United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
and	)	**Docket No. 22-1315**
	)	**Issued: July 12, 2023**
U.S. POSTAL SERVICE, ITALY POST OFFICE, Italy, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On September 1, 2022 appellant filed a timely appeal from a March 29, 2022 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.[2]

ISSUE

The issue is whether OWCP has abused its discretion in denying appellant's request for authorization for a cervical fusion.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the March 29, 2022 decision, appellant submitted additional evidence to OWCP. However, the Boards *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*.

FACTUAL HISTORY

On June 23, 2009 appellant, then a 49-year-old rural carrier associate, filed a traumatic injury claim (Form CA-1) alleging that on June 16, 2009 she injured her neck and right knee when her vehicle was struck by a truck and trailer while in the performance of duty. OWCP accepted the claim for brachial neuritis or radiculitis, sciatica, closed dislocation of multiple cervical vertebrae, sprain of the neck, chondromalacia patellae on the right, and acute myringitis. Appellant stopped work on June 16, 2009. OWCP paid her wage-loss compensation on the supplemental rolls, effective August 1, 2009 and on the periodic rolls, effective October 25, 2009.

OWCP subsequently expanded the acceptance of appellant's claim to include derangement of the right lateral meniscus, traumatic arthropathy of the right lower leg, localized primary osteoarthritis of the left lower leg, and disorder of the bursae and tendons in the left shoulder region.

Dr. Venkat Sethruaman, a Board-certified orthopedist, treated appellant on April 4 and 29, 2014 for radiating low back pain that began after a motor vehicle accident at work in June 2009. Appellant reported neck pain radiating into her left arm, impaired balance, fine motor skill deficits, headaches, and weakness of the upper extremities. He noted findings on physical examination of mild strength deficits on the left side and positive straight leg raise with the left leg. Dr. Sethruaman diagnosed lumbar disc displacement, lumbosacral neuritis, pain in the neck, and radiculopathy. He performed a series of cervical epidural steroid injections. In reports dated September 26, 2014, February 18, September 16 and December 30, 2015, and November 9, 2016, Dr. Sethruaman evaluated appellant in follow-up and described her symptoms as severe and worsening. Appellant reported that she was currently unable to perform activities of daily living including work and housework. Dr. Sethruaman indicated that appellant's myelopathy had worsened and she developed increased bowel and bladder dysfunction. He diagnosed cervical sprain with radiculopathy with spondylolysis myeloradiculopathy. Dr. Sethruaman opined that appellant underwent conservative treatment including cervical epidural steroid injections and physical therapy without relief in her symptoms. He indicated that x-rays revealed cervical retrolisthesis at C3-C4 with severe cervical spondylosis at C3-C4, C4-C5, and C5-C6 with disc herniations. Dr. Sethruaman recommended an anterior cervical discectomy with interbody fusion with anterior plating from C3-C7 and left carpal tunnel release.

A magnetic resonance imaging (MRI) scan of the cervical spine dated May 8, 2014 revealed retrolisthesis of C3 on C4, moderate degenerative disc disease at C3-C4 with broad disc osteophyte complex and uncovertebral hypertrophy, several facet arthroses on the right C4-C5, fusion at C5-C6, severe stenosis of the neural foramen at C3-C4, and moderate stenosis of the right neural foramen at C4-C5.

An electromyogram (EMG) and nerve conduction velocity (NCV) study dated May 29, 2014 revealed evidence of bilateral very mild carpal tunnel syndrome and evidence of an old axonal left L5 radiculopathy.

An MRI scan of the cervical spine dated November 1, 2016 revealed an osteophyte and disc extrusion complex at C3-C4, bulging at C4-C5, and new anterolisthesis at C5 on C6.

An EMG/NCV study dated October 31, 2016 revealed evidence of mild right sensory median mononeuropathy at the wrist and moderate left sensorimotor median mononeuropathy at the wrist.

