File Number:
HR10-D-H

RECEIVED SEP 29 2009

U S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

SEP 23 2009

Date of Injury:
Employee:

Dear Mr. :

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 06/29/2009. As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Debra Harvey
Hearing Representative

PAUL H. FESLER
ESQ.
FELSER LAW FIRM, P.C.
7 EASTCONGRESS ST., SUITE 400
SAVANNAH, GA 31412

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et seq. of Claimant, Employed by the , Case No . Hearing was held on June 29, 2009, in Atlanta, Georgia.

The issue is whether the claimant has an impairment of one or both of the lower extremities that would entitle him to schedule award benefits.

The claimant, date of birth, , is employed by the in , , as a . On , he filed the Form CA-1, Notice of Traumatic Injury, stating on , he was pulling a patient up from the bed and felt severe pain and popping in his lower back and down his left leg. An August 3, 2005, MRI of the lumbar spine showed disc bulges at L1-2, L2-3, L3-4, and L5-S1 levels along with a moderate right foramina herniated nucleus pulposis with stenosis at t L4-5 level.

A September 14, 2005, lumbar myelogram showed disc bulges at the L2-3 and L3-4 levels with a "vacuum disc phenomenon, broad based disc bulge, and right disc protrusion" at the L4-5 level, and a small central disc protrusion at the L5-S1 level.

The Attending Physician, Dr , submitted a letter dated September 26, 2005, stating, "Mr 's diagnosis is that of lumbar radiculitis and lumbar disc herniation L4-5. Based upon information provided to me by Mr and my nurse practitioner, Mr did suffer a work related injury on 08/01/05 while lifting a patient working as a nurse."

The Office accepted an L4-5 herniated disc on October 4, 2005. He underwent epidural steroid injections.

On December 13, 2005, Dr referred the claimant for EMG and nerve conduction studies. These were performed on December 19, 2005, by Dr. Dr. stated the electrophysiological findings suggested a left L4 radiculopathy. On February 16, 2005, the EMG/NCS studies were repeated. Dr. stated these studies showed involvement of the L5 nerve root as well.

A July 20, 2006, note from Dr , Professor of Neurosurgery, stated, "I think that he suffered a lateral disc herniation approximately a year ago that produced a proximal radiculopathy, either L3 or L4 or perhaps both."

He was held off work but returned to full-time, limited duty work with restrictions of no lifting more than 50 pounds on April 17, 2007. A May 10, 2007, report from Dr , neurologist, was received. Dr. stated he had treated the claimant on June 5, 2006, August 7, 2006, and January 23, 2007. These notes are not in the file. He provided a history of an injury to the back after lifting a patient in bed on August 1, 2005. "He felt a popping sensation in his low back and then a pain from the back into the right leg." He noted the MRI results and stated there was stenosis at all levels of the spine with the worst degree at L5-S1. He stated the claimant had "back problems at multiple levels due to bulging disks and arthritic bone spurs that cause both spinal stenosis and foraminal stenosis at multiple levels. He symptomatically gets

intermittent problems with back pain radiating into his legs and at one point had a foot drop on the left due to a nerve root involvement Job-related activities that would likely increase back problems would include heavy lifting, bending, activities that would jostle the back, activities requiring a lot of movements up and down stairs – etc." He did not discuss causal relationship of the back condition to work

On January 11, 2008, the Office accepted lumbar radiculopathy.

On June 17, 2008, the Office referred the claimant to Dr. , orthopedist, who stated the claimant ambulated without difficulty. Straight leg raise on the left side was negative with some back pain but no radicular pain. Straight leg on the right caused some knee pain lying in a supine position. There was pain in a prone position and with flexing the knees. Motor function was 5/5 on the right and the right lower extremities and 4/5 motor strength on the left lower extremities. He had ½ inch calf atrophy proximal to the patella and there was some decreased sensation of the medial side of the left lower leg. His diagnosis was "resolved L4/5 and 5/S1 multi level HNP." He stated the problem had "resolved, even then with only minimal weakness on the left lower extremities."

On August 12, 2008, the claimant filed the Form CA-7, Claim for Compensation, for permanent impairment of the lower extremities as a result of the back condition. A report from Dr. of March 31, 2008, noted 13 percent impairment based on a Functional Capacity Evaluation (FCE). The Office's District Medical Advisor (DMA), Dr. , reviewed the medical file on September 3, 2008, and stated, "Claimant had work related aggravation of degenerative disc lumbar which was meniscal without surgical intervention. He has returned to work without restriction. There is no documentation of a radiculopathy." He stated there was no impairment to either lower extremity.

