United States Department of Labor
Employees' Compensation Appeals Board

L.D., Appellant	)	
and	)	**Docket No. 13-69**
	)	**Issued: June 4, 2013**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Coppell, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 10, 2012 appellant filed a timely appeal from a September 7, 2012 Office of Workers' Compensation Programs' (OWCP) merit decision denying her request for surgery. 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 the case.

ISSUE

The issue is whether OWCP properly denied authorization for lumbar fusion surgery.

FACTUAL HISTORY

On July 11, 2006 appellant, then a 40-year-old transportation security screener, filed a traumatic injury claim alleging that on the same day while assisting a passenger through a metal detector, the passenger pulled her hand jerking her forward and injuring her back. She stopped

[1] 5 U.S.C. §§ 8101-8193.

work on July 11, 2006 and returned to light duty on July 19, 2006 and stopped completely on September 11, 2011. OWCP accepted appellant's claim for thoracic or lumbosacral neuritis or radiculitis and sprain of the ribs.[2]

Appellant was treated by Dr. U.S. Walia, a Board-certified orthopedic surgeon, from July 14 to August 1, 2006, who diagnosed S1 radiculopathy aggravated by a work-related injury. Dr. Walia recommended conservative care and returned her to light-duty work. In reports dated February 21 to March 21, 2011, he noted appellant's complaints of increasing pain, radiating down her left leg and diagnosed left L5-S1 radiculopathy. Dr. Walia noted that conservative treatment failed and referred her for a surgical consultation.

On April 19 and June 23, 2011 appellant was treated by Dr. Robert T. Myles, a Board-certified orthopedic surgeon, for low back and left leg pain after a 2004 work injury. Dr. Myles noted findings that included tenderness around L5-S1 and intact sensation and equal strength bilaterally. He diagnosed lumbago, thoracic or lumbosacral neuritis or radiculitis and internal disc derangement at L5-S1 with instability. Dr. Myles opined that appellant failed conservative treatment and recommended surgery. On November 5, 2008 appellant underwent an electromyogram (EMG) which revealed left chronic L5-S1 radiculopathy. On April 22, 2009 she underwent a lumbar discogram which revealed three level disc disease with disruptions at L3-4, L4-5 and L5-S1. A lumbar magnetic resonance imaging (MRI) scan dated June 10, 2011 revealed circumferential disc bulge at L5-S1 that touched the thecal sac, as well as bilateral facet arthrosis and mild bilateral neural foraminal narrowing.

On September 13, 2011 Dr. Myles requested authorization for surgery. In an accompanying June 23, 2011 report, he diagnosed internal disarrangement at L5-S1 with instability and recommended a lumbar spine fusion with instrumentation at L5-S1. In subsequent reports, Dr. Myles noted diagnoses and recommended surgery.

In a September 16, 2011 letter, OWCP advised that further claim development was needed before surgery authorization could be given. On October 18, 2011 it referred appellant's case record to OWCP's medical adviser for an opinion as to whether the proposed lumbar fusion surgery was indicated in the treatment of appellant's July 11, 2006 work injury that was accepted for thoracic or lumbosacral neuritis or radiculitis and sprain of the ribs. In an October 20, 2011 report, the medical adviser noted that Dr. Myle's June 23, 2011 report noted left-sided pain, while the EMG revealed right-sided radiculopathy. He also noted that the discogram showed positive findings at L3-4 and L4-5 which were levels noted to be normal on the MRI scan dated June 10, 2011. The medical adviser opined that the pain generator was not well defined and recommended that a second surgical opinion be obtained.

Reports from Dr. Walia dated October 14, 2011 to January 17, 2012, diagnosed left L5-S1 radiculopathy and recommended electrical stimulation therapy, pain medications and surgery.

[2] This claim is consolidated with two other claims. In file number xxxxxx706, OWCP accepted that on May 20, 2004 appellant sustained a lumbar sprain/strain while loading luggage on a belt. In file number xxxxxx816, it accepted that on April 4. 2012, she slipped on a wet floor and sustained multiple contusions of her upper body, including her back, as well as sprains of the neck and left shoulder region.

OWCP referred appellant to Dr. Marvin E. Van Hal, a Board-certified orthopedic surgeon, for a second opinion examination. In a December 28, 2011 report, Dr. Van Hal indicated that he reviewed the records provided and examined appellant. He noted findings of intact sensation and strength in the upper and lower extremities, straight leg raises caused low back pain and limited cervical and lumbar range of motion due to pain. Dr. Van Hal noted that April 11, 2011 lumbar spine x-rays revealed no instability, spondylolysis or spondylolisthesis. His diagnoses included status post lumbar sprain/strain associated with the 2006 work incident which involved a strain to the thoracic cage but no evidence of radiculopathy. Dr. Van Hal advised that appellant had adequate conservative treatment with symptoms greater than findings. He advised that she was not a surgical candidate for her lumbar spine noting that a discogram was positive at L3-4 and L4-5 and the L5-S1 level was not accessible. Dr. Van Hal noted the proposed surgery would be to level L4-S1 and build on the platform of level L3-4 which appellant notes was painful. He also stated that appellant was a smoker which is a contraindication to fusion surgery. Dr. Van Hal opined that she should not be considered for lumbar spine fusion surgery for discogenic type of pain disorder as she had no spine instability and her self-limited behavior and excessive and prolonged symptoms were harbingers of dismal results from surgery. He further opined that appellant's work-related condition was at most a lumbar sprain or strain which would not require a fusion procedure and he found no evidence based medicine to support a fusion procedure.

