United States Department of Labor
Employees' Compensation Appeals Board

B.J., Appellant	)	
and	)	**Docket No. 18-1186**
	)	**Issued: July 9, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Baltimore, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 18, 2018 appellant, through counsel, filed a timely appeal from a November 29, 2017 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 following the November 29, 2017 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.*

ISSUE

The issue is whether OWCP abused its discretion by denying authorization for thoracic outlet surgery.

FACTUAL HISTORY

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

On July 8, 1997 appellant, then a 41-year-old mail processor, filed a traumatic injury claim (Form CA-1) alleging that on June 27, 1997 he strained his neck while in the performance of duty, when a rack he was pulling came unhinged and fell down. He stopped work on July 3, 1997. OWCP assigned the claim File No. xxxxxx505, and by decision dated September 15, 1997, accepted the claim for cervical strain. It later expanded acceptance of the claim to include cervical radiculopathy and herniated disc at C6-7. OWCP paid appellant wage-loss compensation until he returned to work on January 6, 1998. On September 15, 2000 appellant underwent OWCP-authorized cervical surgery.

On March 2, 2005 appellant was separated from federal employment due to his "physical inability to perform duties of position and/or [leave without pay] for 365 days."

On April 11, 2008 appellant filed an occupational disease claim (Form CA-2). OWCP assigned this latter claim File No. xxxxxx565. It accepted the occupational disease claim for aggravation of bilateral thoracic outlet syndrome. OWCP administratively combined appellant's traumatic injury and occupational disease claims, with File No. xxxxxx505 designated as the master file.

OWCP subsequently received a series of medical reports by Dr. Avraam Karas, a Board-certified cardiothoracic surgeon. In an initial April 21, 2004 report, Dr. Karas reviewed appellant's history and conducted an examination. He reported that transaxillary examination of appellant's thoracic outlet over the first rib was intolerable and painful on both sides. Adson's and Roos' test maneuvers were positive on both sides. Dr. Karas diagnosed cervical disc disease, status post cervical fusion, ulnar neuropathy bilaterally, bilateral carpal tunnel syndrome, and severe bilateral thoracic outlet syndrome. He continued to treat appellant and provided medical reports. In a June 17, 2004 report, Dr. Karas opined that appellant's symptomatology was so severe and longstanding that surgical decompression of the thoracic outlet syndrome would be the only treatment to benefit him.

On February 25, 2009 OWCP referred appellant's case, along with a statement of accepted facts (SOAF) and the medical record, to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and OWCP district medical adviser, to determine whether thoracic outlet surgery was medically necessary to treat appellant's accepted condition. In a March 10, 2009 report, Dr. Berman indicated that although appellant's condition was accepted for aggravation of thoracic

[4] Docket No. 15-1961 (issued September 7, 2016); Docket No. 13-1157 (issued May 15, 2014).

outlet syndrome bilaterally, he did not believe that this was necessarily the correct diagnosis. He recommended a repeat magnetic resonance imaging scan of appellant's cervical spine and a repeat electromyography (EMG) study. Dr. Berman concluded that, based on the medical record, thoracic outlet surgery was not medically indicated as he did not think that the diagnosis of thoracic outlet syndrome had been established.

On March 31, 2009 appellant underwent EMG and nerve conduction velocity (NCV) testing. The report did not contain any impression of findings.

On April 7, 2010 appellant also underwent an upper extremity vascular arterial stress, which was indicative of thoracic outlet syndrome. The report noted that he was not able to fully get into the correct position, so his condition may likely be more severe than shown.

OWCP referred appellant's case, along with the SOAF and the medical record, to Dr. Robert Draper, Jr., a Board-certified orthopedic surgeon and second opinion examiner, to determine whether he continued to suffer residuals of, and remained disabled as a result of his work-related injuries, and whether thoracic outlet surgery was medically necessary to treat appellant's accepted conditions. In a May 21, 2010 report, Dr. Draper discussed appellant's medical records and provided examination findings. He reported that examination of appellant's bilateral upper extremities showed negative Tinel's sign and Adson's test. Dr. Draper related that appellant had no motor or sensory deficits in the upper extremities, which would suggest or be compatible with thoracic outlet syndrome. He noted that there was no indication to perform surgery for thoracic outlet syndrome as the physical examination findings did not show a finding of thoracic outlet syndrome.

