

**United States Department of Labor
Employees' Compensation Appeals Board**

K.S., Appellant

and

**DEPARTMENT OF VETERANS AFFAIRS,
VETERANS ADMINISTRATION MEDICAL
CENTER, Perry Point, MD, Employer**

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**Docket No. 14-1148
Issued: December 23, 2014**

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 21, 2014 appellant, through her attorney, filed a timely appeal from a January 9, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish disability from work for the period July 26 to December 17, 2011 as a result of her March 23, 2009 back injury; and (2) whether OWCP properly denied authorization for lumbar surgery.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 12, 2009 appellant, then a 44-year-old part-time, intermittent licensed practical nurse, filed a traumatic injury claim alleging that on March 23, 2009 she slipped on a wet floor and fell on her left side. OWCP accepted her claim for left side herniated disc at L4-5 and associated radiculopathy. Appellant began to work part-time modified duty on May 21, 2009 at the employing establishment. She held several other part-time jobs in addition to working for the employing establishment.²

On July 25, 2011 appellant stopped working at the employing establishment. She filed various disability compensation claims for the period July 26 to December 17, 2011.³

The medical evidence relevant to the dates of claimed wage loss includes various reports by Dr. Hugo Benalcazar, a Board-certified neurological surgeon. In an August 22, 2011 report, he noted appellant's complaints of persistent pain in the lower back and gluteal area since a March 23, 2009 injury when she fell down at work. Dr. Benalcazar related that her pain initially improved with physical therapy but her back and neck pain had returned and progressively worsened. Upon examination, he observed normal lumbar spine evaluation and diagnosed lumbar degenerative disc disease, lumbar disc displacement, cervical degenerative disc disease with cervical myelopathy, and cervical disc displacement. In a November 17, 2011 note, Dr. Benalcazar related appellant's complaints of worsening back pain. He reviewed her history and noted no changes. In a November 17, 2011 work status note, Dr. Benalcazar indicated that appellant was unable to return to work from November 17 to December 17, 2011. He stated that she would be getting work notes from another physician after December 17, 2011.

In an October 13, 2011 schedule award report, Dr. Robert W. Macht, a Board-certified surgeon, described the history of injury and reviewed appellant's medical treatment, which included physical therapy and steroid injections. He related her complaints of moderate to severe pain in her back, left hip, and left leg. Dr. Macht conducted an examination and diagnosed soft tissue injury to left hip and left L5 radiculopathy. He opined that according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* appellant had 13 percent impairment of the left lower extremity.

In a December 15, 2011 narrative report, Dr. Henry A. Spindler, Board-certified in physical medicine and rehabilitation, related that on March 23, 2009 appellant sustained a slip-and-fall injury at work and had since complained of neck and low back pain with radicular pain down both legs. Upon examination, he reported that she complained of pain on the left at 45 degrees in the sciatic distribution with straight leg raising test. Sensation appeared intact and

² Appellant worked for a private rehabilitation center from December 29, 2004 to January 1, 2011 as a charge nurse. She also worked as a substitute nurse for the public school system beginning on December 20, 2011. A November 8, 2011 statement by Debbie L. Cannon, a human resources compliance specialist, revealed that appellant had not done any substitute nursing for the 2011-2012 school year.

³ The record reveals that appellant also submitted a September 30, 2011 claim form for disability compensation for the period January 1 to June 28, 2011. Appellant indicated that she worked light duty during that time at a school. As OWCP has not issued a formal decision regarding disability compensation during this period, the Board will not address her claim for disability from January 1 to June 28, 2011. See 5 U.S.C. § 501.2(c).

strength was normal. Dr. Spindler stated that diagnostic findings were compatible with a left L5 radiculopathy. In a medical status form, he noted that appellant was unable to work commencing December 14, 2011.

By letters dated December 6 and 23, 2011, OWCP advised appellant that the medical evidence submitted was insufficient to establish her disability claim for the alleged period. It requested additional evidence to demonstrate that she was disabled during the claimed period as a result of her accepted employment injury. No additional evidence was received.

