United States Department of Labor
Employees' Compensation Appeals Board

W.C., Appellant	)	
and	)	**Docket No. 23-0204**
	)	**Issued: September 5, 2023**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Long Beach, CA, Employer	)	

Appearances:
Kelley Craig, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On November 28, 2022 appellant, through counsel, filed a timely appeal from a June 7, 2022 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 June 7, 2022 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 properly denied appellant's request for authorization for a C3-4 anterior cervical discectomy and fusion.

FACTUAL HISTORY

On April 22, 2005 appellant, then a 44-year-old supervisory entry officer, filed a traumatic injury claim (Form CA-1) alleging that she was lifting large heavy reports from a shelf when she pulled her left shoulder, neck, and back while in the performance of duty. She stopped work that same day and returned on April 25, 2005. OWCP initially accepted the claim for herniated discs at the C5-6 and C6-7 levels and cervical discogenic pain. It later expanded the acceptance of the claim to include chronic pain syndrome; displacement of cervical intervertebral disc without myelopathy; other and unspecified disc disorders, cervical region; other psychogenic pain; sprain of shoulder and upper arm, unspecified site, left; cervical spondylosis without myelopathy; and major depression. OWCP paid appellant wage-loss compensation on the supplemental rolls as of June 20, 2005, and on the periodic rolls as of October 2, 2005.

OWCP authorized anterior cervical complete discectomy C4-5, C5-6, and C6-7, partial vertebrectomy C4, C5, C6, and C7, fusion with allograft bone C4-5, C5-6, and C6-7, and anterior rigid fixation of C4-7 with Hallmark plate, performed on April 25, 2006. It authorized reexploration of cervical wound with removal of bone plug and repairs of left foraminal cerebrospinal fluid leak and reassemble bone grafting and cervical plate performed on April 27, 2007. OWCP authorized removal of anterior fixation plate C4-7, debridement, inspection of arthrodesis C4-5, C5-6, takedown of pseudoarthrosis C6-7 with partial vertebrectomy C6 and 7, redo fusion at C6-7 with allograft and trinity bone matrix, and placement of anterior fixation plate C6-7, performed on April 24, 2007. It authorized left shoulder surgery performed on April 23, 2011 and left C4-5 hemilaminotomy and left C4-5, C5-6 posterior cervical foraminotomy and medial fasciectomy performed on March 2, 2012.

On February 22, 2017 OWCP received a request for authorization for C3-4 anterior cervical discectomy and fusion from the treating physician, Dr. Tariq Javed, a Board-certified neurosurgeon.

On February 22, 2017 OWCP referred the surgical request, appellant's medical records, and a statement of accepted facts (SOAF) to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon acting as the district medical adviser (DMA).

In a February 27, 2017 report, the DMA, Dr. Berman, noted that appellant had undergone several surgeries. He noted an April 27, 2007 reexploration of cervical wound with removal of bone plug, repairs of left foraminal cerebrospinal fluid leak, and reassembly of bone grafting and cervical plate, with a postoperative diagnosis of status post revision fusion cervical C6-7 with C6-7 cerebrospinal fluid leak. The DMA also noted that on March 2, 2012 appellant underwent a left C4-5 hemilaminotomy and left C4-5, C5-6 posterior cervical foraminotomy and medial fasciectomy; a C4-5, C5-6 posterior arthrodesis; a C4-5, C5-6 posterior instrumentation with lateral mass screws and rods; micellized autologous local bone graft plus morcellized allograft (demineralized bone matrix putty), with intraoperative fluoroscopy with professional interpretation and intraoperative nerve physiologic monitoring, including somatosensory evoked potentials and motor evoked potentials monitoring; and a postoperative diagnosis of C4-5, C5-6

pseudoarthrosis and left C4-5, C5-6 foraminal stenosis. Dr. Berman explained that, because of the complex nature of the case and multiple failed procedures, including infection, he disagreed with the surgical request from Dr. Javed, and opined that it would be appropriate to obtain additional studies and to consider other measures prior to additional surgical intervention. The DMA recommended an electromyography (EMG) study to determine the specific level of radiculopathy and whether or not the pain that appellant was experiencing was in fact emanating from the disc level under consideration at C3-4. Dr. Berman also recommended a computerized tomography (CT) scan of the cervical spine with sagittal reconstruction to more precisely determine the exact nature of the pathology, both at the level of the proposed surgery and at the levels of the prior surgical interventions.