By decision dated December 23, 2010, OWCP again denied authorization for thoracic outlet surgery. It found that the weight of the medical evidence rested with Dr. Draper's May 21, 2010 and Dr. Berman's March 10, 2009 medical reports, which determined that appellant did not have thoracic outlet syndrome, and accordingly, that he did not need surgery.

Following the initial denial, appellant filed multiple requests for reconsideration and/or appeals.[5]

In its most recent decision dated September 7, 2016, the Board set aside and remanded OWCP's July 30, 2015 decision, which denied authorization for thoracic outlet surgery. It found that the June 15, 2011 and July 14, 2014 reports of Dr. Donald Haskins, a Board-certified orthopedic surgeon and impartial medical examiner,[6] were of insufficient probative value to carry the special weight of the medical evidence afforded to an impartial medical report. The Board noted that Dr. Haskins did not conduct a thorough examination for his July 14, 2014 report, and essentially conducted a review of the record. It also determined that his reports lacked probative

[5] The procedural history of appellant's request for authorization for thoracic outlet surgery has been set forth in detail in the Board's prior decision, and is incorporated herein by reference.

[6] In a March 18, 2011 decision, an OWCP hearing representative set aside and remanded the December 23, 2010 decision because a conflict in medical opinion evidence existed regarding whether thoracic outlet surgery was necessary to treat appellant's accepted condition(s). Accordingly, it referred appellant's claim to Dr. Haskins for an impartial medical examination in order to resolve the conflict.

value because he provided insufficient medical rationale for his conclusion that OWCP should not authorize thoracic outlet surgery.[7] The Board remanded the case to OWCP for referral to a new impartial medical examiner followed by a *de novo* decision.

On remand, OWCP referred appellant, along with the medical record, and an updated SOAF, to Dr. Michael Mitrick a Board-certified orthopedic surgeon, for an impartial medical examination in order to resolve the conflict on whether it was medically necessary for appellant to undergo thoracic outlet surgery.[8]

In a February 8, 2017 report, Dr. Mitrick reviewed appellant's history and related that according to the updated SOAF, OWCP had accepted appellant's claim for cervical strain, cervical radiculopathy, and herniated cervical disc at C6-7 as a result of a June 27, 1997 work injury. He noted that, according to an April 11, 2008 occupational disease claim, OWCP had also accepted that appellant sustained aggravation of thoracic outlet syndrome as a result of his employment duties. Dr. Mitrick related that appellant's chief complaints were of pain between his shoulder blades radiating down both arms and numbness in his fingers. Upon physical examination of appellant's cervical spine, he observed no evidence of any muscle spasms. Dr. Mitrick related that she complained of tenderness all the way down to T12 and more laterally in the area of the thoracic spine. He reported range of motion findings of extension to 20 degrees, lateral rotation to 30 degrees on each side, lateral flexion to 15 degrees, and no forward flexion. Dr. Mitrick noted that appellant complained of neck tenderness at every level in the cervical spine and of trapezius tenderness. He reported that he was unable to get him to distinguish whether there was any altered sensation in either upper extremity because appellant simply insisted that his arms felt "stingy." Phalen's test was negative bilaterally. Tinel's test resulted in appellant complaining of a tingling slightly up the forearm. Dr. Mitrick reported that Roos' test showed no pain, weakness, or numbness down appellant's arms. He also noted that Adson's test showed no diminution of appellant's right and left radial pulses.

In response to OWCP's questionnaire, Dr. Mitrick opined that he could not find any evidence of thoracic outlet syndrome. He explained that appellant had no evidence of radiculopathy in the lower extremities and had normal reflexes and good strength in the upper extremities. Dr. Mitrick reported that he found absolutely no muscle atrophy in either upper extremity and found no evidence of any thoracic outlet. He also related that an EMG study dated April 10, 2002, showed no evidence of other peripheral nerve injury or entrapment, cervical radiculopathy, brachial plexus lesion, or thoracic outlet. Dr. Mitrick noted that this examination was within two years of appellant's surgery, so he did not see how appellant could have developed thoracic outlet after that time. He further explained that appellant's symptoms of neck pain, upper

[7] The Board noted that Dr. Haskins determined that, based on his examination findings, appellant did not have thoracic outlet syndrome. The Board related that, although Dr. Haskins acknowledged that appellant had abnormal diagnostic results, he failed to give any medical explanation as to how appellant's physical examination and history negated the abnormal diagnostic testing.

