United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 21-0854**
	)	**Issued: May 18, 2023**
U.S. POSTAL SERVICE, POST OFFICE, St. Louis, MO, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On May 19, 2021 appellant, through counsel, filed a timely appeal from an April 8, 2021 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]

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[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 appellant submitted additional evidence to OWCP following the April 8, 2021 decision. 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 at the time of its final decision 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 abused its discretion by denying authorization for additional cervical surgery.

FACTUAL HISTORY

On November 13, 2009 appellant, then a 50-year-old data entry operator, filed a traumatic injury claim (Form CA-1) alleging that on November 6, 2009 she sustained injuries to her neck while in the performance of duty. In an accompanying statement, she indicated that the injury occurred while lifting several boxes.

December 21, 2009 electromyogram and nerve conduction velocity (EMG/NCV) studies revealed evidence of severe peripheral neuropathy at the median nerves.

A July 23, 2010 magnetic resonance imaging (MRI) scan of the cervical spine read by Dr. Greg A. Jamroz, a diagnostic radiology specialist, revealed C3-C4 diffuse disc bulging with mild central canal narrowing; C4-C5 diffuse disc bulging with small superimposed central disc protrusion, and mild central canal narrowing; and C5-C6 moderate-size right disc protrusion, with flattening of the right anterior aspect of the cervical cord, moderate central canal narrowing and moderate bilateral neural foraminal narrowing.

OWCP accepted the claim for neck sprain, displacement of cervical intervertebral disc, cervical spondylosis without myelopathy, C5-C6 and C6-C7 displacement of cervical disc, C5-C6 cervical spondylosis without myelopathy, and C5-C6 spinal stenosis.[4] Appellant underwent OWCP-approved cervical surgery on March 20, 2014, performed by Dr. Donald A. deGrange, a Board-certified orthopedic surgeon. The procedure performed included C5-C6 partial corpectomy with decompression of the spinal cord and nerve roots; C5-C6 anterior cervical fusion with allograft; C6-C7anterior cervical discectomy with decompression of spinal cord and nerve roots; C6-C7 anterior cervical fusion with allograft; C5-C7 anterior segmental instrumentation with cervical plate.

A February 8, 2018 MRI scan read by Dr. Albert Hammerman, a Board-certified diagnostic radiologist, revealed mild disc bulging at C2-C3, mild posterior disc bulging at C3-C4 with mild foraminal narrowing on the right; C4-C5 mild-to-moderate posterior disc bulging mildly impressing on the adjacent cervical cord; postsurgical changes at C5-C6 and C6-C7, disc bulging, and foraminal narrowing.

In a May 16, 2019 report, Dr. deGrange diagnosed a C4-C5 herniated nucleus pulposus (HNP). After reviewing the February 8, 2018 MRI scan, he noted that it revealed findings of a central disc herniation at C4-C5 and a small bulge at C3-C4. Dr. deGrange recommended a C4-C5 cervical discectomy and fusion. He advised that appellant had a congenital spinal stenosis condition that remained present.

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[4] Appellant has a separate claim under OWCP File No. xxxxxx962 for an April 27, 2005 injury, accepted for minor thoracic sprain and preexisting disc bulge in the cervical area. OWCP denied claims for carpal tunnel syndrome due to work factors on September 9, 2013 and September 21, 2016 under OWCP File Nos. xxxxxx847 and xxxxxx731.

On June 10, 2019 OWCP denied authorization for exploration of spinal fusion, neck spine fusion and removal of Bel C2, insert spine fixation device and "SP Bone Algrft Struct Add-On."

In a June 14, 2019 report, Dr. deGrange noted appellant's history of injury and treatment and related that she had received multiple epidural injections that no longer provided relief. He examined her and noted her complaints of neck pain with bilateral upper extremity pain, tingling, numbness, and weakness. Dr. deGrange explained that appellant's symptoms were present on a daily basis and were moderate to severe. He noted that a February 2018 MRI scan revealed solid fusions at C5-C6 and C6-C7 and a new herniation at C4-C5. Dr. deGrange opined that the prior work-related fusion at C5-C6 and C6-C7 was the principal cause of appellant's further degeneration and herniation at C4-C5. He explained that adjacent segment degeneration, also known as breakdown, was a well-recognized cause of adjacent segment disease above or below the prior fusion levels.

