United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 19-0687**
	)	**Issued: March 31, 2021**
DEPARTMENT OF VETERANS AFFAIRS, HUNTER HOLMES McGUIRE VA MEDICAL CENTER, Richmond, VA, Employer	)	

Appearances:
Jennifer D. Marshall, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 30, 2019 appellant, through her representative, filed a timely appeal from an October 31, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).[2]

[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] Appellant timely requested oral argument pursuant to section 501.5(b) of the Board's *Rules of Procedure*. 20 C.F.R. § 501.5(b). By order dated July 16, 2020, the Board exercised its discretion and denied the request, finding that the arguments on appeal could adequately be addressed based on the case record. *Order Denying Request for Oral Argument*, Docket No. 19-0687 (issued July 16, 2020).

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

ISSUES

The issues are: (1) whether OWCP abused its discretion by denying appellant's request for authorization of lumbar spine surgery; and (2) whether appellant has met her burden of proof to establish expansion of the acceptance of her claim to include additional medical conditions.

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[5] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On August 17, 2004 appellant, then a 40-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on August 16, 2004 she sustained injuries when attempting to restrain a patient while in the performance of duty. She explained that the patient fell on her right arm/shoulder while trying to get out of bed, pulling her over the bed railing. Appellant stopped work on the date of injury and did not return. OWCP assigned the claim File No. xxxxxx603,[6] and on September 30, 2004, accepted it for right shoulder contusion and right elbow contusion. On March 23, 2005 it expanded the accepted conditions to include sprain of back, lumbar region. OWCP paid appellant wage-loss compensation on the supplemental rolls as of October 1, 2004, and on the periodic rolls as of July 10, 2005.

Relevant medical evidence includes an August 18, 2004 report in which Dr. Sidney R. Jones, III, an attending Board-certified internist, noted a history that appellant had been injured at work by a combative patient two days prior. Dr. Jones described examination findings and diagnosed cervical and lumbar strains/strain and tendinitis in the shoulder, elbow, and wrist, and ulnar neuropathy with exacerbation. He continued to provide appellant medical treatment.

[3] 5 U.S.C. § 8101 *et seq.*

[4] The Board notes that following the October 31, 2018 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*.

[5] Docket No. 16-0128 (issued April 8, 2016).

[6] On December 2, 2003 appellant filed an occupational disease claim (Form CA-2) alleging that she sustained carpal tunnel syndrome and ulnar nerve compression in the performance of duty. OWCP assigned File No. xxxxxx443. On September 27, 2004 she filed another occupational disease claim alleging that a right carpal tunnel release resulted in persistent chronic right arm pain with reactive depression and anxiety that was directly related to an accepted work-related injury. OWCP assigned File No. xxxxxx705. On December 8, 2004 OWCP administratively combined File Nos. xxxxxx603, xxxxxx443, and xxxxxx705, with the present case, File No. xxxxxx603, serving as the master file.

On January 13, 2005 Dr. Edward R. Isaacs, a Board-certified neurologist, performed a second opinion evaluation for OWCP. He noted appellant's descriptions of her employment injuries and medical care. Following an extensive examination, Dr. Isaacs found no evidence of loss of normal function or of any significant pain on musculoskeletal evaluation. He indicated that appellant had no restrictions, based on his physical findings.

Diagnostic studies included a May 16, 2005 magnetic resonance imaging (MRI) scan of the lumbar spine that demonstrated mild facet degenerative changes in the lower lumbar spine. A December 29, 2007 MRI scan of the cervical spine demonstrated no fracture or herniated disc with mild multilevel spondylosis. A lumbar spine MRI scan of the same date demonstrated a moderate diffuse disc bulge at L5-S1 with probable disc protrusion.

On July 20, 2009 appellant filed a notice of recurrence (Form CA-2a) asserting that she sustained consequential cervical and lumbar conditions as shown on MRI scans and other imaging studies.

A January 14, 2010 cervical spine MRI scan indicated mild cervical spondylosis had possibly progressed since a 2004 study, with mild central canal stenosis at C4-5, and foraminal narrowing at C3-T1.