Appellant submitted reports from Dr. Walia dated February 20 to July 23, 2012 who diagnosed left L5-S1 radiculopathy. In reports dated March 15 and May 10, 2012, Dr. Myles diagnosed lumbago and internal disc derangement of the lumbar spine. He indicated that appellant continued to have debilitating low back pain with radiculopathy and recommended a second opinion. Appellant was seen by Dr. Larry Kjeldgaard, an osteopath, on April 10, 2012, who noted a history of injury in 2004 and 2006 and diagnosed pars interarticularis defect L5 bilaterally with spondylolysis and internal disc disruption at L5-S1. Dr. Kjeldgaard noted examination findings of pain with straight leg raises, quadriceps and hamstring strength intact and symmetrical, sensation was intact to light touch but diminished over the right S1 dermatome, with limited spinal extension. He noted that the MRI scan of June 10, 2011 missed spondylosis but noted it was obvious on plain films. Dr. Kjeldgaard recommended a 360 fusion at L5-S1.[3]

OWCP found that a conflict of medical opinion existed between Dr. Myles, who diagnosed internal disc derangement of the lumbar spine at L5-S1 with instability and recommended a lumbar fusion and Dr. Van Hal, who diagnosed status post lumbar sprain/strain and opined that a lumbar spine fusion was inappropriate as appellant had no spinal instability and that the proposed surgery was not causally related to the work injury.

To resolve the conflict OWCP, on July 5, 2012, referred appellant to a referee physician, Dr. Charles W. Kennedy, Jr., a Board-certified orthopedic surgeon. In an August 17, 2012

[3] The employing establishment submitted a June 14, 2012 report from Dr. Marianne Cloeren, an employing establishment physician Board-certified in occupational and internal medicine, who reviewed the file and opined that there was a conflict of opinion between the treating physician, Dr. Myles and the second opinion physician with regards to authorizing the proposed lumbar fusion surgery. Dr. Cloeren opined that surgery had a low chance of making appellant better and a high chance of making her worse and recommended that OWCP refer appellant for a referee examination.

report, Dr. Kennedy noted reviewing the record, including the history of appellant's work injury. Examination revealed mild tenderness across the low back. Appellant was able to walk on heels and toes without difficulty and get on the examination table without difficulty. Patellar tendon reflexes were equal bilaterally, there was no numbness or weakness of the legs, no atrophy, negative straight leg raises and a negative Faber's test. Dr. Kennedy opined that appellant did not have any objective findings upon examination and no neurological findings, rather, appellant expressed subjective complaints of pain. He noted that the June 6, 2011 MRI scan of the lumbar spine revealed multilevel degenerative disc disease, mild at L4-5, no disc herniation at L5-S1, mild degenerative disc and bulge and opined that these findings were normal for a person of appellant's age. Dr. Kennedy opined that the proposed surgical procedure was not related to the work injury of July 11, 2006 and he did not believe the diagnosed condition warranted surgery. He noted that upon clinical examination and review of the medical records, appellant was not a candidate for any type of injection therapy or surgical procedure including a fusion as there were no abnormalities supporting this on physical examination. Dr. Kennedy recommended an aggressive home exercise and strengthening program three times a week indefinitely. He opined that surgery was not appropriate and he saw no reason why appellant could not return to light duty. Dr. Kennedy noted that she was not working because of a left shoulder injury.

On July 10, 2012 Dr. Myles requested authorization for a lumbar spine fusion, removal of vertebral body and removal of spinal lamina.

In a decision dated September 7, 2012, OWCP found that Dr. Kennedy's opinion represented the weight of medical evidence and denied authorization for the lumbar spinal fusion.

LEGAL PRECEDENT

Section 8103 of FECA[4] 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.[5] While OWCP is obligated to pay for treatment of employment-related conditions, the employee has the burden of establishing that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.[6]

In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in approving services provided under section 8103, with the only limitation on OWCP's authority being that of reasonableness.[7] 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

[4] 5 U.S.C. §§ 8101-8193.

[5] *Id.* at § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

[6] *Kennett O. Collins, Jr.*, 55 ECAB 648 (2004).