In a decision dated January 20, 2012, OWCP denied appellant's claim for disability compensation for the period July 26 to December 17, 2011. It found that none of the evidence provided any medical rationale explaining why she was unable to work during the claimed period as a result of her accepted employment injury.⁴

By letter dated January 27, 2012, appellant, through counsel, requested a telephone hearing, which was held on April 9, 2012. She was represented by her attorney. Appellant stated that she was hired by the employing establishment in 2008 as an intermittent, personal care nurse to patients. She described her duties at the employing establishment and noted that she worked other part-time nursing jobs. Appellant accurately described the March 23, 2009 employment injury and the medical treatment she received. She stated that beginning in 2010 she informed her caseworker that she was in too much pain to continue to work. Appellant noted that she should have been working light duty but had actually been working full duty. She explained that she still experienced pain, weakness, and numbness in her neck, back, and left lower extremity. Appellant stated that she was not involved in any other injuries outside of work since the March 23, 2009 employment injury. She believed that she had been unable to work since July 28, 2011 due to her accepted conditions.

In a May 5, 2012 statement, Linda L. Greenawalt, a workers' compensation program manager at the employing establishment, explained that appellant was hired on a temporary appointment with an "as needed," on-call schedule. She noted that appellant worked three additional part-time jobs. Ms. Greenawalt alleged that the employing establishment offered appellant a light-duty assignment but appellant was often not available to work or failed to return the employing establishment's telephone calls due to working her other jobs. She also pointed out that appellant testified that she had resigned from two of her part-time jobs and provided no evidence that she was medically unable to perform her duties at her other jobs.

On March 13, 2012 OWCP referred appellant's claim to Dr. Willie Thompson, a Board-certified orthopedic surgeon, for a second opinion examination to determine the nature and extent of appellant's disability from January 2011 until the present.

⁴ On January 18, 2012 Dr. Benalcazar requested authorization for epidural steroid injections. On January 24, 2012 OWCP referred appellant, along with a statement of accepted facts, to a district medical adviser to determine whether foramen epidural injections were medically necessary to treat her medical conditions. In a February 22, 2012 report, the district medical adviser reviewed the record and the statement of accepted facts (SOAF). He recommended that she undergo a series of three epidural steroid injections two weeks apart, which should not be repeated without a six-month interval to improve the effectiveness of the epidural injections.

In an April 13, 2012 report, Dr. Thompson reviewed the statement of accepted facts and the medical record. He noted that appellant's claim was accepted for herniated lumbar disc on the left side at L4-5 and that her medical treatment had consisted of oral medication, physical therapy, and epidural steroid injections. Dr. Thompson related her present complaints of low back pain radiating into both the right and left lower extremities. Upon examination, he observed no tenderness in the lower back and no evidence of any paraspinous muscles. Dr. Thompson stated that, when requested to perform range of motion of the lumbosacral junction, appellant actively flexed to 60 degrees, extended to 0 degrees, and bent to the right and left at 10 degrees. He believed that these limitations of motion to be voluntary in nature. Sitting straight leg raise test was negative bilaterally, but appellant would not raise her left lower extremity more than 30 degrees in the supine position. Dr. Thompson reviewed her diagnostic reports and observed that a January 11, 2011 magnetic resonance imaging (MRI) scan of the lumbar spine revealed a herniated disc on the left side at L4-5, which was decreasing. Flexion and extension x-rays performed on February 3, 2011 were within normal limits.

Dr. Thompson opined based on the medical records and his evaluation, that appellant suffered soft tissue injuries to the lower back in the hip region. He stated that, in regard to the interpretation of an abnormal MRI scan, there must be a close correlation between the MRI scan and the findings on physical examination. Dr. Thompson reported that in this case there were no findings on physical examination to support that appellant had a herniated disc. He stated it appeared that she was overstating her symptomatology and that the lack of motion at the lumbosacral joint appeared to be voluntary in nature. Dr. Thompson explained that the inconsistent straight leg raising in the sitting and supine position were indicative of an attempt to magnify symptoms. He stated that "at this point in time" there was no objective evidence to indicate the need to place any physical limitations on appellant and opined that she may return to work without restrictions immediately. Dr. Thompson also found no continued effects of the March 2009 work injury and no evidence to indicate a need for additional medical treatment.

In a May 11, 2012 letter, appellant's attorney alleged that there was a conflict in medical opinion between Dr. Thompson's April 13, 2012 report and appellant's physicians' reports regarding whether appellant continued to suffer from her accepted disc herniation condition and was unable to work beginning July 26, 2011. He contended that there was a need for a referee examination pursuant to 5 U.S.C. § 8123(a) as it related to ongoing disability.

In a decision dated July 9, 2012, an OWCP hearing representative affirmed the January 20, 2012 denial decision. It found that there was no objective medical evidence to establish that appellant experienced a change or worsening in the nature and extent of her accepted conditions or modified duty on or around the date of the claimed disability.

