U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LISA L. KENNELL and DEPARTMENT OF THE TREASURY, U.S. CUSTOMS SERVICE, Blaine, Wash.

Docket No. 97-1183; Submitted on the Record;
Issued January 11, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON, WILLIE T.C. THOMAS

The issue is whether appellant sustained a disc protrusion at the L5-S1 level as a result of her July 1, 1996 employment injury.

On July 1, 1996 appellant, a canine enforcement officer, filed a claim asserting that she sustained an injury to her back that day while in the performance of her duty. While screening passengers and searching luggage at a bus terminal, and while controlling her drug dog's leash with her left hand, she reached down with her right hand to pick up a large hard-sided piece of luggage. "As I turned to my right to set the luggage down," she stated, "I heard a loud pop and felt extreme pain run down my back and into my right leg."

Appellant was taken to an emergency room by ambulance. In an emergency department report dated July 1, 1996, Dr. Marvin Wayne, a specialist in emergency medicine, related that appellant had somehow stepped and twisted wrong and heard a tearing sensation in her mid back. She complained of severe low back pain but was found to have no neurological deficits when attended to by paramedics. Appellant was found to have no related dysfunction in the lower extremities. She reported that she had never had a prior problem like this. A physical examination of her back showed some diffuse paraspinous tenderness in the lumbosacral region. Dr. Wayne stated:

> "[Appellant] is really very uncomfortable with flexion, extension and rotation. There is no obvious step-off or acute deficit. She has good straight leg raising bilaterally. Proprioception, sensory and reflexes are normal in the lower extremities. She does have a lot of pain though when she [tries] to straight leg raise. The pain is in the lower back. No radiation."

Even with medication appellant was unable to ambulate because of pain. "This appears to be a severe low-back strain," Dr. Wayne stated. Arrangements were made to take appellant to the special care facility for control of the pain over the next 24 hours.

Dr. David L. Goldman, then a Board-eligible neurosurgeon and consulting physician at the hospital, saw appellant that same day. He reported that appellant had experienced the onset of severe sharp pain in the back with radiation into the right buttock and a progression of pain and stiffness. After reporting his findings on physical examination, Dr. Goldman stated that appellant had a severe lumbar strain, muscle spasm and right L5 radiculopathy with a sensory deficit in the L5 distribution and a subtle weakness of the right extensor hallucis longus. "It [is] possible," he stated, "that this patient has a disc herniation, and she has been scheduled for a lumbar MRI [magnetic resonance imaging] scan."

An MRI report dated July 2, 1996 stated that there was a small central and right posterolateral disc protrusion at the L5-S1 level abutting the right S1 nerve root.

Appellant was discharged on July 4, 1996. A discharge summary prepared by Dr. Thomas F. Schneider gave appellant's assessment as acute low back strain with severe spasm, much improved, and L5-S1 disc protrusion with radiculopathy. Dr. Schneider stated that this "seemed much improved post Decadron -- probably less likely the true source of her pain than the spasm. It was felt that this would probably resolve unremarkably and would not require surgical intervention."

Appellant returned for a follow-up examination on July 10, 1996. In a treatment note that date, Dr. James A. Ross, appellant's attending physician, indicated that Dr. Goldman was of the feeling that appellant's small disc prolapse was not associated with the pain episode of July 1, 1996. Dr. Ross made the following assessment: "At this point, we are signing it out as a severe muscular spasm with myofascial pain as an on-the-job injury with Dr. Goldman being the neurosurgical consult and the MRI showing disc protrusion at L5-S1, but felt by Dr. Goldman not to be associated specifically with the pain."

In a report dated September 10, 1996, Dr. Goldman stated that appellant had failed conservative management and was currently having progression of a right S1 radiculopathy. He stated that appellant had a right S1 sensory deficit and weakness corresponding to the radiographic lesion of the L5-S1 disc compressing the S1 nerve root. Dr. Goldman scheduled appellant for a right L5-S1 microdiscectomy pending approval. On September 16, 1996 he requested authorization from the Office of Workers' Compensation Programs for surgery.

Noting some discrepancy in the findings and the unusual degree of symptomatology early on, the Office referred appellant to Dr. Richard G. McCollum, a Board-certified orthopedic surgeon, for a second opinion. In a report dated October 3, 1996, Dr. McCollum related appellant's history of injury, clinical course and current complaints. After reporting his findings on physical examination, he addressed diagnostic testing as follows:

> "The MRI was read as showing a small central and right posterior lateral disc protrusion at L5, S1 abutting on the right S1 nerve root. The films were reviewed and this examiner cannot see much in the way of pathology at L5, S1 to the point that he questions whether it is even abnormal. It certainly does not correlate with any of the clinical findings."

Dr. McCollum diagnosed lumbar strain secondary to the injury of July 1, 1996. Noting a marked number of nonphysiological responses, he found that there was no firm evidence that appellant had an S1 or L5 radiculopathy based on his examination and that he saw no indication for surgery based on his findings.

The Office accepted appellant's claim for lumbar strain. In a decision dated October 9, 1996, the Office denied appellant's claim for the condition of herniated disc. The Office found that the weight of the medical evidence rested with Dr. McCollum.

