United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 22-1236**
	)	**Issued: May 16, 2023**
DEPARTMENT OF VETERANS AFFAIRS, JOHN COCHRAN VA HOSPITAL, St. Louis, MO, Employer	)	

Appearances:
Appellant, pro se
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 August 8, 2022 appellant filed a timely appeal from a February 9, 2022 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.[2]

ISSUE

The issue is whether OWCP abused its discretion by denying appellant's request for authorization of lumbar spine surgery.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the February 9, 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*.

FACTUAL HISTORY

On March 17, 2000 appellant, then a 43-year-old supply technician, filed a traumatic injury claim (Form CA-1) alleging that on March 14, 2000 he sustained contusions to the back of his head and neck spasms when the chair he was leaning back in fell backwards and he hit his head. He stopped work on March 14, 2000 and returned to work with restrictions on March 16, 2000. OWCP accepted the claim for cervical intervertebral C4-5 and C6-7 disc displacement without myelopathy, cervical spondylosis without myelopathy.[3] It authorized anterior cervical microdiscectomy, osteophytectomy with fusion arthrosis C4-5, C5-6 and C6-7, stabilization with anterior cervical plate, which was performed on February 8, 2002. Appellant also underwent an C3-4 anterior cervical discectomy and fusion, with C3-4 cage and plate placement and local autogenous bone graft, which was performed on July 17, 2013.

In a January 31, 2019 report, Dr. Gregory A. Stynowick, a Board-certified pain medicine physician and anesthesiologist, detailed examination findings and diagnosed cervical radiculopathy, cervical spondylosis without myelopathy or radiculopathy, post-laminectomy syndrome, lumbar radiculopathy, and lumbar spondylosis without myelopathy or radiculopathy.

In a May 16, 2019 report, Dr. Thomas K. Lee, a Board-certified orthopedic surgeon, noted appellant's history of injury and medical treatment. He related appellant's physical examination findings and diagnosed L4-5 herniation and status post C3-4 fusion and prior C4-7 fusion. Dr. Lee explained that the L3-4 herniation was consistent with appellant's accepted March 14, 2000 fall at work and his medical record.

Dr. Lee, in a July 30, 2019 report, noted appellant's March 2000 injury and related that he had treated appellant since 2010. Based upon his review of appellant's medical records, his history of injury, and complaints of low back pain since March 2000, Dr. Lee opined that appellant sustained large L4-5 disc herniation due to the March 14, 2000 work injury.

By decision dated September 3, 2019, OWCP expanded acceptance of appellant's claim to include L4-5 lumbar disc herniation.

In an office visit note dated December 6, 2019, Dr. Hugh Berry, a Board-certified anesthesiologist, detailed examination findings and diagnosed chronic headaches, lumbar L4-5 disc herniation, nerve damage, and spondylosis.

A December 6, 2019 lumbar x-ray interpretation reported multilevel degenerative disc disease and facet arthropathy throughout the thoracolumbar spine, most significant at L3-4 and L5-S1, L5-S1 significant foraminal narrowing bilateral, and no fracture or spondylolisthesis noted.

A January 2, 2020 lumbar magnetic resonance imaging (MRI) scan showed severe multilevel degenerative disc and joint disease from L4-S1.

[3] OWCP assigned the present claim OWCP File No. xxxxxx974. Appellant has a subsequently accepted August 13, 2008 claim for a lumbar sprain under OWCP File No. xxxxxx571. Under OWCP File No. xxxxxx870, OWCP also accepted an October 21, 2003 claim for cervical stain and aggravation of cervical degenerative disc disease. On March 1, 2004 it combined the current claim with OWCP File No. xxxxxx870. On March 18, 2009 OWCP combined the current claim with OWCP File Nos. xxxxxx571 and xxxxxx870, with OWCP File No. xxxxx974 listed as the master file.

Dr. Berry, in a January 24, 2020 office visit note, provided examination findings and noted the MRI scan findings of severe multilevel degenerative disc and joint disease findings from L4-S1, as well as lumbar intervertebral disc displacement without myelopathy, cervical intervertebral disc displacement without myelopathy, cervical spinal canal stenosis, and lumbar spinal stenosis, and unspecified neurogenic claudication.