On August 10, 2012 OWCP determined that a conflict in medical opinion existed regarding whether appellant continued to suffer residuals of her work injury and was unable to work. It referred her, along with a SOAF and the medical record, to Dr. Raymond D. Drapkin, a Board-certified orthopedic surgeon, as an impartial medical examiner to resolve the conflict. The impartial medical specialist was asked to address whether appellant's current lumbar, thoracic, and cervical complaints were causally related to her March 23, 2009 injury. He was also asked to describe the extent of her work-related disability.

In a September 24, 2012 report, Dr. Drapkin accurately described the March 23, 2009 employment injury and reviewed appellant's history. He noted that she currently complained of discomfort over the lower lumbar region on the left side. Dr. Drapkin related that a July 24, 2009 MRI scan of appellant's lumbar spine revealed a disc herniation at L4-5 and a January 11, 2011 MRI scan revealed a disc protrusion at L4-5. Upon examination, he observed satisfactory range of motion in all planes and no restricted range of motion. Dr. Drapkin reported complaints of some pain with straight leg raising on the left side about 40 degrees and negative on the right. Examination of the neurological lower extremity demonstrated intact motor and no significant weakness. Dr. Drapkin observed that x-rays of the lumbar spine revealed some spurring at L4-5, some narrowing at the L4-5 level and facet hypertrophy increased at L4-5, and some degenerative disc disease at L4-5. He diagnosed lumbar disc protrusion at L4-L5.

Dr. Drapkin opined that appellant sustained a lumbar disc protrusion at the L4-5 level as a result of the March 23, 2009 employment injury. He explained that, according to the MRI scan findings in 2011, the disc protrusion was smaller compared to the scan from 2009 and that current MRI scan and x-rays revealed some degenerative changes. Dr. Drapkin stated that appellant's current complaints were a combination of the herniation and the degenerative disc disease at that level. He reported that "at this point in time" she was able to do her occupation. Dr. Drapkin concluded that appellant was not a candidate for surgery because it had been over three years since her injury and she had already received all forms of conservative care, including epidural steroids, medication, and therapy.⁵

In a February 26, 2013 report, Dr. Benalcazar noted appellant's continued complaints of low back and leg pain since a March 2009 fall at work. He related that the low back pain caused her to lose days at work and eventually to stop working all together in 2011. Dr. Benalcazar noted that a February 11, 2013 MRI scan revealed damaged disc with herniation and grade 1 spondylosis. He explained that this finding was consistent with appellant's complaints of low back pain. Dr. Benalcazar opined that her March 2009 fall at work was the cause of her low back and leg pain. He reported that appellant would require a lumbar fusion with interbody spacer at L4-5, including discectomy and decompression in order to have any meaningful recovery of her preinjury function. On March 5, 2013 Dr. Benalcazar requested authorization for lumbar spine fusion surgery.

On July 9, 2013 OWCP received appellant's request for reconsideration. Appellant's counsel contended that Dr. Benalcazar's reports established that she still suffered residuals of her low back injury.

In a June 19, 2013 report submitted by appellant, Dr. Steven J. Valentino, an orthopedic spine surgeon, stated that appellant experienced localized low back pain at the bilateral L3

⁵ On February 8, 2013 OWCP referred appellant's claim to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and district medical adviser, to determine whether continued epidural spinal injections were medically necessary to treat her medical conditions. In a February 24, 2013 report, he reviewed appellant's history, including various diagnostic tests and medical reports. Dr. Berman stated that because of the persistent radiculopathy and dominance of the leg pain of a recurrent nature, epidural steroid injections were justified with the caveat that she must participate in aquatic exercise, water-walking, and nonsteroidal anti-inflammatory exercises. He opined that surgery was not justified and that appellant may work a light-duty position as proposed in the past, including the job offer of November 14, 2011.

through S1 region with radiation into the left leg laterally with numbness and weakness since a 2009 work injury. He noted that she had been unresponsive to thermal modalities, home exercises, or physical therapy injections. Dr. Valentino reported that appellant had not worked since 2011. Upon examination of her lower back, he observed significantly limited range of motion in all planes. Dr. Valentino noted significant spasm, facet synovitis, and effusion upon palpation of the spine. Straight leg raise testing revealed left leg pain. Dr. Valentino diagnosed sciatica, lumbago, and displacement of lumbar intervertebral disc without myelopathy. He explained that given the length of appellant's symptoms, the nature of her injury, and failure to respond to conservative care surgical intervention of decompression or fusion would be reasonable. Dr. Valentino further noted that she was capable of a light to sedentary position but could not return to her preinjury position.

