United States Department of Labor
Employees' Compensation Appeals Board

J.R., Appellant	)	
and	)	**Docket No. 17-1523**
	)	**Issued: April 3, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Baytown, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 3, 2017 appellant, through counsel, filed a timely appeal from a May 22, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether OWCP abused its discretion by denying authorization for a stationary bicycle.

FACTUAL HISTORY

On August 7, 2007 appellant, then a 41-year-old rural carrier, injured his neck, shoulder, and left arm when his mail truck was struck from behind while stopped at a traffic light in the performance of duty. OWCP accepted appellant's traumatic injury claim (Form CA-1) for left

[1] 5 U.S.C. § 8101 *et seq.*

shoulder bursae tendon disorders and expanded the acceptance of his claim to include bilateral disorder of the bursae and tendons in shoulder region, sprain of back, lumbar region, sprain of neck, degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, displacement of lumbar or lumbosacral intervertebral disc, and acquired spondylolisthesis. Appellant stopped work on August 7, 2007 and received supplemental payments from October 2 to 27, 2007. OWCP placed him on the periodic rolls on October 28, 2007.

Appellant was treated by Dr. K. Bobby Pervez, a Board-certified anesthesiologist, on August 20, 2007 for cervical and lumbar spine pain that developed after an August 7, 2007 work-related motor vehicle accident. Dr. Pervez diagnosed status post traumatic injury cervical and lumbar discogenic pain and cervical and lumbar radiculopathy. He recommended continued physical therapy. In an August 20, 2007 duty status report (Form CA-17), Dr. Pervez diagnosed cervical and discogenic pain and radiculopathy and indicated that appellant was off work until further notice.

Dr. Pervez continued to treat appellant. A magnetic resonance imaging (MRI) scan of the left shoulder dated September 17, 2007 revealed no fracture, intact acromioclavicular joint, thinning of cartilage of the glenohumeral joint, grade I signal change of the rotator cuff indicating degenerative changes with no evidence of a rotator cuff tear. An October 24, 2007 MRI scan of the cervical spine, revealed mild reversed lordosis of the cervical spine, moderate narrowing of C5-6 disc, posterior bulge at C3-4, C4-5, and C5-6. An October 24, 2007 lumbar spine MRI scan revealed grade I spondylolisthesis at L5-S1, disc bulge at L3-4 and L4-5.[2]

A February 16, 2016 MRI scan of the lumbar spine revealed spondylolisthesis at L5-S1, broad-based central disc herniation at L4-L5. A cervical spine MRI scan of even date revealed central left disc herniations at C4-C5, C5-C6, and C6-C7 with central stenosis and cord compression at C4-C5, C5-C6, and C6-C7.

Appellant saw Dr. Mical S. Duvall, a Board-certified orthopedist, on June 29, August 3 and 29, September 26, and October 24, 2016 for neck pain that radiated into both shoulders and lower back pain that radiated down both legs. He reported a back injury at work on August 7, 2007 when his mail truck was rear ended while he was stopped. Findings included limited range of motion of the cervical spine, right-sided C8 and T1 radiculopathy, and paraspinal muscular tenderness at extremes of range of motion. Dr. Duvall diagnosed degeneration of lumbosacral and lumbar intervertebral disc, displacement of lumbar and cervical intervertebral disc without myelopathy, rotator cuff disorder, and rotator cuff syndrome. He recommended physical therapy, aqua therapy, cervical epidural steroid injections, and trigger point injections. On August 15, 2016 Dr. Duvall also diagnosed muscle spasm. He performed ultrasound guidance trigger point

[2] On May 18, 2012 OWCP granted appellant a schedule award for 11 percent permanent impairment of the right upper extremity and 8 percent permanent impairment of the left upper extremity. Appellant disagreed with this decision and requested reconsideration. OWCP further developed appellant's schedule award claim (Form CA-7) and sent him to a second opinion physician and an OWCP medical adviser. It found a conflict of opinion and referred appellant to an impartial medical examiner. On March 15, 2017 OWCP denied appellant's claim for an increased schedule award. On March 31, 2017 appellant requested a review of the written record by an OWCP hearing representative and submitted additional medical evidence. The schedule award issue is not before the Board on the present appeal.

injections into the erector spine and transversarius and iliocostal and injections by fluoroscopic guidance at L4-L5.