By report dated January 16, 2010, Dr. Lawrence Manning, an orthopedic surgeon serving as DMA, noted that the accepted conditions were multiple and included lumbar sprain and pain in limb but that a cervical condition had not been accepted. He indicated that medical records documented lumbar degenerative disc disease, facet arthrosis of the lumbar spine, a bulging of disc at L5-S1 with right S1 radiculitis, and mild degenerative changes of the cervical spine. The DMA advised that it was as likely as not that the L5-S1 disc herniation was a consequence of one or more of her employment injuries. On February 3, 2010 OWCP notified Dr. Manning that it was going to accept disc herniation at L5-S1 as a consequential injury and asked him whether degenerative disc disease of the lumbar spine should also be accepted as a consequential injury. In a February 13, 2010 response, he indicated that degenerative disc disease was probably preexisting.

By decision dated March 9, 2010, OWCP expanded the acceptance of the claim to include lumbar disc herniation without myelopathy. By separate decision dated March 9, 2010, it found that appellant had not met her burden of proof to establish that cervical and lumbar degenerative disc disease were caused by employment factors.

A May 16, 2012 cervical spine MRI scan noted that there had been relatively mild interval progression of degenerative changes since 2007. A December 6, 2013 upper extremity electromyogram and nerve conduction velocity study demonstrated in relevant part left chronic partial C5 radiculopathy. An April 26, 2014 MRI scan of the lumbar spine demonstrated a mild disc protrusion at L5-S1 with mild central canal stenosis. A cervical spine MRI scan of same date demonstrated mild degenerative changes. The study indicated that when compared to a May 16, 2012 scan, no substantial change was demonstrated.

Dr. Charles Matthew Gibellato, a Board-certified physiatrist, began pain management on August 29, 2014. He diagnosed chronic neck and low back pain with cervical and lumbar

degenerative disc disease, myofascial pain syndrome/fibromyalgia, and bilateral sacroiliitis. On an attending physician's report (Form CA-20) dated September 17, 2014, Dr. Gibellato noted that on August 16, 2004 appellant was injured by a combative patient and this caused neck, back, and right upper extremity injuries. He advised that this caused cervical radiculopathy, cervical stenosis, a cervical disc bulge/herniation, cervical degeneration, bilateral carpal tunnel, lumbar radiculopathy, and fibromyalgia.

On April 21, 2015 Dr. Jed Vanichkachorn, a Board-certified orthopedic surgeon, noted that appellant was transitioning into his care. He described appellant's complaint of radiating low back pain that was worsening and described her past medical history. Physical examination demonstrated moderate tenderness of the lumbosacral spine. Dr. Vanichkachorn diagnosed low back pain and acquired spondylolisthesis. On July 8, 2015 he noted seeing appellant in follow-up for lumbar pain.

In correspondence dated September 25, 2015, Dr. Gibellato, who continued pain management, related that appellant continued to have chronic neck and back pain and hand numbness and opined that these conditions were due to the August 16, 2004 work incident. In December 23, 2015 correspondence, he indicated that he had been appellant's treating physiatrist for her chronic pain condition for years and described her pain management. Dr. Gibellato advised that her current conditions included exacerbation of fibromyalgia, chronic neck pain, cervical degenerative disc disease with C5-6 radiculopathy, cervical stenosis, cervical disc bulge/ herniation, cervical spondylosis, right rotator cuff tendinitis, shoulder impingement, de Quervains tenosynovitis of the right thumb, bilateral carpal tunnel syndrome, chronic low back pain with lumbar degenerative disc disease, lumbar facet arthropathy, and chronic right L5 and S1 radiculopathy. He advised that, due the above listed conditions, which were permanent, and caused widespread pain, appellant could not perform her prior work duties but could work with modifications and accommodations such as telework. Dr. Gibellato continued appellant's pain management through August 2016.

A January 21, 2016 MRI scan of the lumbar spine demonstrated a mild disc protrusion at L5-S1 with mild central canal stenosis. It noted that since the April 26, 2014 study, a synovial cyst had arisen from the facet joint causing severe right lateral recess stenosis at L5-S1 and effacement of nerve roots extending to the right L5-S1 foramen and otherwise, no interval change.

