United States Department of Labor
Employees' Compensation Appeals Board

M.U., Appellant	)	
and	)	**Docket No. 16-1822**
	)	**Issued: June 18, 2018**
U.S. POSTAL SERVICE, POST OFFICE, La Puente, CA, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 14, 2016 appellant, through counsel, filed a timely appeal from a July 18, 2016 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.

[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.*

ISSUE

The issue is whether OWCP abused its discretion in denying appellant's request for cervical surgery.

FACTUAL HISTORY

On March 18, 2013 appellant, then a 57-year-old city carrier, filed an occupational disease claim (Form CA-2) alleging that he developed neck and left shoulder conditions as a result of repetitive lifting and tossing of parcels. On June 21, 2013 OWCP accepted his claim for left rotator cuff tear and cervical strain.[3]

Following unsuccessful courses of physical therapy, appellant's treating physician, Dr. Hosea Brown III, an internist, referred appellant to Dr. Serge Obukhoff, a Board-certified neurosurgeon. In a report dated June 28, 2013, Dr. Obukhoff examined appellant and reviewed his history of injury. He noted that appellant initially experienced neck pain in August 2012, which appellant attributed to repetitively twisting and turning his neck. Dr. Obukhoff reviewed a magnetic resonance imaging (MRI) scan of appellant's cervical spine, which showed severe cervical canal stenosis due to a herniated disc at C4-5 and C6-7 and an effacement of the ventral spinal cord by herniating disc material. He requested that appellant's accepted diagnosis be revised to cervical disc herniations with myelopathy, and he explained appellant's job had for many years required lifting and carrying heavy objects on a regular basis. Dr. Obukhoff explained that, with this type of physical activity, patients often sustained injury to the ligamentous complex of axial spine, particularly cervical spine, and as a result of these injuries, developed accelerated degeneration of cervical discs and subsequently cord compression and foraminal stenosis. He noted that appellant was gradually developing symptoms, which correlated with his examination findings and clinical presentation.

In a July 9, 2013 progress report, Dr. Brown noted that Dr. Obukhoff felt that appropriate treatment for appellant would be a C4-5 and C6 discectomy with decompression of spinal cord followed by fusion. In an August 5, 2013 progress note, he noted that appellant was in the process of contemplating the recommended surgical intervention.

By letter dated August 5, 2013, Dr. Brown requested that OWCP expand appellant's list of accepted conditions to include permanent aggravation of degenerative joint disease of the cervical spine, cervical intervertebral disc syndrome with myelopathy, cervical radiculopathy, left rotator cuff syndrome, and left-sided acromioclavicular arthropathy. He noted that the MRI scan of appellant's cervical spine, in addition to x-rays, were consistent with these diagnoses. Dr. Brown opined that appellant's medical conditions arose as a direct result of the performance of duties as a city letter carrier throughout his extensive 34-year employment history. He related that, with regard to appellant's neck, he indicated that appellant performed repetitive twisting and turning of his cervical spine when transferring parcels throughout the day from the front to the back of the

[3] The present claim was assigned OWCP File No. xxxxxx924. Appellant also has a prior claim before OWCP. In File No. xxxxxx890, OWCP accepted his January 14, 1999 traumatic injury claim for right elbow strain, right biceps tendinitis, and right lateral epicondylitis. OWCP File Nos. xxxxxx924 and xxxxxx890 have been administratively combined, with File No. xxxxxx890 serving as the master file.

van into the appropriate receptacles. Appellant recounted that, during this process, he was repetitively twisting and turning his neck from six to seven hours daily. He noticed that he experienced significant pain, discomfort, and stiffness in his neck upon completion of his employment tasks. With regard to appellant's left shoulder, he indicated that he performed transfers of parcels from the front of his vehicle to the back, which caused him to develop progressively increasing pain and discomfort in his left shoulder as well as his neck. Unfortunately, this employment-related activity caused him to undergo left rotator cuff tear syndrome as well as accelerate, aggravate and precipitate the significant degenerative disc disease of the cervical spine. Dr. Brown opined that the sheer repetitive flexing and extending of the cervical spine required by appellant's employment duties clearly increased the biomechanical load to his cervical spine as well as his left shoulder thereby causing progressive inflammation, desiccation, degeneration, and irritation in these areas causing both a significant degenerative disc disease of the cervical spine as well as a left rotator cuff syndrome.

On October 15, 2013 Dr. Obukhoff requested authorization for cervical surgery, including spine fusion, insertion of a spine fixation device, application of a prosthetic device, and decompression.

In an October 30, 2013 letter, OWCP informed Dr. Obukhoff that further medical development was needed before his request for authorization could be approved or denied.

By letter dated November 8, 2013, OWCP referred appellant, along with the case record and a statement of accepted facts (SOAF) to a second opinion physician, in order to determine whether his diagnosed conditions were connected to the accepted injury, the current residuals, periods of disability, current work restrictions, and whether the requested cervical surgery should be authorized.