A September 28, 2016 electromyogram (EMG) revealed findings consistent with bilateral carpal tunnel syndrome, bilateral ulnar sensory neuropathy, bilateral peripheral sensory neuropathy of both legs, right C7 nerve root irritation, and left L5 radiculopathy.

On September 28, 2016 OWCP authorized a series of three cervical and thoracic spine injections. On October 4, 2016 it authorized an MRI scan of the arms. On October 7, 2016 OWCP authorized three units of cervical and thoracic spine injections.

Appellant underwent a right shoulder MRI scan on October 5, 2016 which revealed bursal surface partial tear supraspinatus tendon, small insertional partial infraspinatus anchor, mild subdeltoid bursitis, and mild subacromial outlet narrowing.

On October 10, 2016 Dr. Duvall performed fluoroscopic guided injections at C7-T1, cervical interlaminar epidural steroid injection at C7-T1 and ultrasound guided trigger point injections into the bilateral rhomboids, trapezius, and supraspinatus. In an attending physician's report (Form CA-20) dated October 24, 2016, he noted that appellant was rear ended in a mail truck and injured his back and both shoulders. Dr. Duvall diagnosed lumbosacral, lumbar, and cervical disc displacement, and bilateral rotator cuff disorders. He checked a box marked "yes" that appellant's condition was work related noting that being hit while holding a steering wheel would cause his conditions. Dr. Duvall also requested that appellant have a stationary bike for range of motion and restrengthening along with physical therapy and aqua therapy.

Appellant subsequently submitted an August 29, 2016 prescription from Dr. Duvall requesting a stationary bike with electronic heart rate monitor. On October 24, 2016 Dr. Duvall advised that appellant was under his care for injuries he sustained at work. He noted that appellant did not experience significant improvement with conservative therapy and medical management. Dr. Duvall requested that appellant exercise at home with a stationary bike to improve range of motion, decrease pain, and increase mobility. He noted that appellant's compensable injuries were lumbar disc displacement, lumbar degeneration, and acquired spondylosis. Dr. Duvall reiterated that appellant was motivated, dedicated to improving his condition, and was compliant with regard to his treatment. He opined that appellant had the potential to significantly improve his recovery if provided with necessary and proper equipment to assist him in his recovery. In a durable medical equipment authorization request dated October 25, 2016, Dr. Duvall requested authorization for a stationary bike with a heart monitor for treatment of lumbar and cervical spine conditions.

On November 2, 2016 OWCP authorized a series of three cervical and thoracic spine injections, trigger point injections, and fluoroscopic guidance injections. It also authorized physical therapy and aqua therapy.

On November 7, 2016 Dr. Duvall performed injections at C7-T1, cervical interlaminar epidural steroid injection at C7-T1, and ultrasound trigger point injections into the bilateral rhomboids, trapezius, and supraspinatus.

On November 15, 2016 a durable medical equipment authorization request was submitted noting three quotes were obtained for a stationary bike with a heart monitor. OWCP requested

that a medical adviser address whether the requested stationary bicycle was warranted and necessitated by the accepted conditions.

In a November 14, 2016 report, the medical adviser noted reviewing the medical record and statement of accepted facts. He noted that on October 24, 2016 Dr. Duvall recommended the use of a home exercise bicycle to improve range of motion, decrease pain, and increase mobility. The medical adviser noted that the use of a stationary bicycle would not improve range of motion, mobility, or decrease pain in the cervical spine, lumbar spine, or bilateral shoulders. The primary goal of an exercise bicycle was to provide cardiopulmonary exercise as well as strengthening of the lower extremities. The medical adviser opined that based on the above he did not feel that the weight of the medical evidence supported the need for a stationary bicycle as medically necessary or reasonable to treat appellant's ongoing work-related problems with the cervical spine, lumbar spine, and bilateral shoulders.[3]

By decision dated November 30, 2016, OWCP denied authorization for a home stationary bicycle as the evidence of record did not support that it was medically necessary to address the effects of the work-related injury.