Following further development, OWCP received an August 21, 2017 clarification report from the DMA. Dr. Berman noted that the February 2, 2015 nerve conduction velocity (NCV) studies of the median and ulnar nerve were normal and the August 26, 2015 EMG, and NCV of the right upper extremity were normal. The DMA also noted that an April 17, 2017 repeat CT scan of the cervical spine, when compared with the December 5, 2016 magnetic resonance imaging (MRI) scan and August 7, 2016 CT scan, continued to show solid fusion from C4 to C6, with mature posterior osseous fusion mass present and mature inter body osseous fusion mass present at C4-5, C5-6, and C6-7. Dr. Berman further noted degenerative disease to a moderate degree at C4-5, the level of the proposed fusion, no evidence of any nerve root compression clinically or radiologically, and no electrodiagnostic evidence of nerve root compression. The DMA opined that, in view of the prior surgeries, there was no compelling reason for additional surgery, and no objective findings, either radiologically or clinically, that would justify additional surgery for radiculopathy. While Dr. Berman noted axial cervical spine pain, he explained this would be expected after the prior extensive fusion surgery and recommended conservative measures of exercise and possibly epidural steroid injections. The DMA opined that, because there was no evidence of disabling discogenic disease at C3-4, the requested surgery should not be performed, and noted that he had reviewed the diagnostic studies to reach this conclusion.

On October 8, 2019 Dr. Javed again requested authorization for a C3-4 anterior cervical discectomy and fusion. He related that the likelihood of success was about 50/50 since appellant had undergone four prior surgical procedures and she still had chronic pain in the neck and radiating to the left shoulder and down the arm. Dr. Javed noted that the surgical procedure would most likely help her left shoulder pain, and less likely to help with her neck pain as her prior surgeries had increased stiffness and loss of movement of the neck. He also noted that there was a slight risk that appellant would have difficulty swallowing after the proposed cervical surgery.

On November 5, 2019 OWCP referred the surgery request, appellant's medical records, and the SOAF to another DMA to determine if the surgery request was medically necessary based on her accepted conditions.

On November 16, 2019 Dr. Franklin M. Epstein, a Board-certified neurosurgeon serving as a district medical adviser (DMA), reviewed appellant's medical record and the SOAF and opined that the surgery requested by Dr. Javed was not medically necessary. The DMA opined, "While I appreciate Dr. Javed's candor, it is my medical opinion that the surgery proposed has very little chance -- much less than 50/50 -- of ameliorating this very chronic pain syndrome." Dr. Epstein explained that a fourth operation requires decisive and compelling pathology for justification which was not present in this case. The DMA noted that the current imaging study demonstrated "mild[-]to[-]moderate" foraminal stenosis that appeared to be symmetric at C3-4

and this degree of stenosis surrounding the exiting C4 nerve roots was not sufficient to warrant implicating the pathology as the cause of the 14-year chronic pain syndrome. Dr. Epstein explained that the C4 root innervates neck muscles and the trapezius and provides little innervation of the shoulder and no innervation of the arm, and therefore decompression of this root would not relieve the shoulder and arm symptoms. The DMA also noted evidence of substantial spinal cord injury at the C6-7 level, that would be a source of oppressive and intractable central pain referred to either or both upper extremities and opined that there was no surgical intervention that would resolve this pathology. Dr. Epstein further noted that appellant had not worked since the work injury 14 years prior at age 45 and opined that ongoing care should be minimized as her neurologic examination remained normal.

In a development letter dated November 26, 2019, OWCP provided a copy of the DMA's findings to appellant and requested that her physician respond. It afforded her and her physician 30 days to submit the requested evidence.

In a letter dated December 23, 2019, appellant, through counsel, requested an extension of time to respond to the November 26, 2019 development letter.

In a report dated January 15, 2020, Dr. Michael S. Lott, a Board-certified pain medicine specialist, opined that appellant was unemployable due to the long segment fusion of the cervical spine with myelomalacia, moderate spinal stenosis above the fusion, and multiple left shoulder surgeries.

On January 4, 2021 OWCP referred appellant to Dr. John G. Keating, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine the nature and extent of her accepted employment-related conditions.