In correspondence dated June 15, 2016, Dr. Abilio A. Reis, a Board-certified orthopedic surgeon, noted that he first saw appellant on January 7, 2016 for lower back and right lower extremity complaints related to an August 16, 2004 work injury. He also noted MRI scan findings of a synovial cyst at L5-S1 and spondylolisthesis at L4-5 with stenosis. Dr. Reis indicated that appellant had exhausted nonoperative measures without finding relief and advised that it was reasonable to proceed with surgical decompression and fusion. He repeated this opinion on June 23, 2016.

A June 22, 2016 lumbar MRI scan demonstrated degenerative disc disease and facet arthropathy at L4-5 and L5-S1 with bilateral lateral recess narrowing and bilateral neural foraminal narrowing at those levels.

In correspondence dated August 10, 2016, appellant requested that her claim be expanded to include the conditions of chronic neck, shoulder, and back pain; degenerative disc disease; L5-S1 disc herniation with tear and severe lateral recess stenosis; facet arthropathy with L4 synovial cyst; a temporomandibular joint (TMJ) condition; fibromyalgia/myalgia; cervical radiculopathy of both arms; cervical stenosis, cervical spondylosis; C3-6 disc bulging; and lumbar spondylolisthesis. She indicated that the medical evidence of record indicated that these conditions were caused by the August 16, 2004 employment injury.

On November 3, 2016 Dr. Vanichkachorn noted that he had last seen appellant 16 months prior and that she had complaints of continuing low back pain that radiated into both legs. He reviewed lumbar MRI scans and found tenderness on examination of the lumbosacral spine with decreased range of motion. Dr. Vanichkachorn diagnosed worsening spinal stenosis at L4-5 due to a large synovial cyst. He recommended lumbar fusion.

Dr. Vanichkachorn completed an attending physician's report (Form CA-20) on December 23, 2016. He noted work injuries in 1993, 1997, 2002, and 2004 to the neck, back, both shoulders, and right elbow, wrist, and hand. Dr. Vanichkachorn advised that these caused lumbar stenosis, spondylolisthesis, and disc degeneration. He stated that appellant had no injuries other than work injuries, and that the 2004 work injury exacerbated previous injuries. Dr. Vanichkachorn again noted that a lumbar synovial cyst seen on x-ray caused stenosis.

A December 31, 2016 MRI scan of the cervical spine demonstrated multilevel degenerative disc disease and joint hypertrophy with mild spinal canal stenosis extending from C3-4 through C6-7, and multilevel neuroforaminal narrowing ranging from mild to severe, worst at the C6-7 and C5-6 levels. A February 14, 2017 myelogram of the lumbar spine indicated that L4-5 demonstrated severe spinal stenosis while standing and minimal/mild stenosis with mild anterior extradural defect at L5-S1. A computerized tomography (CT) scan of the lumbar spine of same date demonstrated L4-5 advanced chronic facet arthrosis, disc bulge/protrusion greater on the left and degenerative changes related to contact between the posterior spinous processes with at least moderate spinal stenosis and left greater than right foraminal stenosis. At L5-S1 there was a broad-based posterior central disc bulge/protrusion with minimal stenosis.

On April 12, 2017 OWCP asked its DMA for an opinion regarding the necessity for the surgery recommended by Dr. Reis. In an undated response, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as DMA, noted his review of an April 12, 2017 statement of accepted facts (SOAF) and medical evidence up to February 14, 2017, and advised that no surgery was warranted for the lumbar spine, SI joints, or cervical spine. The DMA also indicated that there was no basis to expand the accepted conditions.

Dr. Vanichkachorn performed L4-5, L5-S1 laminectomy with L4-5 fusion on April 13, 2017. The operative report noted that a large synovial cyst was also removed. Preoperative and postoperative diagnoses were lumbar spondylolisthesis at L4-5, lumbar stenosis at L3-4 and L4-5, and facet arthropathy and facet cyst at L4-5.

By decision dated June 16, 2017, OWCP denied authorization for the April 13, 2017 lumbar spine surgery. It found that the evidence of record did not support that the surgery was medically necessary to address the effects of appellant's work-related conditions.