Appellant came under the treatment of Dr. Paul E. Kobza, an osteopath, on October 31, 2016, for right shoulder pain due to a work-related motor vehicle accident on August 7, 2007. He reported no relief with physical therapy or injections. Dr. Kobza diagnosed right shoulder impingement syndrome and right shoulder partial thickness supraspinatus and infraspinatus tear and recommended additional physical therapy. In a November 14, 2016 Texas Workers' Compensation Work Status Report, he noted that appellant could return to work on November 14, 2016 with restrictions through December 5, 2016.

Appellant subsequently submitted reports from Dr. Duvall dated November 28, 2016 and January 16, 2017, which indicated that appellant's cervical epidural steroid injections improved his arm and shoulder pain and increased his range of motion. Dr. Duvall noted findings on examination of right-sided C8 and T1 radiculopathy and diagnosed degeneration of lumbosacral and lumbar intervertebral disc, displacement of lumbar and cervical intervertebral disc without myelopathy, disorder of rotator cuff, and rotator cuff syndrome. He recommended another series of cervical epidural steroid injections and trigger point injections.

On December 12, 2016 Dr. Duvall performed injections at C7-T1, C5-C6, and into the bilateral rhomboid, trapezius, and supraspinatus muscles.

In an undated letter appellant requested reconsideration. He requested that OWCP consider all evidence of record in his case and all positive and negative evidence material to the determination of the matter and give him the benefit of the doubt with respect to the exercise bike. In an appeal request form dated February 16, 2017, received by OWCP on February 21, 2017, appellant requested reconsideration of the November 30, 2016 OWCP decision.

[3] The memorandum from the medical adviser also addressed appellant's claim for a schedule award; however, this issue is not before the Board on appeal.

Appellant submitted an EMG dated October 3, 2016 which revealed right and left sensorimotor median neuropathy at the wrists consistent with carpal tunnel syndrome, bilateral ulnar sensory neuropathy, bilateral peripheral sensory neuropathy affecting the lower extremities, right C7 nerve root irritation, and left L5 radiculopathy.

Appellant submitted a December 19, 2016 report from Dr. Kobza who noted his continued complaints of bilateral shoulder pain stemming from a work injury on August 7, 2007. Dr. Kobza reported no relief from pain with therapy or steroid injections. He diagnosed right shoulder impingement syndrome and right shoulder partial thickness tear of the supraspinatus and infraspinatus muscles and recommended physical therapy. Appellant submitted reports from Dr. Duvall dated February 16, March 14, and April 12, 2017 who indicated that appellant had significant improvement with the Medrol dosepak. Dr. Duvall noted findings of right-sided C8-T1 radiculopathy and paraspinal muscular tenderness at extremes of range of motion. He noted diagnoses and recommended cervical epidural steroid injections, trigger point injections, physical therapy, and aqua therapy. Dr. Duvall also submitted evidence previously of record.

In a decision dated May 22, 2017, OWCP denied modification of the decision dated November 30, 2016.

LEGAL PRECEDENT

Section 8103(a) of FECA 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.[4] In interpreting section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[5] OWCP has administrative discretion in choosing the means to achieve this goal 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 establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[7] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[8]

[4] 5 U.S.C. § 8103(a).

[5] *Dale E. Jones*, 48 ECAB 648, 649 (1997).

[6] *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).

[7] *See Debra S. King*, 44 ECAB 203, 209 (1992).

[8] *Id.; see also Bertha L. Arnold*, 38 ECAB 282 (1986).

Section 10.310(a) of OWCP's implementing regulations provides 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.[9] OWCP procedures provide that nonmedical equipment such as waterbeds, saunas, weight-lifting sets, exercise bicycles, *etc.*, may be authorized only if recommended by the attending physician and if OWCP finds that the item is likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.[10]

ANALYSIS

OWCP accepted that appellant sustained a bilateral disorder of the bursae and tendons in shoulder region, sprain of back, lumbar region, sprain of neck, degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, displacement of lumbar or lumbosacral intervertebral disc, and acquired spondylolisthesis. Appellant seeks authorization for a stationary bicycle with a heart monitor. The Board finds that OWCP did not abuse its discretion by denying authorization for a stationary bike with a heart monitor.