In a July 18, 2019 report, Dr. deGrange noted that he had requested authorization for hardware removal, fusion exploration at C5-C6 and C6-C7, and decompression and fusion at C4-C5. He explained that authorization had been received for hardware removal, but not the other requested procedures. Dr. deGrange opined that it made no sense to perform the operation to remove the hardware without the authorization for the C4-C5 decompression and fusion. He explained that the prior work-related fusion at C5-C6 and C6-C7 was a well-recognized cause of adjacent segment disease, either above or below the prior fusion levels, and opined that the recent disc herniation discovered at C4-C5 was the result of the initial work-related injury.

On August 21, 2019 OWCP expanded acceptance of the claim to include the additional conditions of C4-C5 herniated nucleus pulposus, and C4-C5 disc degeneration as causally related to the accepted work injury.

On August 21, 2019 OWCP referred the case record and a statement of accepted facts (SOAF) to Dr. Kenechukwu Ugokwe, Board-certified in emergency medicine and serving as the OWCP district medical adviser (DMA), for review and an opinion on whether the procedures proposed by Dr. deGrange were medically warranted and causally related to the accepted, work-related medical conditions.

In a September 19, 2019 report, Dr. Ugokwe noted appellant's history of injury and treatment and the proposed procedures, and advised that he had reviewed reports from Dr. deGrange dated June 14 and July 18, 2019. He agreed that the current condition was causally related to the original work injury because appellant did not have neck pain prior to the work injury. However, Dr. Ugokwe advised that he did not agree with Dr. deGrange that the requested surgery was medically necessary because there was no recent MRI scan showing significant stenosis at C4-C5.

An October 3, 2019 MRI scan of the cervical spine read by Dr. James Douglas, a Board-certified diagnostic radiologist, revealed that appellant was post C5-C7 anterior/interbody fusion with slight straightening of the normal cervical lordosis, but no fracture or subluxation, and multilevel disc profile abnormalities and/or spur-disc complexes which contributed to mild-to-moderate multilevel central canal stenosis and multilevel foraminal encroachment. Regarding the C4-C5 level, Dr. Douglas noted that the MRI scan revealed left paracentral disc protrusion with

ventral cord contact and flattening, a shallow posterior disc bulge resulting in mild bilateral foraminal encroachment, and an AP diameter of the central canal of seven millimeters.

On October 9, 2019 OWCP requested that the DMA, Dr. Ugokwe, review the additional medical evidence and provide an updated opinion on the pending request for surgery authorization.

In an October 31, 2019 report, Dr. Ugokwe explained that he did not agree that the surgery was medically necessary because the October 3, 2019 MRI scan report did not show any significant stenosis.

On November 5, 2019 OWCP referred appellant for a second opinion examination with Dr. Jose A. Marchosky, a Board-certified neurosurgery specialist, for a current evaluation of the accepted conditions and a reasoned medical opinion addressing the request for surgical intervention.