In a January 27, 2021 report, Dr. Keating reviewed the SOAF, and noted that appellant's claim was accepted for cervical disc herniation at C5-6 and C6-7, sprain of the left shoulder, cervical spondylosis without myelopathy, cervical discogenic pain, and major depressive disorder. He also noted that surgery was requested for a C3-4 anterior approach for stabilization above the level that had already been fused. Dr. Keating opined that appellant was "not a candidate for further surgery today and based on the functional overlay that she displayed today on today's examination. This is a fertile field for disaster in regard to adjacent segment surgery as high as C3-4." He explained that he could not find any compelling clinical evidence on examination of an organic problem that could be improved with further surgery. Dr. Keating further explained that appellant's history with prior surgery had been poor, and opined that the chances of the requested surgery being successful were minimal. He advised that she was permanently disabled from any gainful employment.

By decision dated March 10, 2021, OWCP denied authorization for a C3-4 anterior cervical discectomy and fusion. It found that the evidence of record did not support that the surgery request was medically necessary to address the effects of appellant's work-related injury or accepted conditions under FECA.

On March 9, 2022 appellant, through counsel, requested reconsideration and submitted additional evidence. In a September 11, 2020 report, Dr. Javed explained that appellant presented with complaints of neck pain, bilateral trapezius, and shoulder pain, worse on the left than the right, and also had pain radiating down the arm, but her major complaint was neck pain and

trapezius pain bilaterally. He noted her history of a prior C4-7 anterior cervical discectomy and fusion; a pseudoarthrosis at the C6-7 level requiring a refusion using an anterior cervical plate, a C4-6 posterior decompression and instrumented fusion, findings of myelomalacia of the cervical spinal cord at the C6-7 level from her previous injury; and pain for management of some of the residual symptoms. Dr. Javed advised that an August 12, 2020 MRI scan showed development of junctional disease above and below the solid fusion at C4-7 from the prior anterior and posterior surgery. He diagnosed loss of disc height at C3-4 due to spondylosis, disc osteophyte complex anteriorly, and ligamentum flavum hypertrophy posteriorly, resulting in moderate spinal canal stenosis and mild-to-moderate bilateral foraminal stenosis, and disc osteophyte complex and spondylosis at the lower level below the fusion at C7-T1 resulting in mild spinal canal stenosis. Dr. Javed explained that development of degenerative changes with spinal and foraminal stenosis and spinal instability is a well-recognized complication of a fusion procedure in the spine and has been reported to occur at a rate of 3 percent a year and at a 10-year time interval following cervical fusion 20 to 25 percent of patients required additional surgery at the adjacent level in the cervical spine, based on the literature. He opined that appellant had developed junctional disease at the C3-4 level and early junctional changes at the C7-T1 level as a result of the previous C4-7 fusion and that, if she had not required a C4-7 fusion as a result of her work injury, she would be unlikely to develop C3-4 spondylosis and ligamentum flavum hypertrophy resulting in neck pain and trapezius pain, within a reasonable degree of medical certainty. Dr. Javed explained that, although the C4 nerve root supplies the trapezius muscle, the cervical musculature, and the diaphragm, as mentioned by Dr. Epstein, the sensory distribution of the C4 nerve root also includes the neck and shoulder area, and patients with C3-4 stenosis and C4 cervical radiculopathy often have pain in both shoulders and the trapezius muscle causing the type of symptoms appellant was experiencing. He concurred with Dr. Epstein that appellant had some residual symptoms as a result of the myelomalacia changes seen at the C6-7 level, but her major complaint was neck pain in the trapezius muscle and shoulder region which was consistent with the radiological abnormality seen at the C3-4 level. Dr. Javed opined within a reasonable degree of medical certainty that the C3-4 cervical spondylosis with moderate spinal stenosis accounted for the neck pain and the pain in the trapezius muscles and shoulder region, and had more than 50 percent chance of being helped by the surgery. He noted that appellant was fully aware that she would never obtain complete relief of all of the arm symptoms and some of the neck pain, but had been through a lengthy period of nonsurgical treatments none of which had produced a reduction in her neck pain, trapezius pain, and shoulder pain. Dr. Javed opined that, "based on my examination evaluation of [appellant's] radiological studies and review of a previous history that within a reasonable degree of medical certainty that a C3-4 anterior cervical discectomy and fusion would produce more than 50 percent relief of her neck pain trapezius pain and bilateral shoulder pain, but would not relieve the pain in her hands or numbness in her hands."

In a March 2, 2022 report, Dr. Lott diagnosed spondylosis without myelopathy or radiculopathy, cervical region, other cervical disc disorder, chronic pain syndrome, and other long-term drug therapy. He noted that Dr. Javed recommended C3-4 surgery in September 2020, and it was denied by OWCP on two separate occasions. Dr. Lott recommended the surgery request be approved to address the left cervical radiculopathy.