In progress notes dated February 12 and May 6, 2020, Dr. Robert A. Morgan, a Board-certified orthopedic surgeon, noted appellant's medical history, provided examination findings, and diagnosed L3 through S1 stenosis.

A February 19, 2020 x-ray interpretation showed lumbar intervertebral disc displacement without myelopathy and thoracic spinal stenosis.

In an orthopedic spine surgery clinic note dated June 8, 2020, Dr. Jonathan Patrick Behrens, a resident, provided examination findings, reviewed diagnostic tests, and diagnosed lumbar stenosis with neurogenic claudication, suspected thoracic stenosis. He recommended that appellant undergo further MRI studies to determine whether appellant should undergo operative or nonoperative interventions. On June 14, 2020 Dr. Pooria Salari, a Board-certified orthopedic surgeon, noted that he saw and examined the patient with Dr. Behrens and concurred with his plan of care.

A July 3, 2020 lumbar MRI scan showed advanced multilevel degenerative disc and joint disease from L3-S1.

A July 22, 2020 computerized tomography (CT) scan of the lumbar and thoracic spine showed facet arthritic changes and multiple spurs on lumbar spine vertebral bodies.

On August 19, 2020 Dr. Salari requested authorization for thoracic spine fusion and lumbar surgery. Diagnoses included spinal stenosis and lumbar spinal stenosis with claudication from L3-S1. Dr. Salari checked "no" to the question of whether surgery had been performed on the same anatomical site.

In an orthopedic spine surgery clinic note dated September 2, 2020, Dr. John Green, IV, a resident, provided examination findings, reviewed diagnostic tests, and diagnosed lumbar stenosis with neurogenic claudication. He noted that he had discussed risks, benefits and alternatives for lumbar laminectomy from T10, L1 or L2 to the pelvis. On September 4, 2020 Dr. Salari noted that he saw and examined the patient with Dr. Green and concurred with his plan of care.

On September 9, 2020 OWCP referred appellant's case to Dr. Franklin M. Epstein, a Board-certified neurologist and neurosurgeon serving as an OWCP district medical adviser (DMA). It requested that he evaluate whether the requested T10 to pelvis decompression and fusion surgery was necessitated by a work-related condition.

In a report dated September 15, 2020, Dr. Franklin M. Epstein, a Board-certified neurologist and neurosurgeon and district medical adviser (DMA), opined that the requested T10 to pelvis decompression and fusion surgery was not medically necessary. He explained that there was no dispositive radiographic evidence warranting the requested surgery for possible T10-11 stenosis. Dr. Epstein further explained that the 2020 lumbar MRI scan found no stenosis at L1-2 and L2-3. Thus, he found no compelling rationale for either fusion or decompression surgery for these levels. Next, Dr. Epstein noted that decompression and fusion at L3-4 and L5-S1 was

reasonable based on evidence of spinal canal stenosis at L3-4 and L5-S1, but that there was no evidence warranting extending the surgery to T10. He concluded that the requested surgery from T10 to the pelvis was not medically necessary, and the issue of causality need not be addressed as the surgery as proposed was not to be authorized.

On September 15, 2020 Dr. Salari performed L2-3, L3-4, L4-5, and L5-S1 laminectomies including medial facetectomy and bilateral foraminal decompression, L3-5 posterior column ostectomies, pelvic fixation, and dural repair. Preoperative diagnoses included lumbar stenosis and lumbar spondylosis.

On September 22, 2020 OWCP referred appellant, together with a series of questions, medical record, and statement of accepted facts (SOAF), to Dr. Michael H. Ralph, an orthopedic surgeon, to evaluate whether the requested T10 to pelvis decompression and fusion surgery was necessitated by a work-related condition.