On July 7, 2017 OWCP asked Dr. Berman, the DMA, to again comment on the need for lumbar surgery recommended by Dr. Reis. It again forwarded the April 12, 2017 SOAF and some medical reports. In a July 20, 2017 addendum report, the DMA essentially repeated his prior report. He again advised that surgery was not indicated.

On July 7, 2017 OWCP referred appellant to Dr. Chester DiLallo, a Board-certified orthopedic surgeon, for a second opinion evaluation. It requested that he provide an opinion, based on an attached SOAF regarding appellant's limitations, any period of total disability, whether she could perform her regular position, if she had employment-related residuals, and whether additional conditions should be accepted.

In an August 1, 2017 report, Dr. DiLallo noted his review of appellant's medical records including an April 21, 2017 SOAF. He related that appellant told him she had additional accepted conditions but that his opinion was based on the information provided by OWCP. Dr. DiLallo wrote that appellant told him that on August 16, 2004 an uncontrollable patient fell on her, pinning her under his body, and this affected her entire right side, with continuing neck and back symptoms, and pain in her right hip. He noted that she was right-handed, walked with a cane in her right hand, and that she reported that her left sciatic pain had significantly decreased following surgery. Dr. DiLallo described extensive cervical and lumbar spine examination findings.

In response to OWCP's questions, Dr. DiLallo indicated that it was notable that appellant did not have strong objective findings on physical examination but did have MRI scan findings with resolution of symptoms referable to her lower extremities following her recent lumbar surgery. He opined that she had no measurable percent of impairment, and advised that, while she could not perform the duties of a registered nurse, she could be gainfully employed with restrictions on standing, sitting, bending, and lifting referable to the lumbar spine, and with restrictions to pushing, pulling, and overhead work referable to the cervical spine. Dr. DiLallo indicated that the only periods of total disability would be immediately following injections of no more than three days, and for a total of six months following the April 2017 lumbar surgery. He saw no need for continued physical therapy after she had completed the postoperative regimen, but noted that she would need continued supportive medication. As to residuals, Dr. DiLallo indicated that, based on physical examination, his review of medical records including diagnostic studies, it was reasonable to project that she would have no residuals referable to her back or lower extremities following a postoperative period. He further opined that, given the progression of symptoms referable to the cervical area and appellant's immediate post injury complaints, the cervical conditions that had been identified and treated were related to the work injury.

As to the need for the lumbar surgery, Dr. DiLallo noted that appellant had persistent symptoms, which were most likely referable to the degenerative disc disease which was a progression of her injury as shown on sequential MRI scans. He opined that the April 2017 surgery was obviously needed and was warranted. On an attached work capacity evaluation (Form OWCP-5c), Dr. DiLallo wrote that appellant could perform eight hours of limited-duty work daily and described specific permanent restrictions. He recommended monthly follow-up for pain management, continued psychological support, and annual follow-up by the operating spine surgeon.

OWCP requested clarification from Dr. DiLallo on August 30, 2017. It referenced diagnostic studies and asked that he advise if the medical evidence of record supported that the April 2017 surgical procedure was causally related and medically necessary based on accepted condition of lumbar disc herniation without myelopathy. OWCP further asked if cervical spine surgery was warranted and attached a copy of appellant's position description. It asked if appellant could return to this position, or any nurse position, without restrictions.

In a supplemental report dated September 6, 2017, Dr. DiLallo noted that he had reviewed his August 1, 2017 report and the SOAF. He advised that, since a disc herniation without myelopathy had been accepted, then the April 12, 2017 surgery was necessary, and that the removal of the synovial cyst, which was a consequential condition, was incident to that procedure. In regard to the cervical spine, Dr. DiLallo noted that it was not an accepted condition and opined that it was the result of aging and normal wear and tear. He further opined that appellant could perform nursing duties as long as pushing, pulling, lifting, or carrying heavy materials were not required.

By decision dated October 17, 2017, OWCP again noted that the June 16, 2017 decision had been superseded. It found that updated evidence did not support that the April 13, 2017 lumbar spine surgery was medically necessary to address the effects of the August 16, 2004 work injury and denied that the claim should be expanded to include cervical and lumbar spine conditions. OWCP indicated that the synovial cyst at L4-5 was accepted and "authorization was granted diagnostically."

