United States Department of Labor
Employees' Compensation Appeals Board

B.J., Appellant	)	
and	)	**Docket No. 15-1961**
	)	**Issued: September 7, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Baltimore, MD, Employer	)	

Appearances:
Richard A. Daniels, for the appellant[1]
Office of Solicitor, for the Director

Oral Argument June 22, 2016

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 29, 2015 appellant, through his representative, filed a timely appeal from a July 30, 2015 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]

[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 following the July 30, 2015 decision. Since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).

ISSUE

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

FACTUAL HISTORY

This case was previously before the Board.[4] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are set forth below.

Under File No. xxxxxx505, OWCP accepted that on June 27, 1997 appellant, then a 41-year-old mail processor, sustained a cervical strain when a rack he was pulling came unhinged and fell down. It expanded the claim to include cervical radiculopathy and herniated disc at C6-7. Appellant underwent authorized cervical surgery on September 15, 2000.

Under File No. xxxxxx565, OWCP accepted that appellant sustained aggravated thoracic outlet syndrome as a result of his employment duties, which required repetitive lifting, twisting, and turning. Appellant indicated that he first became aware of his condition and realized that it resulted from his employment on or about November 7, 2003.

Appellant was initially treated by Dr. Avraam Karas, a Board-certified cardiothoracic surgeon, who indicated in reports dated April 21, 2004 to April 7, 2010 that appellant continued to complain of severe tightness in his neck and mid-cervical pain radiating to the occipital area, and left shoulder pain. Upon examination, he observed that the transaxillary examination of the thoracic outlet over the first rib was intolerable and painful on both sides. Adson's and Roos' tests were also positive on both sides. Dr. Karas diagnosed cervical disc disease, status post cervical fusion, bilateral ulnar neuropathy, bilateral carpal tunnel syndrome, and severe bilateral thoracic outlet syndrome. In a June 17, 2004 report, he opined that appellant's symptomatology was so severe that thoracic outlet surgery was necessary to treat his symptoms.

On March 2, 2005 appellant was terminated from employment.

Appellant underwent an electromyography (EMG) and nerve conduction study (NCS) of the upper extremities by Dr. Mark A. Reischer, Board-certified in internal medicine and physical medicine and rehabilitation, who indicated in a March 31, 2009 report that appellant complained of neck and shoulder pain and upper extremity pain, tingling, numbness, and weakness. Dr. Reischer reported that appellant's electrodiagnostic findings supported a diagnosis of right thoracic outlet syndrome with decreased amplitude at the ulnar and median anterior brachial cutaneous sensory evoked responses.

In March 1, 2009 and January 16, 2010 reports, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and an OWCP medical adviser, reviewed appellant's medical records and opined that thoracic outlet surgery was not medically necessary to treat appellant's work-related conditions. He explained that there were no recent diagnostic studies or other objective evidence

[4] Docket No. 13-1157 (issued May 15, 2014).

to justify the diagnosis of thoracic outlet syndrome and to indicate the need for thoracic outlet surgery.

Dr. Mouhamad O. Annous, a Board-certified surgeon, conducted vascular testing of appellant and in an April 7, 2010 report noted that appellant had normal upper extremity arterial duplex with no aneurysm or stenosis. He provided peak velocity testing results and reported that appellant had thoracic outlet syndrome.

OWCP referred appellant's claim, along with the statement of accepted facts (SOAF) and medical record, to Dr. Robert Draper, Jr., a Board-certified orthopedic surgeon and second opinion examiner. In a May 21, 2010 report, Dr. Draper indicated that while examination findings supported a diagnosis of work-related cervical disc herniation, there was no objective evidence of thoracic outlet syndrome on either side. He reported that thoracic outlet surgery would not alleviate any of appellant's symptoms.

In a decision dated December 23, 2010, OWCP denied authorization for appellant to undergo thoracic outlet surgery based on Dr. Draper and Dr. Berman's reports, which established that the surgical procedures were not medically necessary.

Appellant, through counsel, requested a hearing before an OWCP hearing representative. By decision dated March 18, 2011, an OWCP hearing representative determined that a conflict in medical opinion existed between Dr. Karas, appellant's treating physician, and Drs. Berman and Draper, OWCP medical advisers and referral physicians, respectively, regarding whether appellant continued to suffer residuals of thoracic outlet syndrome and needed surgery. She remanded the claim for OWCP to refer the claim to a referee medical examiner in order to resolve the conflict.