In a report dated October 21, 2020, Dr. Ralph noted that Dr. Salan had wanted to perform a decompression from T10 down to appellant's sacrum, but appellant had only allowed fusion from L1 to the sacrum. He indicated that appellant had undergone a lumber laminectomy in 1989 at L4-5, prior to the accepted March 14, 2000 employment injury. Dr. Ralph also noted that while Dr. Lee related appellant's ongoing problems with the lumbar spine to the 2000 employment injury, he disagreed, as the lumbar diagnostic reports at the L4-5 level from 2020 showed degenerative changes with a thickened posterior longitudinal ligament. He concluded that appellant was status post lumbar laminectomy at L4-5 in 1989, and that he did not consider the accepted 2000 L4-5 disc herniation to relate to the surgery that appellant had just undergone. Dr. Ralph added that while appellant's claim was accepted for L4-5 disc herniation, in reality all he saw on the MRI scan were degenerative changes. As appellant had undergone L4-5 lumbar surgery in 1989, whatever abnormalities he sustained from the minor fall in 2000 resolved within a very short period of time after the injury in 2000.

By decision dated November 30, 2020, OWCP denied authorization for appellant's thoracic and lumbar spine surgery.

On December 19, 2020 appellant requested on oral hearing before a representative of OWCP's Branch of Hearings and Review. A telephonic hearing was held on April 7, 2021.

By decision dated June 4, 2021, OWCP's hearing representative affirmed the November 30, 2020 decision.

In reports dated August 20 and December 17, 2021, Dr. Steven Granberg, a Board-certified anesthesiologist, detailed examination findings and diagnosed post-laminectomy syndrome. He noted that appellant had continued low back pain since his September surgery.

A report dated September 13, 2021 signed by Dr. Tyler Ragsdale, a resident physician, and Dr. Pooria noted that appellant had L2-S1 spinal fusion and L2-5 posterior column osteotomies surgery on September 15, 2020. Diagnoses include lumbar stenosis with neurogenic claudication. Dr. Pooria concluded that appellant's diagnoses were from a work-related injury.

In a report dated October 6, 2021, Dr. Kevin Coleman, an anesthesiologist, noted that appellant had undergone spinal surgery in September 2020. He provided examination findings and diagnosed lumbar and lumbosacral radiculopathy.

In a patient status report dated December 14, 2021, Dr. Peter Cohn, a Board-certified orthopedic surgeon, noted that appellant had cervical surgery in 2013 and lumbar surgery on September 15, 2020. He advised that appellant was currently disabled from work.

Dr. Granberg reported on December 17, 2021 that appellant returned for follow up and that he had low back pain secondary to lumbar degenerative disc disease. He related appellant's diagnoses as lumbar region radiculopathy and post laminectomy syndrome.

On January 6, 2022 appellant requested reconsideration. In support of his request for reconsideration, he submitted physician progress notes dated June 8, 2020 from Dr. Behrens, Dr. Patrick, and Dr. Salari; July 6, 2020 physician progress notes from Dr. Purav S. Brahmbhatt, a resident physician, and Dr. Pooria; September 2 and 4 and 2020 physician progress notes from Dr. Green and Dr. Pooria; October 5, 2020 physician progress notes from Dr. Pooria; and March 15, 2021 physician progress notes from Dr. Kelyn N. Pittman, a resident physician, all noting diagnoses of lumbar stenosis with neurogenic claudication, suspected thoracic stenosis.

By decision dated February 9, 2022, OWCP denied modification.

LEGAL PRECEDENT

Section 8103(a) 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 in the amount of monthly compensation.[5]

In interpreting section 8103 of FECA, the Board has recognized that OWCP has broad discretion in approving services provided, with the only limitation on OWCP's authority being that of reasonableness.[6] 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 to merely show that the evidence could be construed to produce a contrary factual conclusion.[7]

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 criteria must be met for OWCP to authorize payment.[8]

ANALYSIS

The Board finds that this case is not in posture for decision.

[4] *Supra* note 1 at § 8103; *see N.G.*, Docket No. 18-1340 (issued March 6, 2019).

[5] *Id.*; *see B.I.*, Docket No. 22-0090 (issued July 19, 2022); *N.G.*, Docket No. 18-1340 (issued March 6, 2019).

[6] *See B.I.*, *id.*; *D.C.*, Docket No. 20-0854 (issued July 19, 2021); *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *D.K.*, 59 ECAB 141 (2007).

[7] *See E.F.*, Docket No. 20-1680 (issued November 10, 2021); *J.L.*, Docket No. 18-0503 (issued October 16, 2018).

[8] *See P.S.*, Docket No. 20-0075 (issued July 12, 2021).

