[4] Dr. Fellars explained that appellant has a transitional anatomy, leading to an L6 disc level in her spine.

By decision dated April 27, 2017, OWCP denied authorization for the proposed decompression and fusion at L4-5. It found that the weight of the medical evidence rested with Dr. Askin.

On May 2, 2017 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on August 17, 2017.

In a report dated August 4, 2017, Dr. Boulos responded to Dr. Askin's report of April 10, 2017. He noted that appellant had significant pathology at L4-5, which was located between the segments L3-4 and L5-S1, causing her mechanical pain in her back as well as leg symptoms. Dr. Boulos explained that if he unpinned these areas and stabilized them, she would improve. He noted his belief that the conditions to be treated were related to the initial injury, as well as to subsequent treatment. Dr. Boulos explained that, while there was abnormality at L4-5, the stresses of fusion operations could cause further injury to the adjacent segments and appellant had undergone a fusion at L5-S1 in 2004. He noted that Dr. Askin had indicated that this fusion in 2004 was causally related to appellant's employment injury.

By decision dated October 12, 2017, OWCP's hearing representative vacated the April 27, 2017 decision of, finding that an unresolved conflict of medical opinion existed between Drs. Askin and Boulos. The hearing representative directed OWCP to refer appellant to an impartial medical examiner (IME) in order to resolve the conflict.

On June 28, 2018 OWCP referred appellant to Dr. Jonas Gopez, a Board-certified neurosurgeon, to serve as an IME.

In a report dated July 20, 2018, Dr. Gopez reviewed appellant's history of injury and the medical record. He discussed appellant's surgical procedures in 2003, 2004, 2007, and 2013. On physical examination Dr. Gopez observed tenderness to palpation at the midline and paralumbar regions of the lumbosacral junction and extending to the superior gluteal regions bilaterally with mild loss of the normal lordotic curve and restriction of lumbar motion on extension. He also observed appellant's mildly asymmetric gait favoring the left lower extremity. Dr. Gopez noted that an MRI scan taken on July 2, 2018 demonstrated no significant change compared to the MRI scan taken on February 10, 2016. He diagnosed status post work-related injury on July 20, 2002 with accepted conditions of lumbosacral sprain, herniated disc at L5-S1 with sciatica, status post four lumbar surgeries with subsequent failed back syndrome, and chronic back and bilateral lower extremity pain. Dr. Gopez indicated that appellant was currently at maximum medical and surgical improvement and, in response to OWCP's inquiry regarding continuing disability, that she was unable to return to any work.

Dr. Gopez explained that the only objective findings found on appellant's physical examination were related to the four lumbar surgeries performed following her work-related injury. As a result, appellant's lumbar spine had been permanently altered with fusion procedures performed at L3-4 and L5-S1. Dr. Gopez noted that none of the surgeries had provided her with any significant improvement in her symptoms, which was commonly referred to as failed back syndrome. He opined that no further treatment, including lumbar surgical intervention, was warranted, with the exception of medications and a home exercise program. Dr. Gopez explained that she was not a candidate for further decompression and fusion at the L4-5 level, as she had already had four other lumbar surgical procedures, all of which had failed to provide significant

relief. He opined that performing a fifth surgery would not improve her overall condition and posed more risks than benefits.

By decision dated August 22, 2018, OWCP denied authorization for the proposed lumbar decompression of the spinal cord, lumbar spine fusion, insertion of a spinal fixation device, and application of a spinal prosthetic device. It noted that Dr. Gopez, the IME, had indicated that the requested surgery were inappropriate, that appellant would not improve with further surgical intervention, that she was not a candidate for further decompression and fusion, and that another surgery would not improve her condition and posed more risks than benefits.

On August 28, 2018 appellant, through counsel, requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. On January 8, 2019 counsel requested a review of the written record in lieu of an oral hearing.

In a report dated January 24, 2019, Dr. Nancy Kim, Board-certified in physical medicine and rehabilitation, reviewed appellant's history of injury and current complaints of low back pain with radiation to the lower extremities. On physical examination of the lumbar spine, she observed tenderness to palpation, limited flexion, and a positive straight leg raise test. Dr. Kim diagnosed persistent bilateral low back and lower extremity radicular pain related to lumbar disc derangement; chronic low back pain and chronic radicular pain from her July 20, 2002 work-related injury; status post microdisc/decompression/fusion and subsequent hardware removal; status post bilateral laminectomies and facetectomy/foraminectomies at L2-3 and L4-5 with interbody cage at L3-4 and posterior fusion at L3-4; and persistent pain despite treatment. She opined that appellant would benefit from L4-5 surgery with Dr. Boulo, noting that appellant was aware it would not eliminate all of her pain, but may improve it.

By decision dated March 14, 2019, an OWCP hearing representative affirmed the August 22, 2018 decision.