Appellant provided a prescription note from Dr. Duvall dated August 29, 2016 for a stationary bike with electronic heart rate monitor. In October 24, 2016 reports, Dr. Duvall advised that appellant was under his care for injuries he sustained at work. He noted that appellant did not experience significant improvement with conservative therapy and medical management. Dr. Duvall recommended appellant exercise at home with a stationary bike to improve range of motion, decrease pain, and increase mobility. He opined that appellant had the potential to significantly improve his recovery provided the necessary and proper equipment. Likewise, in a durable medical equipment authorization request dated October 25, 2016, Dr. Duvall requested authorization for a stationary bike with a heart monitor for treatment of the bilateral lumbar and cervical spine. However, his reports failed to provide a rationalized opinion addressing why a stationary bicycle was medically warranted.[11] Rather, Dr. Duvall's opinion was speculative, noting the proper equipment "had the potential to significantly improve" appellant's recovery. He did not provide the necessary medical explanation as to how the stationary bicycle would cure, reduce the period of disability, or aid in lessening the amount of monthly compensation.[12] Therefore, this report is insufficient to meet appellant's burden of proof.[13]

[9] 20 C.F.R. § 10.310(a).

[10] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Services and Supplies*, Chapter 3.400.3.d(5) (October 1995); *see also* Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.17.h (June 2014).

[11] *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

[12] *See E.J.*, Docket No. 10-0743 (issued November 2, 2010).

[13] Medical opinions that are speculative or equivocal in character are of diminished probative value. *D.D.*, 57 ECAB 734 (2006)

Other reports provided by Dr. Duvall dated June 29 to October 24, 2016 and November 28, 2016 to April 12, 2017 are of limited probative value as they do not specifically address whether the requested stationary bicycle is medically necessary and warranted and would cure, reduce the period of disability, or aid in lessening the amount of monthly compensation for the accepted bilateral disorder of the bursae and tendons in shoulder region, sprain of back, lumbar region, sprain of neck, degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, displacement of lumbar or lumbosacral intervertebral disc, and acquired spondylolisthesis and medically warranted.[14]

Other reports from Dr. Kobza dated October 31 to December 19, 2016 noted treatment for bilateral shoulder pain due to a work-related motor vehicle accident on August 7, 2007. Dr. Kobza diagnosed right shoulder impingement syndrome and right shoulder partial thickness tear of the supraspinatus and infraspinatus muscles. However, he failed to address whether the stationary bicycle was medically necessary and how it would cure, reduce the period of disability, or aid in lessening the amount of monthly compensation.[15]

Additionally, the Board notes that OWCP sought the advice of its medical adviser in this matter. In a November 14, 2016 report, OWCP's medical adviser opined that the use of a stationary bicycle would not improve range of motion, mobility, or decrease pain in the cervical spine, lumbar spine, or bilateral shoulders. He noted that the primary goal of an exercise bicycle was to provide cardiopulmonary exercise as well as strengthening of the lower extremities. The medical adviser opined that the weight of the medical evidence did not support the need for a stationary bicycle as medically necessary or reasonable to treat appellant's ongoing work-related problems with the cervical spine, lumbar spine, and bilateral shoulders.

As noted, the only limitation on OWCP's authority is approving or disapproving service under FECA is one of reasonableness.[16] Because appellant did not submit a reasoned medical opinion explaining how t stationary bicycle would cure, reduce the period of disability, or aid in lessening the amount of monthly compensation, OWCP properly acted within its discretionary authority to deny authorization for the requested equipment. Therefore, the Board finds that OWCP did not abuse its discretion under section 8103 in denying approval of the stationary bicycle.

On appeal appellant argues that he needed the stationary bicycle to aid in his recovery from the accepted medical conditions, but as discussed, he did not show that the equipment was medically necessary or reasonable to treat his ongoing work-related problems with the cervical spine, lumbar spine, and bilateral shoulders. The medical evidence of record is insufficient to establish that OWCP abused its discretion in denying authorization for the stationary bicycle.

[14] *See A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[15] *See supra* note 12.

[16] *Supra* note 6.

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(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP did not abuse its discretion by denying authorization for the stationary bicycle.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 22, 2017 is affirmed.

Issued: April 3, 2018
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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