Following the hearing representative's remand, OWCP referred appellant's case, along with a SOAF and the medical record, to Dr. Donald Burke Haskins, an orthopedic surgeon and impartial medical examiner, in order to resolve the conflict in medical opinion regarding whether appellant continued to suffer from aggravation of thoracic outlet syndrome, whether he had any periods of disability due to his accepted thoracic outlet syndrome, and whether OWCP should authorize surgery to treat thoracic outlet syndrome.

In a June 15, 2011 report, Dr. Haskins reviewed the SOAF and described appellant's employment duties as a mail processor. He accurately described the histories of the June 27, 1997 traumatic injury claim and the April 11, 2008 occupational disease claim. Dr. Haskins related appellant's accepted conditions for cervical strain, cervical radiculopathy, herniated disc at C6-7, and aggravation of thoracic outlet syndrome. He indicated that appellant continued to complain of pain in his neck, arm, and shoulders and pain in his fingers with symptoms radiating down into the arms and elbows. Upon examination of appellant's cervical spine, Dr. Haskins observed diffuse tenderness over the posterior cervical spine. Forward flexion of the cervical spine was to fingers and extension was to neutral. Dr. Haskins indicated that examination of both shoulders revealed no atrophy or deformity. He related that appellant complained of an area of prominence in the left acromioclavicular region, but he noted prominence in both areas and tenderness to touch on the left. Dr. Haskins noted that Adson's test produced complaints of bilateral shoulder pain without loss of pulse.

Dr. Haskins reviewed appellant's medical records. He diagnosed status postindustrial-related accident with subsequent fusion at C6-7, multiple somatic complaints, abnormal nerve conduction, and vascular studies. Dr. Haskins opined that the diagnosis of thoracic outlet syndrome was not established. He explained that although appellant had laboratory testing consistent with this finding, appellant's current complaints and physical examination did not clearly support the diagnosis of thoracic outlet syndrome. Dr. Haskins mentioned that appellant's complaints were too diffuse and nonspecific and did not have consistent physical findings to support a diagnosis of thoracic outlet syndrome. Accordingly, he reported that surgical intervention for appellant's current complaints would not improve or lessen them. Dr. Haskins further noted that he was unable to ascertain any specific time period for total disability due to appellant's thoracic outlet syndrome.

Dr. Constantine A. Misoul, a Board-certified orthopedic surgeon, treated appellant and in reports dated July 6 and September 19, 2011 indicated that appellant continued to experience substantial pain in his neck and upper back radiating into his arm, with heaviness, and weakness due to his work-related bilateral thoracic outlet syndrome. Upon examination, he noted supraclavicular tenderness and decreased sensation in the hands. Adson's and Roos' maneuvers were positive. Dr. Misoul opined that appellant should be seen by an appropriate specialist to determine whether surgery was necessary.

OWCP denied authorization for thoracic outlet syndrome in a decision dated July 19, 2011. It found that the weight of the medical evidence rested with Dr. Haskins' June 15, 2011 medical report, which determined that appellant did not have thoracic outlet syndrome, and accordingly, that he did not need surgery.[5]

On July 26, 2011 appellant, through counsel, requested an oral hearing before an OWCP hearing representative. In a decision dated October 25, 2011, an OWCP hearing representative vacated and remanded OWCP's July 19, 2011 decision finding that the May 5, 2010 SOAF was inaccurate and that OWCP had failed to administratively combine the two relevant compensation files. On remand, OWCP was instructed to combine the case files, amend the SOAF, and refer the combined medical records to Dr. Draper for a medical opinion regarding authorization for the proposed surgery, whether appellant continued to suffer residuals of work-related thoracic outlet syndrome, and whether he was totally or partially disabled from work since June 2001.[6]

On November 2, 2011 OWCP combined File No. xxxxxx505 with File No. xxxxxx565.

[5] In separate decisions issued of even date, OWCP also denied wage-loss compensation for the period November 7, 2003 to May 14, 2011 and advised appellant of its proposal to terminate medical benefits for treatment of his thoracic outlet syndrome condition. On August 23, 2011 it terminated his medical benefits in his thoracic outlet syndrome claim. Appellant requested a hearing before a hearing representative of the Branch of Hearings and Review.