LEGAL PRECEDENT

Section 8103 of FECA[5] 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.[6] 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.[7]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditure is incurred for treatment of the effects of

[5] *Supra* note 2 at § 8103.

[6] *Id.*, *see also N.G.*, Docket No. 18-1340 (issued March 6, 2019).

[7] *D.W.*, Docket No. 19-0402 (issued November 13, 2019); *see also 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).

an employment-related injury or condition.[8] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[9] In order to prove that the procedure is warranted, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[10]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[11] For a conflict to arise the opposing physicians' viewpoints must be of virtually equal weight and rationale.[12] Where OWCP has referred the case to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[13]

ANALYSIS

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

OWCP properly found that a conflict in medical opinion arose between Dr. Boulos appellant's attending physician, and Dr. Askin, an OWCP referral physician, regarding whether the proposed lumbar surgery should be authorized. Consequently, it referred appellant to Dr. Gopez, an IME, to resolve the conflict in medical opinion pursuant to 5 U.S.C. § 8123(a).[14]

The Board finds that the special weight of the medical evidence rests with the opinion of Dr. Gopez, who examined appellant, reviewed the medical evidence, and found that the proposed lumbar surgery was not medically necessary and should not be authorized.

In his report dated July 20, 2018, Dr. Gopez explained that the only objective findings found on appellant's physical examination were related to the four lumbar surgeries performed following her work-related injury. As a result, appellant's lumbar spine had been permanently altered with fusion procedures performed at L3-4 and L5-S1. Dr. Gopez explained that none of the surgeries had provided her with any significant improvement in her symptoms, which was commonly referred to as failed back syndrome. He explained that appellant was not a candidate for further decompression and fusion at the L4-5 level, as she had already had four other lumbar surgical procedures, all of which had failed to provide significant relief. Dr. Gopez opined that

[8] *See R.M.*, Docket No. 19-1319 (issued December 10, 2019); *Debra S. King*, 44 ECAB 203, 209 (1992).

[9] *Id.*; *see also K.W.*, Docket No. 18-1523 (issued May 22, 2019); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[10] *See T.A.*, Docket No. 19-1030 (issued November 22, 2019); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[11] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *K.C.*, Docket No. 18-0378 (issued June 18, 2019).

[12] *Id.*

[13] *J.H.*, Docket No. 19-0513 (issued September 24, 2019).

[14] *R.M., supra* note 8.

performing a fifth surgery would not improve her overall condition and posed more risks than benefits.

In situations where the case is referred to an IME 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.[15] The Board finds that Dr. Gopez provided a well-rationalized opinion based on a complete background, his review of the SOAF, the medical record, and his examination findings. Dr. Gopez's opinion that the requested lumbar spine procedures were not medically warranted for the accepted conditions is entitled to special weight and represents the weight of the evidence.[16]

Following Dr. Gopez's evaluation, in a report dated January 24, 2019, Dr. Kim noted appellant's current physical examination findings and indicated that she would benefit from another lumbar surgery. She also noted that appellant wanted to proceed with the procedure even though she was aware that it would not eliminate all of her lumbar pain. While Dr. Kim opined that appellant would benefit from the proposed surgery, she failed to provide a reasoned explanation for her opinion and thus it is of limited probative value.[17]

The only limitation on OWCP's authority in approving or denying service under FECA is one of reasonableness.[18] OWCP obtained an impartial medical examination by Dr. Gopez who opined that the requested surgery was not warranted for the accepted conditions. It, therefore, had sufficient evidence upon to deny surgery and did not abuse its discretion.

CONCLUSION

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

[15] *C.W.*, Docket No. 17-0918 (issued January 5, 2018); *Patricia J. Glenn*, 53 ECAB 159 (2001).

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

[17] *See J.L.*, Docket No. 18-0503 (issued October 16, 2018).

[18] *Supra* note 10.

ORDER

IT IS HEREBY ORDERED THAT the March 14, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 18, 2020
Washington, DC

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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

Christopher J. Godfrey, Deputy Chief Judge, concurring:

I join the majority opinion in finding that OWCP did not abuse its discretion in denying appellant's request for authorization of additional lumbar surgery. I write this opinion as I find the medical opinion of Dr. Gopez, the IME, is not a rationalized medical opinion, but rather is conclusory in nature. While I concur that OWCP has not abused its discretion by denying the requested authorization for surgery, I do not find that the report of Dr. Gopez is entitled to the special weight accorded to an IME. As noted in this decision, in order to be accorded the special weight, an IME's opinion must be sufficiently well-reasoned and based upon a proper factual background.[1] As Dr. Gopez merely concluded that the surgery was not warranted, without providing a rationalized opinion to explain why, I cannot find that the IME's report is entitled to the special weight of the medical evidence. However, when his report is read together with the opinion of Dr. Askin, the second opinion physician, I find that OWCP did not abuse its discretion in denying authorization for further surgery.

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

[1] *J.H.*, Docket No. 19-0513 (issued September 24, 2019).