In a July 18, 2013 report, Dr. Valentino related appellant's complaints of low back pain with radiation into the left leg laterally resulting from a March 29, 2009 work-related injury. He noted that a January 11, 2011 MRI scan revealed desiccation and narrowing of the L4-5 disc that was consistent with her subjective complaints and that a February 11, 2013 MRI scan of the lumbar spine showed similar broad-based left paracentral lateral protrusion at L4-5 superimposed upon degenerative change. Dr. Valentino opined that evidence and physical examination findings established a continued work-related disability from July 26, 2011 through the present. He stated that appellant continued to suffer residuals of her work-related injury and was unable to return to work because of these residuals. Dr. Valentino also reported that further care in the form of additional treatment and surgery was reasonable and related to the March 23, 2009 work injury.

On July 25, 2013 OWCP referred appellant's claim to a district medical adviser to determine whether surgery was medically appropriate and causally related to the March 23, 2009 employment injury and whether the current objective medical evidence demonstrated a worsening of her accepted back condition.

In an August 10, 2013 report, Dr. Berman noted that he reviewed appellant's medical records and the SOAF. He provided an accurate history of the March 23, 2009 employment injury and subsequent medical treatment. Dr. Berman related that a July 24, 2009 MRI scan of the lumbar spine demonstrated left lateral L4-5 foraminal disc herniation, which extended lateral to the foramen with compression of the left L4 nerve root, mild L4-5 disc bulge without L4-5 central canal stenosis, and the other disc levels are unremarkable. He also noted that a February 11, 2013 MRI scan of the lumbar spine revealed abnormal findings of broad-based left paracentral to the left lateral disc protrusion at L4-5 superimposed upon degenerative change. Dr. Berman stated that an April 13, 2012 second opinion examination by Dr. Willie Thompson and a September 24, 2012 examination by Dr. Drapkin lacked any objective findings to support appellant's complaints of back and lower leg pain. He explained that there were no objective clinical findings to establish that low back surgery would improve her condition or to demonstrate a worsening of her condition. Dr. Berman explained that the fact that the sitting root test with the sitting straight leg raising test was negative demonstrated symptom magnification. He reported that without clinical correlation the overall results of the surgery would not be satisfactory. Dr. Berman stated that Dr. Benalcazar did not provide any objective clinical evidence of any abnormalities. He noted that the best answer for appellant's condition

was an acceptance of the need for ongoing rehabilitation, such as water-walking and other measures.

In a decision dated August 19, 2013, OWCP denied modification of the July 9, 2012 decision. It found that the record did not contain any objective evidence which demonstrated a change in or worsening of appellant's medical condition on or around July 26, 2011 so that she was unable to work during the claimed period. OWCP also denied her request for low back surgery finding that the weight of medical evidence rested with Dr. Drapkin's impartial medical report.

On October 8, 2013 OWCP denied appellant's request for lumbar fusion surgery.

On October 11, 2013 OWCP received appellant's request for reconsideration. Counsel alleged that Dr. Benalcazar's enclosed October 1, 2013 report clearly established that she continued to suffer from her low back injury and that she required lumbar fusion as a result.

In an October 1, 2013 report, Dr. Benalcazar provided similar examination findings and noted that he reviewed Dr. Drapkin's independent medical examination report. He alleged that there were a number of inconsistencies with Dr. Drapkin's report. Dr. Benalcazar stated that, although Dr. Drapkin reported incremental improvement of appellant's condition between 2009 and 2011, a review of MRI scan reports demonstrated persistent large left disc herniation. He expressed his confusion that Dr. Drapkin agreed that she had exhausted conservative treatment and still experienced consistent pain, but yet he believed that she could return to work. Dr. Benalcazar also disagreed with Dr. Drapkin's opinion that because it had been over three years since appellant's March 23, 2009 injury no further treatment was needed. He explained that the longer the time period from the injury, the longer the lumbar disc has been degenerating and becoming worse. Dr. Benalcazar reported that it was quite logical that the degenerated disc continued to degenerate and became less and less stable, thus causing more pain and not responding to conservative treatment. He stated that conservative treatment could not provide enough stability to the damaged disc to make any significant and long-term difference. Thus, Dr. Benalcazar reiterated the only opportunity for appellant to improve and return to work was through lumbar fusion surgery in order to add stability to the spine at the damaged level.

