United States Department of Labor
Employees' Compensation Appeals Board

E.U., Appellant	)	
and	)	**Docket No. 13-1853**
	)	**Issued: January 16, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Denver, CO, 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
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 6, 2013 appellant filed a timely appeal of a July 3, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied authorization for an epidural injection. 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 appellant authorization for an epidural injection.

FACTUAL HISTORY

OWCP accepted that appellant, then a 49-year-old letter carrier, sustained injury as a result of carrying mail with her left arm on September 23, 2011. It accepted sprain of left shoulder and upper arm, sprain of the neck, complete rotator cuff rupture on the left, sprain of the superior glenoid labrum with lesion on the left and sprain of the supraspinatus on the left.

[1] 5 U.S.C. § 8101 *et seq.*

OWCP authorized a March 12, 2012 arthroscopic repair of the left shoulder. Appellant returned to modified duty on June 27, 2012. She received compensation benefits.[2]

OWCP received a request for authorization for an epidural injection of the foramen from appellant's treating physician, Dr. Nicholas K. Olsen, an osteopath and Board-certified physiatrist. In a February 12, 2013 report, Dr. Olsen noted that he had discussed an interventional procedure to address the disc protrusion identified on a magnetic resonance imaging (MRI) scan. The risks and benefits of an epidural steroid injection and the possibility of a surgical consultation was discussed and appellant was interested in the injection. She understood that it was not a fix but was designed to decrease inflammation and work adjunctively with her exercise routine. Dr. Olsen recommended a left C5-6 transforaminal epidural steroid injection.

In a letter dated February 19, 2013, OWCP advised appellant that the evidence of record was insufficient to authorize the proposed treatment as it did not appear to be medically necessary for or causally related to the accepted conditions. It requested that she submit additional evidence from her physician supporting the request.

In a March 4, 2013 report, Dr. Olsen noted that appellant returned for reexamination of her cervical spine. He determined that her neural foraminal compression test remained positive on the left. Dr. Olsen explained that appellant's neurological examination was unchanged demonstrating decreased sensation to pinprick test in the left C5 and C6 dermatomes. He diagnosed cervical sprain; strain work related, disc protrusion at C5-6 per MRI scan from December 12, 2011 and clinical signs of left C5-6 radiculitis. Dr. Olsen advised that appellant was being referred to a surgeon as the request for a C5-6 transforaminal epidural steroid injection was denied.

In a March 11, 2013 report, Dr. Bryan Andrew Castro, a Board-certified orthopedic surgeon, noted appellant's history of injury and medical treatment. He stated that an MRI scan revealed a bulging C5-6 disc, which was posteriorly displacing a left greater than right central canal and cord, although there was no cord signal change appreciated. Dr. Castro explained that appellant had ongoing neck and left shoulder pain. He stated that the left shoulder was her main problem and explained that, because of the disc herniation at the C5-6 level, it was reasonable to consider an injection. Dr. Castro concurred with Dr. Olsen that a C5-6 transforaminal injection could be helpful for treatment as well as diagnostic consideration. He also recommended further evaluation.

In a March 25, 2013 report, Dr. Olsen examined appellant and noted that her neural foraminal compression test demonstrated decreased left lateral bending and extension. Spurling's maneuver was positive on the left causing radiation into the left shoulder girdle and inspection of the left shoulder demonstrated no atrophy. Arthroscopic portals were well healed. Dr. Olsen indicated impingement signs I and II remained positive. Appellant had weakness with abduction and forward flexion. Dr. Olsen diagnosed disc protrusion at C5-6 with left-sided stenosis and history of shoulder decompression on the left side on March 2, 2012. He advised

[2] On November 13, 2012 appellant received a schedule award for five percent impairment of the left upper extremity.

that he had submitted a request for a left C5-6 transforaminal epidural steroid injection as well as an electromyography (EMG) scan and nerve conduction study (NCS) of the left upper extremity.

In an April 10, 2013 report, Dr. Olsen advised that he performed a left C5-6 transforaminal epidural steroid injection. In an April 25, 2013 report, he noted that appellant returned following the injection and she had significant improvement in her cervical complaints. Appellant's neck was 85 percent better with a 25 percent improvement in her left upper extremity symptoms. Dr. Olsen diagnosed work-related cervical sprain/strain, disc protrusion at C5-6 and C6-7 per MRI scan of December 12, 2011, and postpartial diagnostic response to a left C5-6 transforaminal epidural steroid injection. Appellant had significant improvement in her cervical complaints and partial relief of her arm symptoms with the possibility of a pain generator at the C6-7 level and a disc protrusion at that level. Dr. Olsen recommended a left C6-7 transforaminal epidural injection to address her ongoing left upper extremity symptoms.