[7] *See D.K.*, 59 ECAB 141 (2007).

to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[8] To be entitled to reimbursement of medical expenses, a claimant has the burden of establishing 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.[9] 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.[10]

Section 8123(a) of FECA 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.[11] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or OWCP's medical adviser, OWCP shall appoint a third physician to make an examination. 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.[12] When there exist opposing medical reports of virtually equal weight and rationale and the 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 upon a proper factual background, must be given special weight.[13]

ANALYSIS

OWCP accepted that appellant sustained an employment-related thoracic or lumbosacral neuritis or radiculitis and sprain of the ribs on July 11, 2006. It determined that a conflict in medical opinion existed between her attending physician, Dr. Myles, who diagnosed lumbago and thoracic or lumbosacral neuritis or radiculitis, internal disc derangement at L5-S1 with instability and recommended a lumbar fusion at L5-S1 and Dr. Van Hal, an OWCP referral physician, who diagnosed status post lumbar sprain/strain and noted that appellant had no spinal instability and opined that the proposed surgery was not causally related to the employment injury and was not medically warranted. Consequently, OWCP properly referred appellant to Dr. Kennedy to resolve the conflict.

The Board finds that the weight of the medical evidence rests with the opinion of Dr. Kennedy, the impartial specialist, who examined appellant, reviewed the medical evidence and found that the lumbar surgery was not medically warranted. As noted, for a surgical procedure to be authorized, a claimant must show that the surgery is for a condition causally

[8] *Minnie B. Lewis*, 53 ECAB 606 (2002).

[9] *M.B.*, 58 ECAB 588 (2007).

[10] *R.C.*, 58 ECAB 238 (2006).

[11] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701(2008).

[12] 20 C.F.R. § 10.321.

[13] *V.G.*, 59 ECAB 635 (2008).

related to a work injury and that it is medically warranted. In an August 17, 2012 report, Dr. Kennedy reviewed appellant's history, reported findings and noted that she did not have any objective findings on examination and no neurological findings. He noted some mild tenderness across the low back but indicated that appellant was able to walk on heels and toes without difficulty, patellar reflexes were equal bilaterally, there was no numbness or weakness of the legs and straight leg raises were negative. Dr. Kennedy noted that the June 6, 2011 MRI scan of the lumbar spine revealed multilevel degenerative disc disease, mild at L4-5 and no disc herniation at L5-S1 and opined that these findings were normal for a person of appellant's age. He opined that the proposed surgery was not related to the work injury and he did not believe the diagnosed condition warranted surgery. Dr. Kennedy further noted that upon clinical examination and review of the medical records, appellant was not a candidate for any type of injection therapy or surgical procedure including a fusion as there were no abnormalities supporting this on physical examination. He recommended conservative and nonsurgical treatment including an aggressive home exercise and strengthening program.

As noted, a reasoned opinion from a referee examiner is entitled to special weight.[14] The Board finds that Dr. Kennedy provided a well-rationalized opinion based on a complete background, his review of the accepted facts and the medical record and his examination findings. Dr. Kennedy's opinion that the lumbar spine surgery was not medically warranted is entitled to special weight and represents the weight of the evidence.[15]

Following Dr. Kennedy's report, appellant submitted evidence from Dr. Myles which requested authorization for surgery. However, submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is, generally, insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[16] Appellant also submitted evidence from other physicians. Reports from Dr. Walia noted appellant's complaints of pain and diagnosed left L5-S1 radiculopathy. Although Dr. Walia indicated in certain reports that appellant needed surgery, he did not specifically discuss how the need for surgery was causally related to her work injuries. As noted, proof of causal relationship in a case such as this must include supporting rationalized medical evidence and his reports are therefore not relevant to the issue in this case. In an April 10, 2012 report, Dr. Kjeldgaard noted the history of appellant's work injuries, provided diagnoses and recommended a 360 fusion at L5-S1. Although Dr. Kjeldgaard recommended the proposed lumbar fusion surgery, he also failed to provide a rationalized showing that the surgery was causally related to the work-related injuries and why it was medically warranted. These reports are insufficient to establish that the need for surgery is causally related to the accepted conditions and that it is medically warranted.

The only limitation on OWCP's authority in approving or disapproving service under FECA is one of reasonableness.[17] In the instant case, appellant requested surgery. OWCP

[14] *Id*.

[15] *Id.*

[16] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[17] *Daniel J. Perea*, 42 ECAB 214, 221 (1990).

obtained an impartial medical examination through Dr. Kennedy who clearly found the surgery unnecessary. It therefore had sufficient evidence upon which it made its decision to deny surgery and did not abuse its discretion.

On appeal, appellant asserts that she disagreed with the decision denying her request for lumbar fusion surgery and notes that she has a bulging disc and is in severe pain. As noted above, OWCP obtained a referee examination from Dr. Kennedy who found that the proposed surgery was not causally related to the accepted work injury and was medically unwarranted based on his examination findings and a review of the record.

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 properly exercised its discretion when it denied authorization for the recommended surgical procedure to appellant's lumbar spine.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 7, 2012 is affirmed.

Issued: June 4, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board