[6] The hearing representative also remanded the case for a medical opinion on whether appellant was totally or partially disabled from work since June 2001 as a result of his accepted work injuries. She further found that the medical evidence was insufficient to establish that he no longer suffered residuals of his accepted thoracic outlet syndrome and that OWCP did not meet its burden of proof to terminate his medical benefits. OWCP was advised to reinstate appellant's medical and wage-loss compensation benefits. Appellant is currently on the periodic rolls.

On April 10, 2012 OWCP referred appellant, along with an amended SOAF, to Dr. Draper for a supplemental second opinion examination. In an April 27, 2012 report, Dr. Draper indicated that throughout the examination appellant exhibited pain behaviors that appeared to be in excess of examination findings. He opined that appellant did not have thoracic outlet syndrome and did not need surgery.[7] In a June 7, 2012 supplemental report, Dr. Draper explained that his examination findings were inconsistent with the diagnosis of thoracic outlet syndrome. He reported that this did not mean that appellant never had thoracic outlet syndrome, but only that appellant did not have thoracic outlet syndrome on the date of his examination.

In a decision dated July 3, 2012, OWCP denied authorization for thoracic outlet surgery based on Dr. Draper's April 27 and June 7, 2012 reports.[8]

Appellant, through counsel, requested a hearing. An OWCP hearing representative affirmed the denial of authorization for thoracic outlet surgery in a decision dated February 5, 2013.

Appellant filed an appeal to the Board. In a decision dated May 15, 2014, the Board determined that Dr. Haskins' June 15, 2011 referee medical report was insufficient to resolve the conflict in medical opinion regarding authorization for surgery to treat appellant's accepted condition. It remanded the case for referral back to Dr. Haskins to provide a supplemental report in order to resolve the conflict in medical evidence regarding authorization for surgery to treat appellant's thoracic outlet condition.[9]

Following the Board's decision, OWCP referred appellant's claim back to Dr. Haskins. In a July 14, 2014 report, Dr. Haskins reviewed appellant's history, including the SOAF, and provided a detailed description of the medical treatment appellant received. He opined that, based on review of the medical record and his examination on June 15, 2011, appellant did not have thoracic outlet syndrome and did not need thoracic outlet surgery. Dr. Haskins acknowledged that previous laboratory testing was consistent with the findings of thoracic outlet syndrome, but noted that when he evaluated appellant in June 2011 the history and examination did not support the diagnosis of thoracic outlet syndrome. He pointed out that other physicians also came to the same conclusion that appellant no longer suffered from thoracic outlet syndrome.

[7] Dr. Draper also related that appellant continued to suffer residuals of his cervical spine injury and was able to work modified duty.

[8] OWCP also affirmed the denial of appellant's wage-loss compensation benefits from November 7, 2003 to May 20, 2010. It found that the medical evidence was insufficient to establish that he was disabled during this time period. OWCP further determined that the current medical evidence established that appellant was unable to work beginning May 21, 2010 due to his accepted cervical spine condition. Thus, appellant was entitled to compensation beginning May 21, 2010. He is currently on the periodic rolls.

[9] The Board also vacated and remanded the February 5, 2013 decision with regard to whether appellant was disabled from work from September 6, 2001 to May 20, 2010 for further development of the medical evidence. Docket No. 13-1157 (issued May 15, 2014).

OWCP denied authorization for thoracic outlet surgery in a decision dated July 31, 2014.[10] Appellant disagreed with the decision and requested a hearing, through counsel, before an OWCP hearing representative, which was held on May 14, 2015. Appellant's representative asserted that OWCP's second opinion physician and impartial medical examiner (IME) lacked the expertise that appellant's treating physician, Dr. Karas, had to properly diagnose thoracic outlet syndrome and determine the proper course of treatment. He further alleged that OWCP should have required that appellant be evaluated by a new IME, other than Dr. Haskins, because OWCP procedures required that the IME not have any prior involvement in the case.