On August 17, 2018 appellant requested reconsideration.

In undated correspondence received by OWCP on September 5, 2018, Dr. Vanichkachorn noted that he first evaluated appellant for lower back complaints on April 21, 2015. He described her subsequent care up to and including the April 13, 2017 lumbar spine surgery. Dr. Vanichkachorn indicated that removal of a synovial cyst at surgery was necessary for proper decompression of the L4-5 and L5-S1 nerve roots. He further advised that, due to existing instability, a lumbar fusion was done at the L4-5 level. Dr. Vanichkachorn opined that appellant's spondylolisthesis and stenosis were not a new injury but the result of the natural degenerative progression related to her previous lumbar spine injury. He maintained that lumbar stenosis and spondylolisthesis should be accepted conditions and that the lumbar surgery was indicated and necessary, relating that she had steady progression from her work injury to an endpoint when surgery became necessary.

On October 16, 2018 appellant again requested reconsideration of the October 17, 2017 decision. She submitted evidence previously of record, and medical literature regarding the lumbar and cervical spines. Appellant also submitted a number of treatment notes describing her medical management.

By decision dated October 31, 2018, OWCP denied modification.

LEGAL PRECEDENT -- ISSUE 1

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 the monthly compensation.[7]

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. 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]

In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under FECA. OWCP has the general objective of ensuring that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time. It therefore has broad administrative discretion in choosing means to achieve this goal. The only limitation on OWCP's authority is that of reasonableness.[10] 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.[11]

While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of proof to establish that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[12]

ANALYSIS -- ISSUE 1

The Board finds that OWCP abused its discretion in denying appellant's request for authorization of lumbar surgery.

OWCP accepted appellant's claim for a back sprain, lumbago, displacement of lumbar intervertebral disc, and a lumbar synovial cyst. Two attending orthopedic surgeons, Dr. Reis and

[7] 5 U.S.C. § 8103; *see B.H.*, Docket No. 17-0479 (issued March 19, 2019); *Dona M. Mahurin*, 54 ECAB 309 (2003).

[8] *M.G.*, Docket No. 19-1791 (issued August 13, 2020); *M.B.*, 58 ECAB 588 (2007).

[9] *M.G., id*.; *R.C.*, 58 ECAB 238 (2006).

[10] *D.K.*, Docket No. 20-0002 (issued August 25, 2020).

[11] *D.K., id*.; *Daniel J. Perea*, 42 ECAB 214 (1990).

[12] *P.L.*, Docket No. 18-0260 (issued April 14, 2020); *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

Dr. Vanichkachorn recommended lumbar surgery. Dr. Reis reported back and right lower extremity complaints related to an August 16, 2004 work injury. On June 15 and 23, 2016 he noted that appellant had exhausted nonoperative measures and advised that it was reasonable to proceed with lumbar surgery. On November 3, 2016 Dr. Vanichkachorn stated that appellant's spinal stenosis was worsening and noted an MRI scan finding of a large synovial cyst that caused stenosis. He recommended lumbar fusion. On December 23, 2016 Dr. Vanichkachorn noted appellant's work injuries and advised that the 2004 injury exacerbated previous injuries. On April 13, 2017 he performed L4-5, L5-S1 laminectomy and L4-5 fusion. Dr. Vanichkachorn also removed a large synovial cyst. He later opined that appellant's spondylolisthesis and stenosis were not a new injury but the result of the natural degenerative progression related to her previous lumbar spine injury. Dr. Vanichkachorn maintained that lumbar stenosis and spondylolisthesis should be accepted conditions and that the lumbar surgery was indicated and necessary, relating that she had steady progression from her work injury to an endpoint when surgery became necessary.

In an August 1, 2017 report, Dr. DiLallo, an OWCP referral physician, noted that appellant's persistent lumbar symptoms were most likely referable to the degenerative disc disease, which was a progression of her work injury as shown on sequential MRI scans. He opined that the April 2017 surgery was obviously needed and was warranted.