In a report dated March 16, 2017, Dr. William Tontz, Jr., a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), reviewed the request for surgical authorization and found that the proposed anterior cervical discectomy with interbody fusion with anterior plating from C3-C7 was causally related to the accepted employment injury. He noted evidence of a temporal relationship between the June 16, 2009 employment injury and the proposed surgery and advised that appellant had persistent symptoms since the employment injury, along with a lack of evidence of preexisting symptoms. Dr. Tontz opined, however, that the proposed surgery was not medically necessary. He asserted that appellant had failed to meet the criteria for a cervical fusion as there was insufficient evidence of failure of conservative management and concluded that an adequate trial of conservative treatment was not attempted.

On May 10, 2017 OWCP provided Dr. Sethuraman with the March 16, 2017 report from Dr. Tontz for his review. It requested that he address whether he agreed or disagreed with the DMA's findings and, if he disagreed, to provide rationale explaining the need for the surgery. No response was received.

OWCP determined that there was a conflict in medical opinion between the treating physician, Dr. Sethuraman, who indicated that the proposed surgery was medically necessary and causally related to the accepted medical conditions, and OWCP's DMA, Dr. Tontz, who opined that criteria set forth in the Official Disability Guidelines for a cervical fusion was not met as an adequate trial of conservative treatment was not attempted.

On July 18, 2017 OWCP referred appellant, along with a statement of accepted facts (SOAF) and the medical record to Dr. Dale R. Allen, a Board-certified orthopedic surgeon, for an impartial medical examination. It provided Dr. Allen with a SOAF, which noted appellant's claim was accepted for cervical sprain, brachial neuritis or radiculitis, sciatica, closed dislocation of multiple cervical vertebrae, chondromalacia patellae on the right, acute myringitis, derangement of the right lateral meniscus, traumatic arthropathy of the right lower leg, localized primary osteoarthritis of the bilateral lower legs, and aggravation of impairment of the left shoulder.

In an August 25, 2017 report, Dr. Allen detailed the history of the injury and appellant's treatment. He reviewed the SOAF. Dr. Allen noted findings on examination of the cervical spine of marked tenderness along the trapezius from the occiput to the rhomboids and over the suprascapular area with swelling, increased pain in the left side of her neck with range of motion, and increased pain with head compression. He diagnosed multilevel cervical disc osteophyte complex with spinal neuroforaminal stenosis at C3-C4, C4-C5, and C5-C6, right knee lateral meniscus tear, chondromalacia of the patella, traumatic arthropathy, aggravation of impingement syndrome right shoulder, sciatica, radiculitis, brachial neuritis, and myringitis. Dr. Allen indicated that the bilateral knee replacement surgery was necessary due to the work-related injury. He noted that both knees were treated conservatively for several months that constituted an adequate trial of conservative treatment. Dr. Allen opined that a total knee arthroplasty for grade IV osteoarthropathy of the knees was the accepted medical practice.

On November 3, 2017 OWCP requested a supplemental opinion from Dr. Allen, specifically asking that he address the conflict of opinion regarding the proposed cervical spine surgery. In a separate letter of even date, it advised that the conflict of opinion concerned the question of whether the proposed cervical spine surgery was medically necessary due to the employment injury. The questions for determination were whether appellant was a candidate for cervical surgery, and if surgery was indicated, was the surgery directly related to the June 16, 2009 employment injury. OWCP provided an updated SOAF and medical records and authorized Dr. Allen to perform any additional diagnostic testing he deemed necessary to complete his assessment. No response was received.

An April 11, 2018 MRI scan of the cervical spine revealed retrolisthesis of C3-C4, anterolisthesis of C5 on C6, multilevel spondylosis with disc space narrowing, disc dehydration, endplate irregularity and spurring, annular disc bulges, disc protrusions, disc osteophytosis, narrowing of the central canal at C3-C4, multilevel neural foraminal narrowing, and low-lying cerebellar tonsils.

On June 28, 2019 Dr. Bala K. Giri, a Board-certified neurosurgeon, evaluated appellant for neck pain and numbness radiating down her left arm. He noted findings on examination of bilateral motor strength deficits in the deltoids and hand and decreased sensation in the left C5, left C7, and left hand. Dr. Giri diagnosed other cervical disc displacement, high cervical region and recommended an updated MRI scan of the cervical spine.