Appellant continued to receive medical treatment from Dr. Misoul and related in reports dated May 5, 2014 to July 6, 2015, that appellant continued to suffer from pain in his neck and upper back radiating into both of his arms with numbness, tingling, and a feeling of heaviness as a result of work-related thoracic outlet syndrome. On examination of his cervicothoracic spine, he observed tenderness over the paracervical musculature and supraclavicular tenderness with positive Tinel's sign. Adson's and Roos' maneuvers were also positive. Dr. Misoul related that appellant still needed to be evaluated by a thoracic outlet surgeon with expertise in the diagnosis and treatment of thoracic outlet syndrome. He pointed out that appellant had only been treated by general orthopedic surgeons.

By decision dated July 30, 2015, an OWCP hearing representative affirmed the July 31, 2014 decision denying authorization for thoracic outlet surgery. She determined that the weight of medical evidence rested with the June 15, 2011 and July 24, 2014 referee medical reports of Dr. Haskins, who determined that appellant did not have thoracic outlet syndrome, and therefore did not need surgery.

Appellant, through counsel, filed an appeal before the Board and requested oral argument, which was held on June 22, 2016. Counsel asserted that OWCP erred in handling appellant's claim because it never referred appellant for examination by a physician who specializes in thoracic outlet syndrome. He asserted that OWCP should have referred appellant to a specialist in thoracic outlet syndrome, but OWCP selected a general orthopedic surgeon, Dr. Haskins. Counsel explained that Dr. Karas was a thoracic outlet syndrome specialist.

LEGAL PRECEDENT

Section 8103(a) of FECA states in pertinent part: 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 the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of the monthly compensation.[11]

[10] OWCP also remanded the case for further development of the medical evidence on the issue of whether appellant was disabled from work for the period September 2001 to September 2007 as a result of his accepted conditions.

[11] 5 U.S.C. § 8103.

The Board has found that OWCP has great discretion in determining whether a particular type of treatment is likely to cure or give relief.[12] The only limitation on OWCP's authority is that of reasonableness.[13] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgments, 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]

Section 8123(a) of FECA provides in pertinent part: If there is a 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.[15] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[16] In situations where 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.[17]

In a situation where OWCP secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[18] If an impartial medical specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[19]

ANALYSIS

OWCP accepted that appellant sustained aggravated thoracic outlet syndrome as a result of his repetitive employment duties as a mail processor. Dr. Karas, appellant's treating physician requested authorization for surgery to treat his thoracic outlet syndrome. Dr. Berman, an OWCP medical adviser, and Dr. Draper, an OWCP second opinion examiner, opined that appellant did not have thoracic outlet syndrome and therefore did not need thoracic outlet surgery. OWCP

[12] *Vicky C. Randall,* 51 ECAB 357 (2000).

[13] *Lecil E. Stevens,* 49 ECAB 673, 675 (1998).

[14] *Rosa Lee Jones,* 36 ECAB 679 (1985).

[15] 5 U.S.C. § 8123(a).

[16] *William C. Bush,* 40 ECAB 1064, 1975 (1989).

[17] *Jack R. Smith,* 41 ECAB 691, 701 (1990); *James P. Roberts,* 31 ECAB 1010, 1021 (1980).

[18] *Nancy Lackner (Jack D. Lackner),* 40 ECAB 232, 238 (1988).

[19] *Harold Travis,* 30 ECAB 1071, 1078 (1979).

determined that a conflict in medical opinion existed and referred appellant's claim to Dr. Haskins, an IME, for review and examination in order to resolve the conflict in medical opinion regarding whether thoracic outlet surgery was necessary to treat appellant's accepted condition. In various decisions, it denied authorization for thoracic outlet surgery based on Dr. Haskins' impartial medical opinion.

The Board finds, however, that this case is not in posture for decision regarding authorization for thoracic outlet surgery, because Dr. Haskins' medical reports are of insufficient probative value to carry the special weight of the medical evidence as an IME.

In a June 15, 2011 report, Dr. Haskins reviewed the SOAF and provided an accurate history of appellant's cervical and upper extremity injuries. He indicated that appellant continued to complain of pain in the neck, arm, shoulders, and fingers. Upon examination, Dr. Haskins reported that appellant was unable to rotate his head normally and had difficulty lifting his arms above shoulder height. He observed that appellant was diffusely tender over the posterior cervical spine. Dr. Haskins provided range of motion findings and noted that Adson's test produced complaints of bilateral shoulder pain without loss of pulse. He reviewed appellant's medical records and noted abnormal nerve conduction studies and vascular studies. Dr. Haskins reported that even though appellant had laboratory testing consistent with thoracic outlet syndrome, appellant's current complaints and physical examination did not support a diagnosis of thoracic outlet syndrome. Accordingly, he concluded that surgical intervention was unnecessary.