By decision dated January 9, 2014, OWCP denied modification of the August 19, 2013 decision finding that Dr. Benalcazar's October 1, 2013 report was insufficient to establish a causal relationship between appellant's herniated disc condition and her disability for the period July 26 to December 17, 2011. It also noted that the recommended lumbar fusion was alleged to be necessary due to her degenerative disc condition, not the accepted herniated disc.

LEGAL PRECEDENT -- ISSUE 1

Under FECA the term disability is defined as incapacity, because of employment injury, to earn the wages that the employee was receiving at the time of injury.⁶ Disability is thus not synonymous with physical impairment which may or may not result in incapacity to earn the wages. An employee who has a physical impairment causally related to a federal employment

⁶ See *Prince E. Wallace*, 52 ECAB 357 (2001).

injury but who nonetheless has the capacity to earn wages he or she was receiving at the time of injury has no disability as that term is used in FECA⁷ and whether a particular injury causes an employee disability for employment is a medical issue which must be resolved by competent medical evidence.⁸ Whether a particular injury causes an employee to be disabled for work and the duration of that disability, are medical issues that must be proved by a preponderance of the reliable, probative and substantial medical evidence.⁹ The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.¹⁰

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden to establish his or her claim, OWCP also has a responsibility in the development of the evidence.¹¹

ANALYSIS -- ISSUE 1

OWCP accepted appellant's claim for left side herniated disc as a result of a March 23, 2009 employment injury. Appellant worked part-time modified duty. On July 25, 2011 she stopped work and filed various claims for disability compensation for the period July 26 to December 17, 2011.

OWCP referred appellant's claim to Dr. Thompson for a second opinion examination to determine the nature and extent of her disability beginning January 2011. In his April 13, 2012 report, Dr. Thompson reviewed the record, including the SOAF, and described appellant's medical treatment. He opined based on the medical records and his physical examination that there was no objective evidence to place any physical limitations upon appellant's functioning. Dr. Thompson found no continued effects of the March 2009 work injury and opined that appellant could return to work without restrictions immediately. The Board notes, however, that he failed to adequately address the question he was asked to address.¹² OWCP requested that Dr. Thompson provide an opinion regarding appellant's ability or inability to work during the alleged period of disability. Dr. Thompson, however, only reported that she may return to work without restrictions and he failed to address her disability beginning July 2011. He did not address whether appellant's inability to work beginning July 26, 2011 was causally related to her accepted back condition.

⁷ *Cheryl L. Decavitch*, 50 ECAB 397 (1999); *Maxine J. Sanders*, 46 ECAB 835 (1995).

⁸ *Donald E. Ewals*, 51 ECAB 428 (2000).

⁹ *Tammy L. Medley*, 55 ECAB 182 (2003).

¹⁰ *William A. Archer*, 55 ECAB 674 (2004); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

¹¹ *See Claudia A. Dixon*, 47 ECAB 168, 170 (1995).

¹² *See Federal (FECA) Procedure Manual, Part 3 – Medical, OWCP Directed Medical Examinations, Chapter 3.500.3 (July 2011).*

While OWCP then referred appellant for an impartial medical evaluation with Dr. Drapkin, the Board finds that his report is similarly deficient. Dr. Drapkin was not asked to address her disability status as of July 26, 2011 and therefore he only reviewed appellant's status as of the date of his evaluation, September 24, 2012. His report therefore cannot constitute the weight of the medical evidence regarding appellant's status as of July 26, 2011. Likewise, the medical adviser, Dr. Berman, only addressed her status as of the date of his report, August 10, 2013.

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.¹³ When it selects a physician for an opinion on causal relationship, it has an obligation to secure, if necessary, clarification of the physician's report and to have a proper evaluation made.¹⁴ Because OWCP referred appellant to a second opinion physician OWCP has the responsibility to obtain a report that addresses the proposed question of whether she was disabled from work during the claimed period as a result of her accepted conditions.

Because Dr. Thompson failed to address her period of disability in his April 13, 2012 report, OWCP should have requested clarification on whether she appellant was disabled beginning in July 2011 as a result of her accepted conditions. Dr. Drapkin and Dr. Berman should also have been asked to address appellant's disability status as of July 26, 2011.