By report dated January 16, 2014, second opinion physician, Dr. Michael Einbund, a Board-certified orthopedic surgeon, maintained that appellant's claim should not be expanded to include additional conditions due to discrepancies in his diagnostic studies. He explained that appellant's MRI scan of the cervical spine described degenerative changes, as well as targetoid lesion, as well as subluxation. There, however, was no description of any nerve root impingement which would account for the multiple levels of radiculopathy described on the electromyogram and nerve conduction velocity (EMG/NCV) studies. Further, there is no evidence that the cervical strain has caused any material changes in any of appellant's underlying conditions. Dr. Einbund further noted that there were no residuals from the accepted cervical strain, but there were residuals from the left shoulder condition. With regard to appellant's requested surgery to his cervical spine, Dr. Einbund observed:

> "Based on [appellant's] MRI scan, he does not appear to be a candidate for the proposed anterior cervical fusion. He does have a positive EMG, but his MRI scan reveals small disc bulges without obvious nerve root impingement…. The detailed abnormalities and conflicting [evidence] based on the MRI scans do not rise to the level of such aggressive treatment. Notably, there is evidence of an ovoid targetoid lesion which is also nonindustrial.… Any treatment for the cervical spine necessary at this time, would not be the result of the January 16, 2013 incident of repetitive lifting and tossing…."

By decision dated February 5, 2014, OWCP denied appellant's request to expand his list of accepted injuries to include permanent aggravation of degenerative joint disease of the cervical spine, cervical intervertebral disc syndrome with myelopathy, and cervical radiculopathy. It also denied the requested cervical surgery. OWCP found that the weight of medical evidence rested with Dr. Einbund's November 8, 2013 report.

By letter dated February 25, 2014, Dr. Brown strongly disagreed with Dr. Einbund's report. He explained that Dr. Einbund erroneously claimed that appellant's cervical spine strain had resolved, and that his findings on physical examination were in error. Dr. Brown noted that all physical examinations of appellant by himself and Dr. Obukhoff had revealed "tremendously decreased range of motion of the cervical spine as well as severe spasm of the paraspinal cervical musculature." He noted that Dr. Einbund had mischaracterized an MRI scan report as showing "no disc in neck," while Dr. Obukhoff had analyzed the same report on June 28, 2014 as demonstrating conditions at C4-5 and C6-7. Dr. Brown suggested that appellant undergo another MRI scan for additional assessment.

In a diagnostic report dated February 20, 2014, Dr. Richard Chai, Board-certified in diagnostic radiology and neuroradiology, examined the new MRI scan of appellant's cervical spine. He stated: impressions of straightening of cervical lordosis; minimal anterolisthesis of C4 on C5; a mild broad-based disc bulge at C3-4 effacing the ventral cerebrospinal fluid space with mild central canal narrowing; minimal anterolisthesis of C4 on C5 and squaring of the uncovertebral joins; mild broad-based disc bulge; mild central canal and bilateral foraminal narrowing; a mild broad-based disc bulge at C6-7 with mild central canal narrowing and mild bilateral foraminal narrowing; and a normal cervical spinal cord signal.

By letter dated April 16, 2014, appellant noted that OWCP had not responded to Dr. Brown's February 25, 2014 letter and requested that OWCP do so, as well as provide an impartial medical evaluation.

On May 16, 2014 OWCP responded, noting that if appellant disagreed with its decision, he should exercise his appeal rights.

On June 16, 2014 appellant requested reconsideration of OWCP's February 5, 2014 decision.

By letter dated June 9, 2014, Dr. Brown noted that OWCP had not yet reviewed his response to Dr. Einbund's second opinion report. He maintained that Dr. Einbund's report did not provide a well-reasoned medical rationale for his claim that any treatment for the cervical spine necessary at this time would not be the result of the January 16, 2013 incident of repetitive lifting and tossing. Dr. Brown claimed that he had previously given a complete explanation of the medical rationale involved as to why further treatment was necessary for the employment-related cervical condition. He further noted that the results of the February 20, 2014 MRI scan were consistent with appellant's several cervical spine conditions and entirely contradictory to Dr. Einbund's findings.[4]

[4] On July 28, 2014 appellant underwent surgery to his left shoulder, authorized by OWCP.

By letter dated October 20, 2014, OWCP referred appellant's claim to a referee physician for resolution of a conflict in the medical evidence between Drs. Einbund and Brown with regard to the nature and extent of appellant's injuries and requested surgical treatment. On November 25, 2014 it informed appellant that it had scheduled an appointment with Dr. Jaime Contreras, a Board-certified orthopedic surgeon, for a referee examination.