Appellant underwent surgery on October 23, 1996. Diagnosing a right L5-S1 disc herniation and radiculopathy, Dr. Goldman performed a right L5, S1 partial hemilaminectomy, a right L5-S1 microdiscectomy, and a right S1 lateral recess decompression. He noted in his report that retracting the S1 nerve root medially exposed a small disc herniation at L5-S1. In a report dated December 6, 1996, Dr. Goldman, now a Board-certified neurological surgeon, stated that appellant's surgery was successful and that she had complete relief of her radicular pain and was able to return to full-time regular duties without restrictions six weeks following surgery.

The Office asked its medical adviser to review Dr. Goldman's operative findings and to report whether the findings were consistent with the employment incident of July 1, 1996. On January 2, 1997 the medical adviser reported that the operative findings did not allow a determination of whether there was a relationship to twisting and holding a dog. The operative report, it was noted, did not describe an extended fragment or ruptured disc; an incision of the annulus was required. The medical adviser also reported that, from his experience and knowledge of the physiology, the herniation of a disc makes no sound and is not a cause of a snapping sensation. Popping in a vertebra is most likely from a facet joint, he stated; the intervertebral disc does not cause a pop or snap by herniating or rupturing.

The Office medical adviser reported that there was a marked difference of opinion between Dr. Goldman and Dr. McCollum. He noted that Dr. Goldman's reports were relatively brief and incomplete, with no negatives or measurements and with no testing to confirm findings or to show nonorganic pain behavior. He noted that Dr. McCollum's examination, on the other hand, was very thorough and complete and documented multiple nonphysiological or nonorganic responses.

The Office medical adviser reported that the MRI findings were found and reported in about 50 percent of the normal population in appellant's age group and for this reason was not an indication for surgery. He also noted that a change in subjective complaints following a surgical procedure, in a single case such as this, also provided no proof of diagnosis or surgical indication due to a significant placebo effect with various treatments or procedures, especially with nonorganic problems. Concluding his report, the Office medical adviser stated that he found the opinion of Dr. McCollum to be valid and that he agreed with Dr. McCollum's conclusions.

In a decision dated January 7, 1997, the Office reviewed the merits of appellant's claim and denied modification of its prior decision. The Office found that the weight of the medical evidence rested with Dr. McCollum, whose report was found to be more complete and to contain a better medical explanation for the findings and opinion.

The Board finds that this case is not in posture for a determination of whether appellant sustained a disc protrusion at the L5-S1 level as a result of her July 1, 1996 employment injury. There is an unresolved conflict in medical opinion between appellant's attending physician and the Office second opinion physician necessitating referral to an impartial medical specialist pursuant to 5 U.S.C. § 8123(a).

Dr. Goldman, appellant's attending neurosurgeon, saw appellant on the date of injury. He reported that appellant had a severe lumbar strain, muscle spasm and right L5 radiculopathy with a sensory deficit in the L5 distribution and a subtle weakness of the right extensor hallucis longus. Appellant related that she had never had a prior problem like this. Dr. Goldman reported that it was possible that appellant had a disc herniation. An MRI obtained the next day was reported to show a small central and right posterolateral disc protrusion at the L5-S1 level abutting the right S1 nerve root. Although both Dr. Schneider and Dr. Goldman (according to Dr. Ross) felt that this disc protrusion was not specifically associated with the true source of appellant's pain, Dr. Goldman reported that appellant had a right S1 sensory deficit and weakness corresponding to the radiographic lesion of the L5-S1 disc compressing the S1 nerve root. Given the failure of conservative management, he requested authorization for surgery. During surgery on October 23, 1996, Dr. Goldman reported that retracting the S1 nerve root medially exposed a small disc herniation at L5-S1. Following surgery he reported that appellant had complete relief of her radicular pain and was able to return to regular duty.

Dr. McCollum, the orthopedic surgeon and Office referral physician, disagreed with Dr. Goldman on the need for surgery. He questioned whether the MRI revealed any abnormality at the L5-S1 level and noted a marked number of nonphysiological responses on examination. While Dr. Goldman reported that appellant's sensory deficit and weakness corresponded to the radiographic lesion of the L5-S1 disc compressing the S1 nerve root, Dr. McCollum reported that the MRI certainly did not correlate with any of the clinical findings.

Section 8123(a) of the Federal Employees' Compensation Act provides in part: "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 make an examination."[1]

To resolve the conflict in opinion between Dr. Goldman and Dr. McCollum, the Office should refer appellant, together with the medical record and a complete statement of accepted facts, to an appropriate impartial specialist for a well-reasoned opinion on whether appellant sustained a herniated disc at the L5-S1 level as a result of her July 1, 1996 employment injury. It is not necessary that the evidence be so conclusive as to suggest causal connection beyond all possible doubt in the mind of a medical scientist. The evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound and logical.[2] The question of whether appellant sustained an employment-related disc protrusion is different from the question of whether surgery for such a condition was warranted. Should the impartial specialist

[1] 5 U.S.C. § 8123(a).

[2] *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983) and cases cited therein at note 1.

conclude that appellant sustained an employment-related disc protrusion on July 1, 1996, the specialist should then discuss, with the benefit of hindsight, whether surgery was likely to or did in fact cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of monthly compensation.[3] After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's claim.

The January 7, 1997 and October 9, 1996 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, D.C.
January 11, 1999

George E. Rivers
Member

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

[3] *See* 5 U.S.C. § 8103(a).