An MRI scan of the cervical spine dated July 5, 2019 revealed no significant interval change since April 11, 2018, no compression fracture, retrolisthesis of C3 on C4, anterolisthesis of C5 on C6, multilevel spondylosis with disc space narrowing, disc dehydration, endplate spurring, annular disc bulges, disc protrusions, disc osteophytosis, narrowing of the central canal at C3-C4, multilevel neural foraminal narrowing, and low-lying cerebellar tonsils.

In a medical authorization record dated July 31, 2019, Dr. Giri requested authorization to perform a cervical fusion.

In a report dated August 31, 2019, Dr. Franklin M. Epstein, a Board-certified neurosurgeon serving as a DMA, noted reviewing the medical record and SOAF. He reviewed the request for surgical authorization and found that the proposed anterior cervical discectomy with interbody fusion and anterior plating from C3-C4 and C4-C5 was not medically necessary or causally related to the accepted employment injury. Dr. Epstein indicated that appellant had chronic, intractable, multisite pain that required chronic daily narcotic analgesic medication despite interventions by numerous pain management physicians. He indicated that appellant's response to 10 knee operations was less than satisfactory, and he was not sure an additional neck surgery would fare any better. Dr. Epstein advised that appellant's chronic, multisite pain syndrome was likely mediated by the central nervous system. He further noted that two objective EMG/NCV studies did not demonstrate any compressive radiculopathy findings in the upper extremities and five sequential cervical MRI scans demonstrate age-related progressive degeneration of the disc and facet joints at all cervical spinal levels. Dr. Epstein did not believe that a C3-C4 and C4-C5 fusion would decisively relieve appellant's chronic pain.

A July 29, 2021 MRI scan of the cervical spine revealed multilevel disc bulges or protrusion with multilevel uncinate and facet hypertrophy producing multilevel neural foraminal stenosis.

On January 31, 2022 Dr. Giri treated appellant in follow-up for bilateral arm pain with numbness and tingling in both arms. He noted appellant's treatment included anti-inflammatory medications, physical therapy for four weeks, and 10 cervical intra-articular injections. Dr. Giri diagnosed other cervical displacement, high cervical region, other cervical displacement at C4-C5 level, foraminal stenosis of cervical region, and neck sprain subsequent encounter. He recommended an updated MRI scan of the cervical spine to evaluate continued pain and weakness and opined that appellant would likely need surgery.

A February 10, 2022 MRI scan of the cervical spine revealed anterolisthesis of C5-C6, retrolisthesis of C3-C4, multilevel spondylosis with disc dehydration, endplate irregularity and spurring, annular disc bulge, disc herniation/disc protrusion with annular tear, slight central canal narrowing at C3-C4, and multilevel neural foraminal narrowing.

On February 14, 2022 Dr. Giri treated appellant in follow-up for bilateral arm pain with numbness and tingling in both arms. He noted no change in appellant's condition. Dr. Giri advised that she had tried conservative treatment without significant symptom relief. He diagnosed other cervical displacement, high cervical region, other cervical displacement at C4-C5 level, foraminal stenosis of cervical region, and neck sprain subsequent encounter. Dr. Giri continued to recommend a C3-C4 and C4-C5 anterior cervical discectomy and fusion with instrumentation.

On February 23, 2022 OWCP requested that an OWCP medical adviser address whether the requested C3-C4 and C4-C5 cervical fusion was warranted and necessitated by the accepted conditions. In a February 24, 2022 report, Dr. Epstein, the DMA, noted reviewing the medical record and SOAF. He noted that appellant had multisite, chronic pain disorder and an additional eleventh surgery was unlikely to provide substantial and dispositive relief. Dr. Epstein advised that she underwent 10 authorized body part surgeries with ongoing pain. He indicated that appellant was previously diagnosed with chronic regional pain syndrome, which was a painful neuropathic condition involving a single limb that can spread to other body parts and was not amenable to surgical intervention. Dr. Epstein reviewed the additional MRI scan of the cervical spine in November 2021, which revealed degenerative changes resulting in stenosis at C3-C4, C4-C5, and C5-C6. He further noted that the previous two EMG/NCV studies demonstrated no evidence of cervical radiculopathy. Dr. Epstein indicated that he found no new objective evidence to alter his 2019 opinion that the cervical spine fusion was not reasonable or medically necessary based on currently accepted medical practice standards.