The case will be remanded to OWCP for further development of the medical evidence. Following any further development deemed necessary, it shall issue a *de novo* decision on appellant's claim.

LEGAL PRECEDENT -- ISSUE 2

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 in the amount of monthly compensation.¹⁵ In interpreting the 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.¹⁶ OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on the OWCP's authority is that of reasonableness.¹⁷ 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

¹³ *Phillip L. Barnes*, 55 ECAB 426, 441 (2004); *see also Virginia Richard (Lionel F. Richard)*, 53 ECAB 430, 433 (2002); *William J. Cantrell*, 34 ECAB 1233, 1237 (1993); *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985).

¹⁴ *Alva L. Brothers, Jr.*, 32 ECAB 812 (1981).

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

¹⁶ *W.T.*, Docket No. 08-812 (issued April 3, 2009); *A.O.*, Docket No. 08-580 (issued January 28, 2009).

¹⁷ *D.C.*, 58 ECAB 629 (2007); *Mira R. Adams*, 48 ECAB 504 (1997).

from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.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

ANALYSIS -- ISSUE 2

The Board finds that the case is not in posture for a decision due to an unresolved conflict in the medical opinion as to whether the recommended lumbar surgery should be authorized.

Appellant requested authorization for lumbar fusion surgery based on the February 26, 2013 medical report of Dr. Benalcazar, who noted her continued complaints of low back and leg pain since a March 2009 employment injury. Dr. Benalcazar reported that a February 11, 2013 MRI scan revealed damaged disc herniation and grade 1 spondylosis, which was consistent with her current complaints of low back pain. He opined that appellant's current complaints resulted from appellant's 2009 fall at work. Dr. Benalcazar stated that she would require a lumbar fusion with interbody spacer at L4-5, including discectomy and decompression in order to have any meaningful recovery of her preinjury function.

Appellant also provided June 19, 2013 report by Dr. Valentino, who related her complaints of low back pain radiating into her left leg since a March 23, 2009 work injury. Dr. Valentino conducted an examination and observed significantly limited range of motion in all planes and significant spasm, facet synovitis, and effusion upon palpation of the spine. Straight leg raise testing revealed left leg pain. Dr. Valentino diagnosed sciatica, lumbago, and displacement of lumbar intervertebral disc without myelopathy. He explained that given the length of appellant's symptoms, the nature of her injury, and failure to respond to conservative care that surgical intervention of decompression or fusion would be reasonable.

OWCP referred appellant's claim to Dr. Berman, a district medical adviser, to determine whether surgery was medically appropriate and causally related to the March 23, 2009 employment injury. In an August 10, 2013 report, Dr. Berman reviewed the medical record, including the statement of accepted facts, and accurately described the March 23, 2009 employment injury. He noted that a recent MRI scan revealed abnormal findings of the lumbar spine but that Dr. Thompson's April 13, 2012 and Dr. Drapkin's September 24, 2012 reports lacked any objective findings to support appellant's complaints of continued back and lower leg pain. Accordingly, Dr. Berman opined that there were no objective clinical findings to establish that low back surgery would improve appellant's condition. He reported that without clinical correlation the overall results of the surgery would not be satisfactory.

¹⁸ *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990).

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).

The Board finds that there is a conflict in the medical evidence between Dr. Berman, for OWCP, and Drs. Benalcazar and Valentino, for appellant, regarding whether her request for lumbar surgery should be authorized. Due to the unresolved conflict of the medical opinion, OWCP should refer her to an appropriate Board-certified specialist for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a), to resolve this issue.²⁰ After this and other such development as OWCP deems necessary, OWCP should issue a *de novo* decision on the issue.

CONCLUSION

The Board finds that additional development of the medical evidence is needed to establish whether appellant was disabled from work for the period July 26 to December 17, 2011 as a result of the March 23, 2009 employment injury. The Board also finds that the case is not in posture for decision, due to a conflict in the medical evidence, with regard to whether her proposed lumbar surgery is medically necessary.

ORDER

IT IS HEREBY ORDERED THAT the January 9, 2014 decision of the Office of Workers' Compensation Programs is set aside and remanded.

Issued: December 23, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

²⁰ The Board notes that, while Dr. Drapkin was selected as a referee medical examiner, he was asked to resolve a conflict regarding whether appellant continued to suffer residuals of her work injury and was unable to work. Thus, he did not provide a referee opinion on whether lumbar surgery was medically necessary to treat her accepted conditions and a conflict in opinion still exists regarding this issue.