OWCP referred appellant for a second opinion, together with a statement of accepted facts, a set of questions and the medical record to Dr. John D. Douthit, a Board-certified orthopedic surgeon. In a May 6, 2013 report, Dr. Douthit noted appellant's history of injury and medical treatment. On examination he advised that she had restricted motion of head to the left and pain with extension and flexion. Dr. Douthit also found tenderness throughout the neck and a range of rotation to the left of 45 degrees and to the right with 60 degrees and lateral bending with 30 degrees bilaterally. He explained that the right shoulder had full range of motion and the left shoulder was measured at 140 degrees of flexion and 110 degrees of abductions, 80 degrees of external rotation, 40 degrees of extension. Appellant had pain and restricted motion of her neck, and pain and restricted motion of the left shoulder with an arthroscopic scar. Dr. Douthit noted that the MRI scan showed degenerative disease of the cervical spine with prior surgery to the left shoulder, which had been unsuccessful. He opined that appellant had work-related pain of the left shoulder and cervical spine. In response to what treatment he would recommend, Dr. Douthit advised that there was no medical treatment to resolve her condition, which was permanent. He indicated that she was disabled and impaired. Dr. Douthit set forth appellant's work restrictions.

In a letter dated June 14, 2013, OWCP requested that Dr. Douthit prove clarification with regard to whether appellant's degenerative cervical spine condition was related to the accepted injury and whether a foraminal steroid injection should be authorized.

In a June 17, 2013 addendum, Dr. Douthit advised that the relationship of the persistent pain in appellant's shoulder and neck were based on her allegations and there were no objective findings. He explained that the degenerative disease process of aging was not caused by work. Appellant had mild cervical spine degenerative disease from which she alleged to have pain. She also had mild pathological changes of her shoulder and alleged pain. Dr. Douthit noted that there were no findings to verify the persistence of impairment related to an on-the-job injury and this was a subjectively based claim. He opined that "the history she gave of injury may have caused a transient pain of her cervical spine but this would have been temporary and would not have persisted except that [it] is related to her aging and intolerances for the type of work she was doing. I would term this an intolerance to her job duties rather than an impairment arising from a work injury." Dr. Douthit indicated that there were no objective findings of the cervical spine or the left shoulder that supported persisting pain that she had as a result of her work. Regarding

the need for epidural steroid injections, he opined that the procedure should not be authorized. Dr. Douthit noted that he found restricted neck and shoulder motion on examination. He advised that shoulder surgery was largely unsuccessful with resultant persistent pain and he had no way to validate her story or of the amount of pain she alleged. Dr. Douthit reiterated that there were no objective or physical findings supporting the degree of reported impairment and disability.

By decision dated July 3, 2013, OWCP denied authorization for the epidural injection as not being medically necessary.

LEGAL PRECEDENT

Section 8103(a) 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.[3] 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.[4] The only limitation on OWCP's authority is that of reasonableness.[5] To be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury. This burden of proof includes providing supporting rationalized medical evidence.[6]

To establish that a medical procedure is warranted, a claimant must submit evidence to show that the procedure is for a condition causally related to the employment injury and that the procedure is medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.[7]

ANALYSIS

On February 12, 2013 Dr. Olsen, appellant's treating physician, requested authorization for an injection of the foramen epidural injection. However, his February 12, 2013 report did not specifically explain how the requested procedure was medically necessary for treatment of the effects of an employment-related condition. Dr. Olsen's March 4, 2013 report, noted appellant's status but again did not specifically address why the requested procedure was necessitated by an accepted condition. His later reports also do not specifically explain why the requested injection was medically warranted for treatment of an accepted condition. In his

[3] 5 U.S.C. § 8103(a).

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

[5] *Daniel J. Perea*, 42 ECAB 214 (1990) (holding that 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).

[6] *F.T.*, Docket No. 09-919 (issued December 7, 2009).

[7] *See R.L.*, Docket No. 08-855 (issued October 6, 2008).

March 11, 2013 report, Dr. Castro indicated that a transforaminal injection could be helpful in treating appellant but he did not specifically address why this procedure was necessary for treatment of the effects of an employment-related injury. Consequently these reports are of limited probative value regarding whether the requested injection was medically needed for the treatment of an accepted work-related condition.

OWCP referred appellant for a second opinion examination with Dr. Douthit, a Board-certified orthopedic surgeon to determine whether the surgery was warranted. In a May 6, 2013 report, Dr. Douthit noted appellant's history and findings. In a June 17, 2013 addendum, he explained that the relationship of persisting pain in her shoulder and neck were based on her allegations and there were no objective findings. Dr. Douthit noted that degenerative disease was a process of aging and not caused by work. He explained that appellant had a mild degenerative disease of the cervical spine and alleged to have pain there as well as mild pathological changes of her shoulder. Dr. Douthit indicated that there were no objective findings of the cervical spine or the left shoulder to support any persisting pain that resulted from her work. He stated that he did not recommend the requested epidural steroid injection. Dr. Douothit explained that he had no way of validating the amount of pain that she claimed and reiterated that there were no objective findings to support the amount of impairment and disability asserted by appellant.

Based on the evidence of record, OWCP reasonably concluded that the proposed procedure was not needed for the treatment of a work-related condition. It did not abuse its discretion in denying authorization for arthroscopic surgery in this case.

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 pursuant to 5 U.S.C. § 8103(a) in refusing to authorize appellant's request for arthroscopic surgery.

ORDER

IT IS HEREBY ORDERED THAT the July 3, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 16, 2014
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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