In a December 19, 2019 report, Dr. Marchosky noted appellant's history of injury and medical treatment, and provided appellant's physical examination findings. He diagnosed carpal tunnel syndrome of the left and right upper extremities; spondylosis without myelopathy or radiculopathy, cervical region; and unspecified obesity. Dr. Marchosky opined that, more likely than not, appellant's ongoing complaints were due to peripheral neuropathy from nerve entrapment at the carpal tunnel bilaterally. He explained that a July 23, 2010 MRI scan of the cervical spine showed degenerative disc disease at C3-C4, C4-C5, and C5-C6 which had preceded the November 6, 2009 work injury by several years. Dr. Marchosky opined that a right paracentral disc protrusion at C5-C6 could not have been the result of the work injury and explained that 2010 EMG/NCV studies, several weeks after the work injury, revealed severe peripheral neuropathy at the median nerves, suggesting that was the more likely diagnosis for her presenting symptoms. He noted that in December 2014, appellant underwent C5-C6 and C6-C7 discectomies and fusion and opined that her persistent pain and paresthesias in the upper extremities after the surgery suggested the true cause of her symptoms had not been treated. Dr. Marchosky also noted that the 2018 and 2019 MRI scans of the cervical spine confirmed progressive degenerative disc and spondylotic disease at the level above the fusion segments and two and three levels above. He explained that this mitigated the assumption that this was only an adjacent level syndrome of the cervical spine. Dr. Marchosky noted that although 25 percent of patients who underwent anterior cervical fusion would develop adjacent level disease, the data was contradictory to the assumption that adjacent level disease was due only or mostly to the immobilization adjacent to the progression. He opined that, rather than embarking on treatment of the adjacent level syndrome, appellant should undergo release of the carpal tunnel entrapment of the median nerves as a first therapeutic and diagnostic procedure. Dr. Marchosky explained that, if a majority of the symptoms were alleviated by carpal tunnel release, then another major operation in the cervical spine with dubious benefits and the risk of accelerating degeneration of C3-C4, would be avoided. He explained that the clinical findings were substantial enough to indicate the disease process was entrapment of the median nerve at the carpal tunnel and noted that the December 21, 2009, EMG/NCV studies were indicative of median nerve entrapment neuropathy. Dr. Marchosky noted that, if further confirmation was needed, EMG/NCV testing could be repeated, but there was no need to do so.

On January 22, 2020 OWCP determined that a conflict of medical opinion evidence existed between Dr. Marchosky, the second opinion physician, and Dr. deGrange, appellant's treating physician, with regard to whether the cervical spine surgery authorization requested by

Dr. deGrange was medically necessary and causally related to the accepted employment conditions.

On February 3, 2020 OWCP referred appellant for an impartial medical evaluation with Dr. Michael H. Ralph, a Board-certified orthopedic surgeon selected as an impartial medical examiner (IME), to resolve the conflict. It provided Dr. Ralph with a SOAF, the medical record, and a series of questions.

In a report dated March 4, 2020, Dr. Ralph reviewed the history of injury, medical treatment, and the SOAF. He examined appellant and provided detailed examination findings. Dr. Ralph noted that appellant had EMG/NCV studies prior to the spinal fusion at C5-C6 and C6-C7 performed by Dr. deGrange in 2014, which were highly indicative of no nerve root compression in the neck. He also noted that she had bilateral carpal tunnel syndrome which had not been addressed. Dr. Ralph advised that his physical examination revealed marked limitation of forward flexion and internal rotation of both shoulders, suggestive of either adhesive capsulitis or primary glenohumeral arthritis. He noted a positive Phalen's test on both hands and that appellant complained of waking up at night. Dr. Ralph found there had been no surgical treatment for either wrist, range of motion of the elbows and wrists were normal, muscle strength testing throughout the upper extremities was normal, reflexes were normal, except for some slight decrease in the triceps on the left side, and muscle mass was within normal limits. He noted that he reviewed the 2018 and 2019 MRI scans of the cervical spine which revealed minimal changes at C4-C5, except for some narrowing of the cervical canal, not of a severe nature. Dr. Ralph noted that the 2019 MRI scan showed some stenosis of the nerve root on the left side between C6 and C7 that was not any different than the 2018 MRI scan and the description prior to surgery. He opined that appellant had some medical conditions that had not been addressed and were symptomatic, to include bilateral carpal tunnel syndrome, adhesive capsulitis, and degenerative arthritis of both shoulders. While he advised that those conditions required treatment, Dr. Ralph opined that they were unrelated to her work activity. He explained that there can be secondary problems long-term after multiple level fusions in the cervical spine, but that was not the case here. Dr. Ralph advised that appellant's current symptomatology was related to carpal tunnel syndrome and primary problems with both shoulders and that she did not require surgical treatment for her neck. He opined that from a medical standpoint, it would not be in her best interest to undergo surgical treatment at C4-C5.

By decision dated March 9, 2020, OWCP denied authorization for exploration of spinal fusion, neck spinal fusion and remove Bel C2, insert spine fixation device and "SP bone ALGRFT

Struct Add-On." It explained that the evidence did not support that the requested surgery was medically necessary "to address the effects of [her] work-related conditions under FECA."

