United States Department of Labor
Employees' Compensation Appeals Board

G.O., Appellant	)	
and	)	**Docket No. 08-642**
	)	**Issued: September 8, 2008**
DEPARTMENT OF THE ARMY, AERIAL DELIVERY DETACHMENT, Fort Polk, LA, Employer	)	

Appearances:
Daniel E. Broussard, Jr., Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 31, 2007 appellant filed a timely appeal from the October 2, 2007 merit decision of the Office of Workers' Compensation Programs, which denied authorization for surgery. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether the Office properly denied authorization for the proposed neck surgery.

FACTUAL HISTORY

On March 21, 2005 appellant, then a 57-year-old materials handler or supply technician, sustained an injury in the performance of duty when a soldier moved a basketball goal and it fell over, striking appellant on the head and left shoulder. The Office accepted his claim for sprain/strain of the neck and sprain/strain acromioclavicular, right. It later expanded its

acceptance to include left carpal and cubital tunnel syndromes and "reaction to spinal or lumbar."

A conflict arose between appellant's physicians and an Office referral physician over whether appellant should have a laminoforaminotomy at C6-7 bilaterally and C7-T1 bilaterally with posterior cervical wiring and fusion at C6-T1. Dr. Dean Moore, appellant's neurosurgeon, requested authorization for the surgery in September 2005. In November 2005, Dr. Manguesh Velingker, an Office second opinion neurologist, reported that the surgery did not appear as indicated. He felt appellant did not have an adequate trial of conservative treatment, and an magnetic resonance imaging (MRI) scan and myelogram showed no evidence of spinal cord impingement or foraminal narrowing causing cervical nerve root impingement.

To resolve the conflict, the Office referred appellant, together with the case record and a statement of accepted facts, to Dr. E. Floyd Robinson, a Board-certified neurosurgeon. On June 27, 2006 Dr. Robinson related appellant's history and complaints. He reviewed appellant's medical records, including electrodiagnostic studies. Dr. Robinson described his findings on physical and neurological examination. Responding to Office questions, he reported that appellant underwent an adequate trial of conservative care, but he felt the proposed surgery was unnecessary:

> "The exact details of the proposed surgery are not available; however, from the examinee's test, it only appears that his doctor wants to do a multiple level cervical fusion and laminectomy with screws and plates. I do not think this is necessary as there is no evidence he has a cervical radiculopathy or evidence that surgery would benefit his complaints."

Dr. Robinson added:

> "As mentioned, [appellant] has cervical spondylosis, which he already has at the time of his injury. He simply had contusion of his neck with strain and there is no reason from the examination to indicate that he has radiculopathy that would be helped with any sort of cervical surgery and the cervical pain would not be helped by any sort of [cervical] surgery as mentioned."

The Office denied authorization for the requested surgery on August 14, 2006. It found that the weight of the medical evidence rested with Dr. Robinson, the impartial medical specialist, and did not establish that the surgery was medically necessary for the accepted work injury. On July 16, 2007, however, an Office hearing representative set aside the Office's August 14, 2006 decision and remanded the case for clarification from Dr. Robinson. It was not clear that he had reviewed a copy of the electrical studies performed on July 18, 2006,[1] and he did not explain why he disregarded the electrical studies performed on April 25, 2005, which were reported to show left C7 radiculopathy.

[1] The hearing representative misidentified the date of the study as June 18, 2006.

In a supplemental report dated September 17, 2007, Dr. Robinson replied:

> "This is an individual who has had preexisting cervical spondylosis, predating his injury. The EMGs [electromyograms] correlate with ulnar neuropathy and possible C7 radiculopathy. However, clinical studies and evaluation do not show any radiculopathy on findings to indicate that he has a clinical radiculopathy. Certainly, the surgery cannot be based on EMGs. [Appellant] has a cervical spondylosis at multiple levels which preexisted his injury and in fact, this does not indicate a reason for surgery on his neck, specifically discectomy, fusions and plates. This would not benefit him in any way from my evaluation, which showed no evidence of radiculopathy and no evidence that he sustained, other than a cervical sprain/strain to his neck at the time of injury."

Dr. Robinson directly addressed whether the proposed surgery was necessary as a result of the accepted work injury:

> "No, it is not necessary and should not be done. This would not relieve [appellant] any problems that has, [sic] specifically he has no radiculopathy. He has only some neck pain, which was a result of cervical sprain superimposed on cervical spondylosis, which he had prior to his injury. The EMG studies are irrelevant to making this decision."

In a decision dated October 2, 2007, the Office denied authorization for the proposed surgery. The Office found that the weight of the medical evidence rested with Dr. Robinson, the impartial medical specialist.

LEGAL PRECEDENT

Section 8103(a) of the Federal Employees' Compensation Act 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 that the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of any disability or aid in lessening the amount of any monthly compensation.[2] The Office must therefore exercise discretion in determining whether the particular service, appliance or supply is likely to effect the purposes specified in the Act.[3] The only limitation on the Office's authority is that of reasonableness.[4]

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

[2] 5 U.S.C. § 8103(a).

[3] *See Marjorie S. Geer*, 39 ECAB 1099 (1988) (the Office has broad discretionary authority in the administration of the Act and must exercise that discretion to achieve the objectives of section 8103).

[4] *Daniel J. Perea*, 42 ECAB 214 (1990). *See generally* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.10 (April 1993) (obtaining second opinions for surgery).

make an examination.[5] 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.[6]

ANALYSIS

When a conflict arose between appellant's physician and the Office second opinion physician on whether appellant should undergo a laminoforaminotomy at C6-7 bilaterally and C7-T1 bilaterally with posterior cervical wiring and fusion at C6-T1, the Office properly referred appellant to an impartial medical specialist to resolve the dispute.

The Office provided Dr. Robinson, a Board-certified neurosurgeon, with the entire case record and a statement of accepted facts so he could base his opinion on a proper factual and medical background. Dr. Robinson physically and neurologically examined appellant and found no indication that appellant had a radiculopathy that would be helped by any sort of cervical surgery. He added that appellant's cervical pain, a result of contusion and strain superimposed on his preexisting spondylosis, would not be helped by a multiple-level cervical fusion and laminectomy with screws and plates.

When the Office asked Dr. Robinson to consider the electrical studies showing or suggesting cervical radiculopathy, he explained that surgery cannot be based on EMGs showing a possible C7 radiculopathy. He explained that appellant's clinical studies and evaluation showed no radiculopathy or findings to indicate that he had a clinical radiculopathy, so the surgery "would not benefit him in any way from my evaluation."

The Board finds that the opinion of the impartial medical specialist is based on a proper factual and medical background and is sufficiently well reasoned that it must be accorded special weight. As the weight of the medical evidence establishes that the proposed surgery is not clinically necessary for the accepted employment injury, the Board finds that the Office properly acted within its broad discretion when it denied authorization for the proposed surgery. The Board will therefore affirm the Office's October 2, 2007 decision.

CONCLUSION

The Board finds that the Office properly denied authorization for the proposed neck surgery. The weight of the medical opinion evidence establishes that the proposed surgery is not clinically necessary for the accepted work injury.

[5] 5 U.S.C. § 8123(a).

[6] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

ORDER

IT IS HEREBY ORDERED THAT the October 2, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 8, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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