OWCP asked its DMA Dr. Berman to comment on Dr. Reis' recommendation for lumbar surgery. However, it does not appear that OWCP provided Dr. Berman either Dr. Vanichkachorn's or Dr. DiLallo's reports. In reports in April and July 2017 that were essentially the same, Dr. Berman did not indicate that he reviewed reports from either physician. The Board thus finds that these reports from the DMA are of diminished probative value because he did not review all relevant medical evidence regarding the questions presented.[13]

As both Dr. Reis and Dr. Vanichkachorn recommended lumbar surgery, and Dr. DiLallo, OWCP's referral physician, advised that the surgery was needed due to progression of appellant's lumbar condition from the 2004 employment injury, the Board finds that OWCP abused its discretion in denying authorization for the April 1, 2017 surgery.[14]

LEGAL PRECEDENT -- ISSUE 2

Where an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[15]

[13] *See G.B.*, Docket No. 20-0750 (issued October 27, 2020); *D.B.*, Docket No. 19-0663 (issued August 27, 2020).

[14] *See generally R.B.*, Docket No. 19-1466 (issued April 9, 2020); *see G.S.*, Docket No. 13-0057 (issued August 26, 2013).

[15] *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

To establish causal relationship, the employee must submit rationalized medical opinion evidence.[16] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the accepted employment injury.[17] The weight of 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]

ANALYSIS -- ISSUE 2

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

Appellant requested that OWCP accept additional lumbar conditions including degenerative disc disease, L5-S1 disc herniation with tear and severe lateral recess stenosis, facet arthropathy with L4 synovial cyst, and lumbar spondylolisthesis. OWCP has accepted lumbar conditions of sprain of back, lumbar region, displacement of lumbar intervertebral disc without myelopathy, and a lumbar synovial cyst. In its October 17, 2017 decision, it denied the expansion of the acceptance of the claim to include additional medical conditions. In its October 31, 2018 decision, OWCP denied modification of the October 17, 2017 decision.

On November 3, 2016 Dr. Vanichkachorn diagnosed worsening spinal stenosis at L4-5 due to a large synovial cyst. On December 23, 2016 he noted work injuries in 1993, 1997, 2002, and advised that these caused lumbar stenosis, spondylolisthesis, and disc degeneration. Dr. Vanichkachorn stated that appellant no injuries other than work injuries, and that the 2004 work injury exacerbated previous injuries. The April 13, 2017 operative report noted pre and postoperative diagnoses of lumbar spondylolisthesis at L4-5, lumbar stenosis at L3-4 and L4-5, and facet arthropathy and facet cyst at L4-5. Dr. Vanichkachorn later opined that appellant's spondylolisthesis and stenosis were not a new injury but the result of the natural degenerative progression related to her previous lumbar spine injury. He maintained that lumbar stenosis and spondylolisthesis should be accepted conditions and that the lumbar surgery was indicated and necessary, relating that she had steady progression from her work injury to an endpoint when surgery became necessary.

Dr. Vanichkachorn is a Board-certified physician who is qualified in his field of medicine to render rationalized opinions on the issue of causal relationship. The Board finds that, although his reports are insufficient to discharge appellant's burden of proof that the diagnosed lumbar stenosis and spondylosis were caused or aggravated by the accepted August 16, 2014 employment injury, his reports constitute substantial evidence in support of appellant's claim, and provide sufficient rationale to require further development of the case record by OWCP.[19] Dr. Vanichkachorn provided a detailed history of injury, referenced objective medical reports

[16] *E.W.*, Docket No. 20-0338 (issued October 9, 2020).

[17] *L.P.*, Docket No. 20-0609 (issued October 15, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[18] *J.L.*, Docket No. 20-0717 (issued October 15, 2020); *James Mack*, 43 ECAB 321 (1991).