On September 3, 2019 OWCP expanded acceptance of appellant's claim to include L4-5 lumbar disc herniation. It thereafter, on September 9, 2020, referred appellant's case to Dr. Epstein, an OWCP DMA, and requested that he evaluate whether the requested T10 to pelvis decompression and fusion surgery was necessitated by a work-related condition. In his September 15, 2020 report, Dr. Epstein opined that the requested T10 to pelvis decompression and fusion surgery were not medically necessary. He explained that there was no dispositive radiographic evidence warranting the requested surgery for possible T10-11 stenosis. Dr. Epstein further explained that the 2020 lumbar MRI scan found no stenosis at L1-2 and L2-3. Thus, he found neither fusion nor decompression surgery was medically warranted for these levels. Next, Dr. Epstein noted that decompression and fusion at L3-4 and L5-S1 was reasonable based on evidence of spinal canal stenosis at L3-4 and L5-S1 but that there was no evidence warranting extending surgery to T10. He declined to address the issue of causality as he indicated that the surgery as proposed was not to be authorized.

Appellant thereafter underwent L2-3, L3-4, L4-5, and L5-S1 laminectomies and L2-5 posterior column osteotomies surgery on September 15, 2020.

OWCP referred appellant for a second opinion evaluation with Dr. Ralph. In his October 21, 2020 report, Dr. Ralph related that he did not believe that the requested surgical procedure which had been performed in September was necessitated by the accepted L4-5 disc herniation. He indicated that appellant had undergone lumbar laminectomy at L4-5 in 1989, and that he did not consider the accepted 2000 L4-5 disc herniation to relate to the surgery appellant just underwent. Dr. Ralph added that while appellant's claim was accepted for L4-5 disc herniation, all he saw on appellant's MRI scan were degenerative changes. He concluded that as appellant had undergone L4-5 lumbar surgery in 1989, whatever abnormalities appellant sustained during his minor work-related fall in 2000 resolved within a very short period after the injury in 2000.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[9] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[10] Once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[11]

Dr. Epstein, OWCP's DMA, opined that appellant's decompression and fusion at L3-4 and L5-S1 was reasonable based on evidence of spinal canal stenosis at L3-4 and L5-S1, but he refused to provide an opinion regarding causal relationship because he did not believe the totality of the requested surgical procedure was reasonable. OWCP did not request that Dr. Epstein clarify his opinion as to whether appellant's fusions at L3-S1 were medically necessary due to the accepted employment injury. Dr. Ralph acknowledged that OWCP had accepted the claim for L4-5 disc herniation, but he opined that appellant's L4-5 disc herniation had resolved with a very short period

[9] *C.F.*, Docket No. 21-0213 (issued January 11, 2022); *N.L.*, Docket No. 19-1592 (issued March 12, 2020); *M.T.*, Docket No. 19-0373 (issued August 22, 2019); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

[10] *C.F.*, *id.*; *S.S.*, Docket No. 18-0397 (issued January 15, 2019); *see also Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[11] *C.F.*, *id.*; *T.K.*, Docket No. 20-0150 (issued July 9, 2020); *T.C.*, Docket No. 17-1906 (issued January 10, 2018).

of time after the 2000 injury. He based his opinion on a finding that appellant had previously undergone L4-5 surgical correction in 1989, prior to the accepted employment injury.

The Board finds that as both Dr. Epstein and Dr. Ralph provided conclusory opinions regarding the medical necessity for surgical correction of appellant's accepted lumbar conditions, without sufficient rationale regarding whether the requested surgery was causally related to the accepted employment injury. As a result, further development is required. The case must, therefore, be remanded to OWCP for clarification. On remand OWCP shall request clarification from Dr. Ralph on whether appellant's spinal surgery was causally related to the accepted injury. If Dr. Ralph is unavailable or unwilling to provide another supplemental opinion, OWCP shall refer appellant, a SOAF, and list of questions to a new second opinion physician in the appropriate field of medicine for a rationalized medical opinion on whether appellant's lumbar surgery was necessitated by his March 14, 2000 employment injury.[12] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the February 9, 2022 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 16, 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

[12] *See K.G.*, Docket No. 22-1307 (issued April 26, 2023); *J.H.*, Docket No. 19-1476 (issued March 23, 2021).