In a March 11, 2022 report, Dr. Javed noted that appellant had undergone an anterior cervical discectomy fusion procedure from C4-5, C5-6, and C6-7, and posterior cervical surgery with lateral mass screw placement at the C4-5 and C5-6 level due to a work-related injury in 2005. He noted that she was seen in his office in 2015 with complaints of neck pain associated with pain

radiating into both shoulders, with right shoulder pain worse than the left, and her examination revealed quite significant restriction of motion of the cervical spine due to neck pain. Dr. Javed explained that cervical spine x-rays confirmed a solid fusion from C4-5 through C6-7 and anterior cervical titanium plate fixation at the C6-7 level. He found cervical spondylosis at the C2-3 and C3-4 levels, and noted that an MRI scan of the cervical spine showed a moderately large diffuse disc osteophyte complex at C3-4, along with ligamentum flavum hypertrophy, resulting in moderate spinal canal and bilateral foraminal stenosis. Dr. Javed also found a small disc bulge at the C2-3 level, spondylosis at the C7-T1 level, and junctional disease at the level above her previous fusion, causing her neck pain and bilateral shoulder pain. He noted that appellant failed to respond to a lengthy period of nonsurgical treatment. Dr. Javed opined within a reasonable degree of medical certainty that she had approximately 50 to 60 percent chance of improvement of her neck pain and shoulder pain from an anterior cervical discectomy and fusion to decompress the spinal canal, and stabilize the cervical spine at the C3-4 level. He explained that the surgery was unlikely to relieve all of appellant's neck pain symptoms, but had a reasonably good chance with a reasonable degree of medical certainty of relieving her shoulder pain which was one of her major complaints. Dr. Javed noted that he discussed with her at length the potential benefits and risks of the surgery, and she was willing to proceed with the surgery. He indicated that he disagreed with Dr. Keating's opinion that a C3-4 anterior cervical discectomy and fusion is a "fertile field for disaster in regard to adjacent segment surgery as high as C3-4" and explained that Dr. Javed had performed over three thousand anterior cervical procedures, many of which had been at the C2-3 and C3-4 levels and in patients that had prior cervical procedures. Dr. Javed opined that, although there was a slightly high risk of complications in patients who had multiple surgeries in the cervical spine, he felt the requested surgery could be performed with a relatively low risk of complications.

By decision dated June 7, 2022, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

Section 8103 of FECA[4] provides for the furnishing of services, appliances, and supplies prescribed or recommended by a qualified physician which OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.[5] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under section 8103, and the only limitation on OWCP's authority is that of reasonableness.[6]

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

[4] *Supra* note 2.

[5] 5 U.S.C. § 8103(a); *see C.G.*, Docket No. 20-0784 (issued May 11, 2021); *M.P.*, Docket No. 19-1557 (issued February 24, 2020); *M.B.*, 58 ECAB 588 (2007).

[6] *B.I.*, Docket No. 18-0988 (issued March 13, 2020); *see also Daniel J. Perea*, 42 ECAB 214, 221 (1990) (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.[7] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[8] 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.[9]

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.[10]

ANALYSIS

The Board finds that OWCP properly denied appellant's request for authorization for a C3-4 anterior cervical discectomy and fusion.

In support of her request for authorization for C3-4 anterior cervical discectomy and fusion, appellant submitted a September 11, 2020 report from Dr. Javed, who opined that a C3-4 anterior cervical discectomy and fusion would produce more than 50 percent relief of her neck pain, trapezius pain, and bilateral shoulder pain, but would not relieve the pain or numbness in her hands. In a March 11, 2022 report, Dr. Javed opined that she had an approximately 50 to 60 percent chance of improvement of her neck pain and shoulder pain from an anterior cervical discectomy and fusion to decompress the spinal canal and stabilize the cervical spine at the C3-4 level. Appellant also provided a March 2, 2022 report from Dr. Lott, who recommended that the surgery request from Dr. Javed be approved to address the left cervical radiculopathy. However, these reports do not contain a rationalized medical opinion that the surgery was for an accepted condition or necessitated by the accepted April 21, 2005 employment injury.[11]

In his September 11, 2020 report, Dr. Javed advised that an August 12, 2020 MRI scan showed development of junctional disease above and below the solid fusion at C4-7 from the prior anterior and posterior surgery. He diagnosed loss of disc height at C3-4 due to spondylosis, disc osteophyte complex anteriorly, and ligamentum flavum hypertrophy posteriorly, resulting in moderate spinal canal stenosis and mild-to-moderate bilateral foraminal stenosis. Dr. Javed explained that development of degenerative changes with spinal and foraminal stenosis and spinal instability is a well-recognized complication of a fusion procedure in the spine and has been

[7] *J.M.*, Docket No. 20-0565 (issued November 5, 2020); *see R.M.*, Docket No. 19-1319 (issued December 10, 2019); *Debra S. King*, 44 ECAB 209 (1992); *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981).