In a July 14, 2014 supplemental report, Dr. Haskins indicated that he reviewed the updated SOAF and provided a detailed and accurate history of appellant's employment injuries and the medical treatment he received. He noted that his opinion was based on his evaluation of June 15, 2011. Dr. Haskins reported:

> "[Appellant] has laboratory testing consistent with the findings of thoracic outlet syndrome. When he was evaluated by myself in June 2011, the history and physical examination did not support the diagnosis of thoracic outlet syndrome. As stated previously, it is my opinion that there is a difference between an abnormal study and the actual syndrome."

Dr. Haskins pointed out that other physicians also concluded that appellant did not have thoracic outlet syndrome. He again concluded that thoracic outlet surgery was not medically necessary to treat appellant's condition.

In his July 14, 2014 report, Dr. Haskins concluded that thoracic outlet surgery was not medically necessary to treat appellant's accepted condition. His opinion, however, was not based on a current physical examination, but on his previous June 15, 2011 findings on examination. In determining the probative value of an IME's medical report, the Board considers such factors as the opportunity for and thoroughness of examination performed by the physician, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed by the physician on

the medical issues addressed to him or her by OWCP.[20] The Board finds that Dr. Haskins essentially conducted a review of the record and not a thorough examination. As Dr. Haskins did not conduct a thorough examination for his July 14, 2014 report, this report is of diminished probative value.[21]

Furthermore, the Board finds that Dr. Haskins provided insufficient medical rationale for his conclusion that OWCP should not authorize thoracic outlet surgery. As noted above, the report of an IME is given special weight if the report is sufficiently rationalized and based upon a proper factual background.[22] Dr. Haskins opined that based on his examination findings, appellant did not have thoracic outlet syndrome. Although he acknowledged that appellant had abnormal diagnostic results, he dismissively explained these abnormal results with a simple statement that "there is difference between an abnormal study and the actual syndrome." Dr. Haskins failed to give any medical explanation as to how appellant's physical examination and history negated the abnormal diagnostic testing. When an IME fails to provide medical reasoning to support his or her conclusory statements about a claimant's condition, it is insufficient to resolve a conflict in the medical evidence.[23]

Because Dr. Haskins' reports lacked probative value, the Board finds that OWCP erred in relying on his June 15, 2011 and July 14, 2014 reports as the basis for denying authorization for thoracic outlet surgery.[24] Dr. Haskins did not conduct a proper examination of appellant and essentially reiterated his previous conclusions without sufficient medical rationale to support his conclusions. The Board has held that, if an impartial medical specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[25]

The Board shall set aside OWCP's decision denying appellant's request for authorization of thoracic outlet surgery and remand the case to OWCP for further development. Appellant and the case record shall be referred to a new impartial medical specialist, who shall conduct a full and complete examination and provide an opinion based on current physical examination findings and other relevant testing, regarding whether his request for authorization of thoracic outlet surgery should be approved. Following this and any necessary further development, OWCP shall issue a *de novo* decision regarding appellant's surgery request.

[20] *James T. Johnson,* 39 ECAB 1252, 1256 (1988).

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

[22] *Supra* note 19.

[23] *See A.R.*, Docket No. 12-443 (issued October 9, 2012); *see also P.F.*, Docket No. 13-728 (issued September 9, 2014); *T.M.,* Docket No. 08-975 (issued February 6, 2009) (a medical report consisting solely of conclusory statements without supporting rationale is of little probative value).

[24] *See C.C.*, Docket No. 08-2485 (issued September 15, 2009).

[25] *T.H.*, Docket No. 14-326 (issued February 5, 2015); *supra* note 19.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether OWCP properly denied appellant's request for authorization of thoracic outlet surgery and the case is remanded to OWCP for further development.

ORDER

IT IS HEREBY ORDERED THAT the July 30, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: September 7, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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