[8] OWCP noted that a conflict in medical opinion evidence existed between Dr. Karas, appellant's treating physician, who recommended surgery, and Dr. Robert Draper, a second-opinion examiner, who determined that appellant did not have thoracic outlet syndrome, and accordingly, that thoracic outlet syndrome was not medically necessary.

thoracic pain, and bilateral shoulder pain did not go along very well with thoracic outlet. Dr. Mitrick concluded that appellant had no evidence of thoracic outlet.

Appellant also received medical treatment from Dr. Constantine A. Misoul, a Board-certified orthopedic surgeon. In a September 19, 2016 report, Dr. Misoul related that appellant continued to have difficulty with aching pain in his neck and upper back radiating to his arms after a June 27, 1997 employment injury. Upon physical examination of appellant's cervical spine, he observed tenderness over the paracervical musculature, dorsoscapular musculature, and trapezii. Dr. Misoul also noted supraclavicular tenderness with positive Tinel's sign over the supraclavicular region. Adson's and Roos' maneuvers were positive. Dr. Misoul recommended that appellant be reevaluated by Dr. Karas, a thoracic outlet syndrome specialist. He continued to treat appellant and provide medical reports.

In a decision dated February 24, 2017, OWCP again denied appellant's request for authorization of thoracic outlet surgery. It found that the special weight of the medical evidence rested with Dr. Mitrick, as the impartial medical examiner, who determined in his February 8, 2017 report that appellant did not have thoracic outlet syndrome, and accordingly, that he did not need surgery.

On March 3, 2017 appellant, through counsel, requested a hearing before a representative from OWCP's Branch of Hearings and Review.[9] A hearing was held on September 15, 2017.

OWCP received June 5 and August 28, 2017 reports and an October 30, 2017 letter by Dr. Misoul. Dr. Misoul noted a date of injury of June 27, 1997 and related that appellant was diagnosed with thoracic outlet syndrome by Dr. Karas, a thoracic outlet syndrome specialist, based on physical examination and vascular studies back in 2004 and 2007. He noted that every physician that OWCP had sent appellant to was not a thoracic outlet surgeon or specialist. Upon physical examination of appellant's cervicothoracic spine, Dr. Misoul observed tenderness over the paracervical and dorsoscapular musculature and positive Tinel's sign in the supraclavicular region. Adson's and Roos' maneuvers were positive bilaterally. Dr. Misoul also noted decreased sensation in the little and ring fingers, bilaterally. He reported that appellant's current work-related diagnoses included neck sprain, brachial neuritis, intervertebral disc disorder with myelopathy cervical region, and thoracic outlet syndrome. Dr. Misoul recommended that appellant follow-up with Dr. Karas regarding surgical options for his thoracic outlet syndrome.

By decision dated November 29, 2017, OWCP's hearing representative affirmed the February 24, 2017 decision. She found that the special weight of medical opinion evidence rested with Dr. Mitrick, as the impartial medical examiner, who determined in a February 7, 2017 report that appellant no longer suffered from thoracic outlet syndrome, and accordingly, surgery was not medically necessary.

[9] Appellant resubmitted various medical reports by Dr. Misoul dated December 7, 2015 to January 23, 2017.

LEGAL PRECEDENT

Section 8103(a) of FECA[10] 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.[11] 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.[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 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]

To be entitled to reimbursement of medical expenses, a claimant has the burden of proof to establish that the expenditures were incurred for treatment of the effects of an employment-related injury or condition.[15] Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.[16] In order for a surgical procedure to be authorized, a claimant must submit evidence to show that the procedure was for a condition related to the employment injury and that the surgery was medically warranted.[17] Both of these criteria must be met in order for OWCP to authorize payment.[18]

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 specialist) who shall make an examination.[19] This is called a referee examination and OWCP will select a physician

[10] *Supra* note 2.

[11] 5 U.S.C. § 8103; *see Thomas W. Stevens*, 50 ECAB 288 (1999).

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

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

[14] *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).

[15] *J.T.*, Docket No. 18-0503 (issued October 16, 2018); *Debra S. King*, 44 ECAB 203, 209 (1992).