In a report dated January 20, 2015, Dr. Contreras examined appellant, reviewed his medical history, and diagnosed appellant with multilevel intervertebral cervical disc syndrome with cervical radiculopathy and postoperative conditions of the left shoulder. He reviewed the MRI scan and EMG reports of record. On examination of appellant's cervical spine, Dr. Contreras noted that appellant had increased cervical lordosis, muscle guarding on palpation of the upper trapezius muscle, tenderness of the interspinous ligaments and transverse processes, tenderness of the cervical roots, and decreased motion of the cervical spine with pain. On neurological examination, he noted: appellant had normal bicipital, tricipital, and brachioradialis reflexes; normal sensation to light touch in the upper extremities; and no localized muscle atrophy of the upper extremities with arms at rest.[5] Dr. Contreras noted, "Clinically, there are no indications for surgery to the neck or for additional surgery to the left shoulder to cure or relieve examinee from the effects of the work injuries."

By decision dated February 20, 2015, OWCP vacated its decision of February 5, 2014 and accepted additional conditions of multilevel intervertebral cervical disc syndrome and cervical radiculopathy. It noted that its February 5, 2014 decision was not altered as to the issue of denial of authorization for neck surgery.

In a report dated April 10, 2015, Dr. James T. Tran, a Board-certified neurosurgeon, noted that he had reviewed Dr. Contreras' report of January 20, 2015, and found that there was no evidence that Dr. Contreras had read an MRI scan of the cervical spine himself. He speculated that Dr. Contreras had merely read an impression of an MRI scan of the cervical spine, rather than examining the results himself. Dr. Tran further noted that there was no evidence that Dr. Contreras had formal training in spinal surgery. He opined that therapy and surgical intervention for cervical spinal cord compression were medically necessary, because appellant experienced spinal cord compression causing weakness of the extremities.

On April 27, 2015 appellant requested reconsideration of OWCP's February 20, 2015 decision denying authorization for cervical surgery.

By letter dated June 29, 2015, Dr. Brown again requested that OWCP approve cervical spine surgery as recommended by himself and Dr. Tran. He noted that Dr. Contreras offered no medical rationale for his opinion that cervical spine surgery was not indicated, instead simply stating that it was not indicated without further elaboration. Dr. Brown observed that Dr. Contreras had not had the opportunity to review Dr. Tran's report and that as such, his opinion concerning cervical spine surgery had less value. He recommended that if surgery could not be

[5] Dr. Contreras noted that, "Clinically, there are no indications for surgery to the neck or for additional surgery to the left shoulder to cure or relieve examinee from the effects of the work injuries."

authorized urgently, that appellant should be sent for a follow-up referee examination in order for the referee examiner to review Dr. Tran's report.

By decision dated July 23, 2015, OWCP reviewed appellant's claim and found that the evidence of record was insufficient to modify its February 20, 2015 decision. It noted that Dr. Tran's questioning of Dr. Contreras' qualifications and findings were insufficient to overcome the weight of his opinion as an impartial medical referee examiner. Specifically, OWCP noted that there was no requirement that Dr. Contreras had to view the MRI scan himself, rather than relying upon the impression of the radiologist, and that he was an orthopedic surgeon and as such was an appropriate specialist for appellant's condition.

On September 9, 2015 appellant requested reconsideration of OWCP's July 23, 2015 decision. With his request, he attached a letter from Dr. Brown dated August 24, 2015. Dr. Brown stated that he had reviewed OWCP's decision and found that OWCP's rationale was "faulty, inadequate, and clearly not based upon the medical evidence in this case." He noted that appellant had been "thoroughly and extensively evaluated by [Dr. Tran], who is a [B]oard-certified neurosurgeon, who opines that the patient clearly requires cervical spine surgery in the form of a posterior laminoforaminotomy and hemilaminotomy at C4-5 and C6-7 for treatment of his accepted work-related cervical conditions." Dr. Brown insisted that Dr. Contreras' lack of training in spinal surgery would render his opinion of less value and questioned OWCP's reasoning in giving it greater value than Dr. Tran's opinion.

By letter dated September 4, 2015, Dr. Tran noted that Dr. Contreras had "failed to perform a motor examination of the right upper extremity and the lower extremities. He neglected to perform a reflex examination of the upper and lower extremities to check for hyperreflexia, which is important in spinal cord compromise or compression." Dr. Tran explained that, while the claims examiner had relied in good faith on Dr. Contreras' report, the report was incomplete without a neurological examination, and as such should be set aside. He maintained that surgery should be approved; or in the alternative, that appellant should be referred to a neurosurgeon instead of an orthopedic surgeon for a further referee examination.