[19] *See B.F.*, Docket No. 20-0990 (issued January 13, 2021); *Y.D.*, Docket No. 19-1200 (issued April 6, 2020).

demonstrating injury, expressed his opinion on causal relationship within a reasonable degree of medical certainty, and provided an explanation as to the cause of appellant's diagnosed lumbar stenosis and spondylosis, noting that the accepted synovial cyst caused lumbar stenosis. His opinion raises an inference of causal relationship sufficient to require further development of the case record by OWCP.[20]

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[21]

The case shall therefore be remanded for OWCP to refer appellant, the case record, and a SOAF to a specialist in the appropriate field of medicine for an evaluation and a rationalized medical opinion on whether appellant's accepted work injuries caused, contributed to, or aggravated her diagnosed lumbar conditions. If the physician opines that the diagnosed lumbar conditions are not causally related to the employment incident, he or she must explain with rationale how or why their opinion differs from that of Dr. Vanichkachorn. Following this and other such further development as OWCP deems necessary, it shall issue a *de novo* decision.

The Board also finds that a conflict in medical evidence has been created regarding whether the claimed cervical conditions are work related.

Appellant also requested that cervical conditions of radiculopathy of both arms, cervical stenosis, cervical spondylosis, and C3-6 disc bulging be accepted. Serial cervical diagnostic studies revealed multilevel degenerative disc disease and foraminal narrowing. OWCP has not accepted any cervical conditions.

Section 8123(a) of FECA provides, in pertinent part: "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."[22] 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.[23] Where a 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 on a proper factual background, must be given special weight.[24]

Dr. Gibellato began pain management on August 29, 2014 and continued to treat appellant through October 2016. On September 17, 2014 he noted a history that a combative patient had

[20] *See A.D.*, Docket No. 20-0758 (issued January 11, 2021); *John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

[21] *C.R.*, Docket No. 20-1102 (issued January 8, 2021); *K.P.*, Docket No. 18-0041 (issued May 24, 2019).

[22] 5 U.S.C. § 8123(a).

[23] *T.J.*, Docket No. 20-0721 (issued November 17, 2020).

[24] *Id*.

injured appellant on August 16, 2004 and this caused cervical radiculopathy, cervical stenosis, a cervical disc bulge/herniation, and cervical degeneration. In correspondence dated September 25 and December 23, 2015, Dr. Gibellato reiterated that the work injury caused cervical conditions.

Dr. DiLallo, OWCP's referral physician, provided an extensive evaluation for OWCP dated August 1, 2017. In that initial report, he advised that, given the progression of symptoms referable to the cervical area and appellant's immediate post injury complaints, the cervical conditions that had been identified and treated were related to the work injury. However, upon further questioning by OWCP, Dr. DiLallo acknowledged on September 6, 2017 that appellant's diagnosed cervical conditions had not been accepted. He provided physical restrictions referable to the cervical spine but opined that appellant's cervical diagnoses were the result of aging and normal wear and tear.

Both Dr. Gibellato and Dr. DiLallo provided a description of appellant's September 16, 2004 employment injury and provided rationale for their respective findings based on their review of the medical evidence and findings on examination. The Board, therefore, finds a conflict in medical opinion regarding whether appellant sustained cervical conditions causally related to or as a consequence of her August 16, 2004 employment injury.[25] Under section 8123(a) of FECA, OWCP must resolve this conflict by referring appellant, together with the case record and an SOAF, to an impartial medical specialist.[26]

On remand OWCP shall refer appellant, along with the case file and an SOAF, to an appropriate specialist for an impartial medical evaluation and a report including a rationalized opinion as to whether appellant's diagnosed cervical conditions are causally related to the accepted September 16, 2004 employment injury. Following this and other such development as OWCP deems necessary, it shall issue a *de novo* decision regarding her claim for employment-related cervical conditions.

CONCLUSION

The Board finds that OWCP abused its discretion by denying appellant authorization for April 13, 2017 lumbar spine surgery. The Board further finds that the case is not in posture for decision regarding whether appellant has met her burden of proof to establish expansion of the acceptance of her claim to include additional medical conditions.

[25] *See D.B.*, Docket No. 20-1142 (issued December 31, 2020).

[26] *Supra* note 22; *see T.T.*, Docket No. 19-0544 (issued August 14, 2020).

ORDER

IT IS HEREBY ORDERED THAT the October 31, 2018 decision of the Office of Workers' Compensation Programs is reversed, in part, and set aside, in part. The case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: March 31, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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