[16] *C.L.*, Docket No. 17-0230 (issued April 24, 2018); *M.B.*, 58 ECAB 588 (2007); *Bertha L. Arnold*, 38 ECAB 282 (1986).

[17] *J.R.*, Docket No. 18-0603 (issued November 13, 2018); *Zane H. Cassell*, 32 ECAB 1537, 1540-41 (1981); *John E. Benton*, 15 ECAB 48, 49 (1963).

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

[19] 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).

who is qualified in the appropriate specialty and who has no prior connection with the case.[20] When there exists 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.[21]

When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[22]

ANALYSIS

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

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. OWCP determined that a conflict in medical opinion existed regarding whether thoracic outlet surgery was necessary to treat appellant's accepted condition. Following the Board's September 7, 2016 decision, it referred his claim to Dr. Mitrick, an impartial medical examiner, for review and examination in order to resolve the conflict in medical opinion, pursuant to 5 U.S.C. § 8123(a). In February 24 and November 29, 2017 decisions, OWCP denied authorization for thoracic outlet surgery based on Dr. Mitrick's February 8, 2017 impartial medical report.

In his February 8, 2017 report, Dr. Mitrick concluded that thoracic outlet surgery was not medically necessary to treat appellant's accepted conditions. He noted that based on his physical examination, he found no evidence of thoracic outlet syndrome. In determining the probative value of an impartial medical examiner'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.[23]

In this case, the Board finds that Dr. Mitrick provided insufficient medical rationale for his conclusion that OWCP should not authorize thoracic outlet surgery. In his February 8, 2017 report, Dr. Mitrick opined that he could not find any evidence of thoracic outlet syndrome. He related that physical examination showed good strength, normal reflexes, and no muscle atrophy in appellant's upper extremities. Dr. Mitrick also related that an April 10, 2002 EMG showed no evidence of other peripheral nerve injury or entrapment, brachial plexus lesion, or thoracic outlet.

[20] 20 C.F.R. § 10.321.

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

[22] *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

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

The Board notes that although Dr. Mitrick's February 8, 2017 report provides more recent physical examination findings, he utilized stale medical evidence.[24] Dr. Mitrick did not explain why he relied on an EMG study from 2002, particularly since appellant was not diagnosed with thoracic outlet syndrome until April 2004 when he was treated by Dr. Karas. In addition, he failed to address the more recent April 7, 2010 arterial stress test, which was indicative of thoracic outlet syndrome and a more recent March 31, 2009 EMG/NCV study. The Board notes that Dr. Mitrick failed to utilize the most recent clinical studies and did not reconcile appellant's subjective complaints with his examination findings.[25] Dr. Mitrick failed to provide a medical explanation as to how appellant no longer had thoracic outlet syndrome despite his history of abnormal diagnostic testing. The Board has found that when an impartial medical examiner 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.[26]

Because Dr. Mitrick's report lacked probative value, the Board finds that OWCP erred in relying on his February 8, 2017 report as the basis for denying authorization for thoracic outlet surgery.[27] When OWCP obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in medical evidence and the specialist's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the specialist to correct the defect in the original report.[28] As it referred appellant to Dr. Mitrick for an impartial medical examination, it has a duty to obtain a report sufficient to resolve the issues raised and the questions posed to the specialist.[29] The case will be remanded to OWCP for further development of the medical evidence, including obtaining new diagnostic testing to assess the extent of appellant's accepted thoracic outlet condition, followed a supplemental opinion from Dr. Mitrick. Following this and any other development as OWCP deems necessary, OWCP shall issue *de novo* decision.

CONCLUSION

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

[24] The Board has held that stale medical evidence cannot form the basis for current evaluation of residual symptomology, disability determination, or other medical determinations. *G.M.*, Docket No. 14-2057 (issued May 12, 2015).

[25] *See W.P., Docket* No. 16-1229 (issued April 12, 2017).

[26] *See A.R.*, Docket No. 12-0443 (issued October 9, 2012); *see also P.F.*, Docket No. 13-0728 (issued September 9, 2014).

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

[28] *Supra* note 22.

[29] *Melvin James*, 55 ECAB 406 (2004).

ORDER

IT IS HEREBY ORDERED THAT the November 29, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this opinion of the Board.

Issued: July 9, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy 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