By decision dated December 8, 2015, OWCP reviewed appellant's claim and found that the evidence of record was insufficient to modify its July 23, 2015 decision. It found that Dr. Tran's and Dr. Brown's opinion that Dr. Contreras did not have the requisite training or experience to offer an opinion on the matter of whether surgery should be authorized was insufficient to modify its prior decision. OWCP further noted that Dr. Contreras had sufficiently explained his reasons for finding that appellant did not require surgery, and that OWCP had not received any concrete evidence to indicate that Dr. Contreras' opinion was incorrect or inconclusive.

By letter dated February 5, 2016, Dr. Tran noted that OWCP indicated in its December 8, 2015 decision that it had not received any concrete evidence to support that Dr. Contreras' opinion was incorrect or inconclusive. He reiterated that Dr. Contreras' failure to conduct a neurological examination was a breach of duty and that, without such an examination, Dr. Contreras' opinion was insufficiently rationalized.

By letter dated March 28, 2016, Dr. Brown noted that appellant continued to exhibit severe residuals pertinent to his accepted cervical spine conditions, and that the delay in surgical intervention had led to a situation where appellant was experiencing tremendous harm. He noted that the evaluation of Dr. Contreras was inadequate in evaluating appellant's cervical spine condition, and requested that appellant be sent to a neurosurgeon for an independent medical evaluation.

On April 19, 2016 appellant requested reconsideration of OWCP's December 8, 2015 decision.

By decision dated July 18, 2016, OWCP reviewed appellant's claim and found that the evidence of record was insufficient to modify its December 8, 2015 decision. It noted that Dr. Contreras had in fact performed a neurological test, as documented in his January 20, 2015 report, and, as such, the arguments of Drs. Tran and Brown were unfounded.[6]

LEGAL PRECEDENT

Section 8103(a) of FECA provides for the furnishing of services, appliances, and supplies prescribed or recommended by a qualified physician who OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.[7] In interpreting section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[8]

OWCP has administrative discretion in choosing the means to achieve the goal of recovery from a work-related injury and the only limitation on OWCP's authority is that of reasonableness.[9]

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.[10]

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[6] On April 3 and December 12, 2017 OWCP issued merit decisions which denied modification of prior decisions denying appellant's request for authorization of cervical surgery. Those decisions, however, are null and void as the Board and OWCP may not simultaneously have jurisdiction over the same case. OWCP may not issue a decision regarding the same issue on appeal before the Board, in this instance, request for authorization of cervical surgery. *See Russell E. Lerman*, 43 ECAB 770, 772 (1992); *Douglas E. Billings*, 41 ECAB 880 (1990).

[7] 5 U.S.C. § 8103(a).

[8] *See Dale E. Jones*, 48 ECAB 648-49 (1997).

[9] *See Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or administrative actions which are contrary to both logic and probable deductions from established facts).

[10] *See Minnie B. Lewis*, 53 ECAB 606 (2002).

Once OWCP undertakes development of the record it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[11]

ANALYSIS

The Board finds this case not in posture for decision.

Dr. Contreras, in his January 20, 2015 report, diagnosed multilevel intervertebral cervical disc syndrome with cervical radiculopathy, and postoperative conditions of the left shoulder. Accordingly, in its February 20, 2015 decision, OWCP expanded appellant's claim to include multilevel intervertebral cervical disc syndrome with cervical radiculopathy as an additional accepted condition. Although the condition for which surgery was requested was subsequently found to be work related, OWCP denied modification of its prior decision denying authorization for neck surgery without sending Dr. Contreras an updated SOAF and requesting a supplemental opinion with regard to whether cervical surgery was now warranted.

The SOAF is the means by which factual findings are separated from medical findings and opinion. This separation of functions is aimed at seeing that the claims examiner does not inadvertently make medical decisions.[12] Without a reasoned medical opinion based on a proper factual and medical background, resolving the conflict in light of the additional accepted conditions, the claims examiner in this case inadvertently made a medical decision when he denied appellant's request for authorization for surgery.

It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done. As OWCP undertook development of the evidence by referring appellant to Dr. Contreras, it had the duty to secure an appropriate report based on a proper factual and medical background, resolving the conflict in medical opinion.[13]

On remand, OWCP should provide Dr. Contreras with an updated SOAF and request a supplemental opinion regarding whether OWCP should authorize the cervical surgery in light of the subsequent acceptance of intervertebral cervical disc syndrome. After such further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds this case not in posture for decision.

[11] *See Phillip L. Barnes*, 55 ECAB 426 (2004); *see also Virginia Richard (Lionel F. Richard)*, 53 ECAB 430 (2002); *William J. Cantrell*, 34 ECAB 1233 (1993); *Dorothy L. Sidwell*, 36 ECAB 699 (1985).

[12] *M.H.* Docket No. 11-1117 (issued December 2, 2011); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.2(c) (September 2009).

[13] *Supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the July 18, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for additional action consistent with the Board's decision.[14]

Issued: June 18, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

[14] Colleen Duffy Kiko, Judge, participated in this decision, but was no longer a member of the Board effective December 11, 2017.