On March 17, 2020 counsel for appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on July 16, 2020.

By decision dated October 1, 2020, OWCP's hearing representative affirmed the March 9, 2020 decision as the special weight of the evidence was represented by the report of the IME, Dr. Ralph.[5]

On February 15, 2021 counsel for appellant requested reconsideration and submitted new medical evidence from Dr. deGrange.

In a report dated January 28, 2021, Dr. deGrange noted that he performed the surgery on appellant for a two-level disc herniation at C5-C6 and C6-C7 in March 2014. He explained that despite good relief, in the ensuing six to seven years, appellant started to develop increasingly severe neck pain owing to a disc herniation at C4-C5, which was just above the previously fused levels. Dr. deGrange referred to the October 3, 2019 MRI scan of the cervical spine and noted that it revealed C4-C5 left paracentral disc protrusion with ventral cord contact and flattening and an AP diameter of the central canal of seven millimeters. He explained that the "key concept" was that there was flattening of the spinal cord and that the seven-millimeter diameter was severe stenosis compared to the normal diameter at that level, which is expected to be 12 to 15 millimeters. Dr. deGrange advised that the rationale for the requested surgery was that "[d]ecompression of the area would relieve the flattening of the spinal cord and provide resolution of the spinal stenosis." He opined that if the evidence of cord contact and flattening did not constitute stenosis, "I do not know what would." Dr. deGrange also recommended bilateral carpal tunnel surgery prior to the spinal fusion, as the hands recovered more quickly, and appellant would experience relief from the troubling symptoms.

In a February 19, 2021 report, Dr. deGrange noted that the diagnostic studies, including the 2018 and 2019 MRI scans of the cervical spine, revealed a disc herniation at C4-C5 which had noticeably worsened and now there was compression of the spinal cord that was not present earlier. He explained that the spinal compression was causing flattening and deformed the cord, and cord signal changes were inevitable. Dr. deGrange also determined that there was complete effacement of the cerebrospinal fluid around the cord, consistent with moderate-to-severe spinal stenosis. He also found a smaller disc herniation at C3-C4, without the attendant compression of the cord. Dr. deGrange diagnosed C4-C5 herniated disc and opined that based upon appellant's subjective complaints and objective findings on physical examination and diagnostic studies, she was a candidate for the C4-C5 decompression and fusion. He explained that, while the DMA did not find any significant stenosis, the 2019 MRI scan report noted "C4-C5: Left paracentral disc protrusion with ventral cord contact and flattening" and "AP diameter of the central canal of 7 mm." Dr. deGrange explained that this was a "textbook definition of spinal stenosis regardless of the omission of those specific words." Furthermore, he opined "[f]lattening of the spinal cord is

[5] On December 21, 2020 appellant's representative filed an appeal with the Board, assigned Docket No. 21-0825. On February 15, 2021 counsel for appellant requested that the appeal be dismissed. The Board subsequently dismissed the appeal on February 26, 2021. Docket No. 21-0825 (issued February 26, 2021).

the consequence of spinal stenosis." Dr. deGrange requested that a Board-certified neurosurgeon review the case.

By decision dated April 8, 2021, OWCP denied modification of its October 10, 2020 decision.

LEGAL PRECEDENT

Section 8103(a) of FECA[6] 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 by 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.[7] In interpreting this section of FECA, the Board has recognized that OWCP has broad discretion in determining whether a particular type of treatment is likely to cure or give relief.[8] The only limitation on OWCP's authority is that of reasonableness.[9]

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.[10] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[11] In order for a surgical procedure to be authorized, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted.[12] Both of these criteria must be met in order for OWCP to authorize payment.[13]

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.[14]

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[6] 5 U.S.C. § 8103(a).

[7] *Id.*; *see J.K.,* Docket No. 20-1313 (issued May 17, 2021); *Thomas W. Stevens*, 50 ECAB 288 (1999).

[8] *R.C.*, Docket No. 18-0612 (issued October 19, 2018); *W.T.*, Docket No. 08-812 (issued April 3, 2009).