The Office then determined a conflict in medical opinion existed and referred the claimant to Dr. to resolve the conflict. Dr. stated on December 8, 2008, the claimant had some limited range of motion but no radiculopathy. He stated he had a 13% whole-body impairment as a result of the herniated disc with radiculopathy, even though his symptoms had significantly improved. On December 30, 2008, the Office wrote Dr. and advised him that OWCP does not accept whole-body ratings and he was asked for an impairment rating using the AMA *Guides to the Evaluation of Permanent Impairment* in terms of loss of use of the affected member of the body. The doctor responded saying there was no impairment due to loss of function from sensory deficit pain or discomfort and no impairment due to loss of function from decreased strength. The DMA again reviewed the file and stated the narrative report indicated a normal neurological exam, and there was zero motor and sensory loss. He stated there was no impairment.

The District Office formally denied schedule award benefits on January 22, 2009, finding no impairment to a scheduled body member. The claimant disagreed with this decision and through her attorney, Mr. Felser, requested an oral hearing before an OWCP Hearing Representative.

The hearing was held on June 20, 2009, in Atlanta, Georgia. The claimant did not appear but was represented by Mr. Felser who argued the instant claim should be evaluated under the 6th edition of the AMA *Guides*. He noted Dr. did not negate a permanent impairment and he noted that radiculopathy indicated continuing residuals.

Mr. Felser argued the claim should be expanded to include multi-level lumbar disc conditions and he referenced Dr. diagnosis of L4-5 and L5-S1 herniations. He also noted the EMG report that showed radiculopathy. In addition, he stated pain had not been considered in the impairment evaluation.

A copy of the hearing transcript was sent to the Employing Agency on July 13, 2009, for review and comment. There was no response.

Mr. Felser submitted a post-hearing brief dated August 7, 2009, summarizing his arguments.

Received after the hearing was an April 29, 2009, letter from Dr. to Dr. This letter stated the claimant was having chronic back problems. He stated the claimant had "loss of quadriceps muscle bulk on the left and diminished left knee jerk, fasciculations of the left quadriceps, weakness of extension at the knee which is mild, some lifting on the left when he walks, and a modestly positive straight leg raise. He has spinal stenosis. He cannot bend or stoop easily without pain. He cannot lift much without pain. He cannot walk or stand for long distances or long periods of time. He clearly does have chronic radicular problems, mostly on the left side, related to his chronic spinal stenosis. The only thing that I can offer him, is conservative treatment."

This case was referred for a referee specialist examination to resolve a conflict the Office determined existed between Drs. and . However, Dr. did not render an opinion on impairment. The DMA who reviewed the file for permanent impairment stated there was no evidence of radiculopathy; however, there are two EMG reports in the file that show radiculopathy at the L4-5 and L5-S1 levels. The DMA's findings were not based on a complete review of the file. I find the evidence is not sufficient to establish there is a conflict in medical opinion between medical providers that carry equal weight.

When there are opposing medical reports of virtually equal weight and rationale, the case will be referred to an impartial specialist, pursuant to section 8123(a), to resolve the conflict in the medical opinion.[1]

I find the medical report of Dr. is not considered to have special weight since it was improperly obtained. Thus, his report is considered a second opinion examination. There now exists a conflict between Dr. and Dr. concerning the percentage of impairment, if any, of the lower extremities. Dr. does not provide sufficient rationale of impairment for his report to carry the weight and Dr. report is conflicting. Thus, a new referee examination is indicated to determine the percentage of impairment.

There is a second issue in this case, however. The attorney has indicated that additional lumbar conditions have been diagnosed but none have been established to be causally related to the employment injury by the preponderance of evidence. Thus, further development is indicated.

Therefore, on REMAND the Statement of Accepted Facts should be updated as necessary. The claimant should be referred to a Board-certified medical specialist for a referee examination to determine if there is permanent impairment of one or both of the lower extremities. In addition, the medical specialist should determine if additional lumbar conditions are causally related to the employment injury of August 1, 2005. The specialist will be considered a second opinion examiner concerning this issue.

[1] *Cathy B. Millin*, 51 ECAB ___ (Docket NO. 97-2898, issued February 10)

After the report of examination has been received and after completion of additional development the District Office deems necessary, *de novo* decisions should be issued

DATED: SEP 23 2009

WASHINGTON, D.C

Debra W. Harvey

DEBRA W HARVEY
Hearing Representative
For
Director, Office of Workers'
Compensation Programs