[8] *K.W.*, Docket No. 18-1523 (issued May 22, 2019); *Bertha L. Arnold*, 38 ECAB 282 (1986); *Zane H. Cassell*, *id*.

[9] *P.L.*, Docket No. 20-0392 (issued October 28, 2020); *see T.A.*, Docket No. 19-1030 (issued November 22, 2019); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[10] *See J.K.*, Docket No. 20-1313 (issued May 17, 2021); *D.S.*, Docket No. 18-0353 (issued February 18, 2020); *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*, *supra* note 6.

[11] *See L.W.*, Docket No. 21-0607 (issued October 18, 2022); *see T.H.*, Docket No. 18-0704 (issued September 6, 2018). *See also L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018); *Charles H. Tomaszewski*, 39 ECAB 461 (1988).

reported to occur at a rate of 3 percent a year and at a 10-year time interval following cervical fusion 20 to 25 percent of patients required additional surgery at the adjacent level in the cervical spine, based on the literature. He opined that appellant had developed junctional disease at the C3-4 level as a result of the previous C4-7 fusion and that, if she had not required a C4-7 fusion as result of her work injury, she would be unlikely to develop C3-4 spondylosis and ligamentum flavum hypertrophy. However, in his report dated July 27, 2022, Dr. Javed explained that cervical spine x-rays confirmed a solid fusion from C4-5 through C6-7 and anterior cervical titanium plate fixation at the C6-7 level. The Board finds that his opinion that appellant developed C3-4 conditions due to her C4-7 conditions is not rationalized in light of his finding that she had a solid fusion at C4-7. Appellant 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] In this case, she has not shown how the requested surgical procedure is due to the effects of an employment-related injury or condition.[13]

The Board notes that the DMA, Dr. Berman, in a February 27, 2017 report, disagreed with the surgical requests from Dr. Javed and explained that, because of the complex nature of the case and multiple failed procedures, including infection, it would be appropriate to obtain additional studies and to consider other measures prior to additional surgical intervention. In an August 21, 2017 report, Dr. Berman explained that there was no compelling reason for additional surgery and no objective findings, either radiologically or clinically, that would justify additional surgery for radiculopathy. He further opined that, because there was no evidence of disabling discogenic disease at C3-4, the requested surgery should not be performed.

The Board further notes that the DMA, Dr. Epstein, in a November 16, 2019 report, opined that the surgery requested by Dr. Javed was not medically necessary and had "very little chance -- much less than 50/50 -- of ameliorating this very chronic pain syndrome." Dr. Epstein explained that a fourth operation required decisive and compelling pathology for justification that was not present in this case.

Furthermore, Dr. Keating, the second opinion physician, in his January 27, 2021 report, noted that surgery was requested for a C3-4 anterior approach for stabilization above the level that had already been fused, and opined that appellant was not a candidate for further surgery, based on the functional overlay that she displayed on examination. He explained that, "This is a fertile field for disaster in regard to adjacent segment surgery as high as C3-4" and that he could not find any compelling clinical evidence of an organic problem that could be improved with further surgery.

The Board finds that appellant has not shown that the requested procedures were causally related to the employment injury, and that the requested procedure was medically warranted. The Board therefore finds that there is no evidence that OWCP abused its discretion in denying authorization for her requested a C3-4 anterior cervical discectomy and fusion.[14]

[12] *Supra* note 7.

[13] *Id*.

[14] *S.W.*, Docket No. 18-1529 (issued April 19, 2019); *Rosa Lee Jones*, 36 ECAB 679 (1985).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128 and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP did not abuse its discretion in denying appellant's request for authorization for a C3-4 anterior cervical discectomy and fusion.

ORDER

IT IS HEREBY ORDERED THAT the June 7, 2022 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 5, 2023
Washington, DC

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

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

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