By decision dated March 29, 2022, OWCP denied authorization for a cervical fusion. It based its decision on the report of the DMA who opined that the proposed surgery was not medically necessary or causally related to the accepted employment-related conditions.

LEGAL PRECEDENT

Section 8103 of FECA[3] 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] 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.[5]

Section 10.310(a) of OWCP's implementing regulations provide that an employee is entitled to receive all medical services, appliances, or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury.[6]

The Board has found that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness. OWCP has the general objective of fully 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.[7]

Abuse of discretion is 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.[8]

Section 8123(a) 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.[9]

ANALYSIS

The Board finds that OWCP improperly denied appellant's request for a cervical fusion. OWCP properly found that a conflict in medical opinion arose between Dr. Sethuraman, appellant's attending physician, and Dr. Tontz, a DMA, regarding whether the proposed cervical

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[3] 5 U.S.C. § 8101 *et seq*.

[4] 5 U.S.C. § 8103; *see D.S.*, Docket No. 18-0353 (issued May 18, 2020); *Thomas W. Stevens*, 50 ECAB 288 (1999).

[5] *M.P.*, Docket No. 19-1557 (issued February 24, 2020); *M.B.*, 58 ECAB 588 (2007).

[6] 20 C.F.R. § 10.310(a); *see D.W.*, Docket No. 19-0402 (issued November 13, 2019).

[7] *D.S.*, *supra* note 4.

[8] *Id.*; *L.W.*, 59 ECAB 471 (2008).

[9] 5 U.S.C. § 8123(a); *see Guiseppe Aversa,* 55 ECAB 164 (2003).

fusion should be authorized. Consequently, it referred appellant to Dr. Allen to resolve the conflict in medical opinion pursuant to 5 U.S.C. § 8123(a).

Dr. Allen, the IME, in his August 25, 2017 report, diagnosed multilevel cervical disc osteophyte complex with spinal neuroforaminal stenosis at C3-C4, C4-C5, and C5-C6, right knee lateral meniscus tear, chondromalacia of the patella, traumatic arthropathy, aggravation of impingement syndrome right shoulder, sciatica, radiculitis, brachial neuritis, and myringitis. He indicated that the bilateral knee replacement surgery was medically necessary and causally related to the accepted employment-related conditions. However, Dr. Allen did not address whether the proposed cervical fusion was medically necessary and causally related to the accepted employment-related conditions.

In a situation where OWCP secures an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification and/or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[10] If the IME is unable to clarify his opinion or if his requested supplemental report is also lacking rationale, OWCP shall refer appellant to a new IME for the purpose of obtaining a rationalized medical opinion on the issue.[11]

In this case, OWCP sought clarification from Dr. Allen on November 3, 2017; however, he failed to respond to OWCP's request for a supplemental report. It did not refer appellant to a new IME for the purpose of obtaining a rationalized medical opinion on the issue. For the above-described reasons, there remains an unresolved conflict in the medical opinion evidence regarding whether the proposed cervical fusion should be authorized.

The Board will set aside OWCP's March 29, 2022 decision and remand the case for proper development of the medical evidence. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that OWCP improperly denied appellant's request for a cervical fusion.

[10] *T.C.*, Docket No. 20-1170 (issued January 29, 2021); *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988).

[11] *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *Harold Travis*, 30 ECAB 1071 (1979).

ORDER

IT IS HEREBY ORDERED THAT the March 29, 2022 decision of the Office of Workers' Compensation Programs is reversed and the case is remanded for further proceedings consistent with the decision of the Board.

Issued: July 12, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board