[9] *D.C.*, Docket No. 18-0080 (issued May 22, 2018); *Mira R. Adams*, 48 ECAB 504 (1997).

[10] *R.M.*, Docket No. 19-1319 (issued December 10, 2019); *J.T.*, Docket No. 18-0503 (issued October 16, 2018); *Debra S. King*, 44 ECAB 203, 209 (1992).

[11] *K.W.*, Docket No. 18-1523 (issued May 22, 2019); *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[12] *T.A.*, Docket No 19-1030 (issued November 22, 2019); *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

[13] *J.L.*, Docket No. 18-0990 (issued March 5, 2019); *R.C.*, 58 ECAB 238 (2006); *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

[14] *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*, 42 ECAB 214 (1990).

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical examiner) who shall make an examination.[15] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[16] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical examiner 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.[17]

ANALYSIS

The Board finds that OWCP properly denied appellant's request for authorization of additional cervical surgery.

OWCP properly referred appellant, pursuant to 5 U.S.C. § 8123(a), to Dr. Ralph for an impartial medical examination and opinion in order to resolve the conflict in the medical opinion evidence between Dr. deGrange, appellant's treating physician, and Dr. Marchosky, an OWCP second opinion examiner, with regard to whether the proposed cervical surgery was medically necessary and causally related to the November 6, 2009 employment injury.

OWCP provided Dr. Ralph with a SOAF, which listed the accepted conditions and noted appellant's prior cervical surgery at C5-C7. In his March 4, 2020 report, Dr. Ralph opined that the proposed C4-C5 decompression and fusion was not medically necessary. He explained that appellant's 2018 and 2019 MRI scans showed minimal changes at C4-C5, except for some narrowing of the cervical canal not of a severe nature. Dr. Ralph explained that there could be secondary problems long term after multiple level fusions in the cervical spine, but that was not the case here. He advised that appellant's current symptomatology was related to carpal tunnel syndrome and primary problems with both shoulders, and that she did not require surgical treatment relating to her cervical spine. Dr. Ralph opined that from a medical standpoint, it would not be in her best interest to undergo cervical surgery.

In situations where the case is referred to an IME for the purpose of resolving a medical conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18] The Board finds that Dr. Ralph provided a well-rationalized opinion based on a complete background, his review of the SOAF, the medical record, and his examination findings. Thus, Dr. Ralph's opinion that the requested procedure was

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[15] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[16] 20 C.F.R. § 10.321.

[17] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[18] *See D.S.*, Docket No. 19-1698 (issued June 18, 2020); *C.W.*, Docket No. 17-0918 (issued January 5, 2018); *Patricia J. Glenn,* 53 ECAB 159 (2001); *James P. Roberts,* 31 ECAB 1010 (1980).

not medically warranted for the accepted conditions is entitled to the special weight of the evidence.[19]

The Board further finds that Dr. deGrange's reports, are insufficient to overcome the special weight accorded to Dr. Ralph, because reports from a physician who was on one side of a medical conflict resolved by an IME are insufficient to overcome the special weight accorded the report of the IME or to create a new conflict.[20]

The only limitation on OWCP's authority in approving or denying service under FECA is one of reasonableness.[21] OWCP obtained an impartial medical examination by Dr. Ralph who opined that the requested cervical surgery was neither medically warranted, nor causally related to the accepted employment conditions. It, therefore, had sufficient evidence upon which to deny surgery and did not abuse its discretion.

CONCLUSION

The Board finds that OWCP properly denied appellant's request for authorization of additional cervical surgery.

[19] *See D.S., id.*; *P.F.,* Docket No. 16-0693 (issued October 24, 2016).

[20] *J.M.*, Docket No. 18-1387 (issued February 1, 2019); *D.M.*, Docket No. 17-1992 (issued September 12, 2018); *S.F.*, Docket No. 17-1427 (issued May 16, 2018).

[21] *See T.A.*, Docket No. 19-1030 (issued November 22, 2019); *Cathy B. Millin,* 51 ECAB 331, 333 (2000).

ORDER

IT IS HEREBY ORDERED THAT the April 8, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 18, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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