United States Department of Labor
Employees' Compensation Appeals Board

WALTER HYNSON, Appellant	)	
and	)	**Docket No. 05-1386**
	)	**Issued: February 8, 2006**
GENERAL SERVICE ADMINSTRATION, Philadelphia, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 15, 2005 appellant, through his attorney, filed an appeal from a decision of a hearing representative dated February 17, 2005 affirming a schedule award for the lower extremities. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a three percent permanent impairment of the right lower extremity and a three percent permanent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

On December 27, 2001 appellant, then a 52-year-old maintenance mechanic, filed a claim for a traumatic injury occurring on July 12, 2001 in the performance of duty. He worked limited-duty employment following his injury.[1] The Office accepted his claim for lumbar strain

[1] Appellant separated from the employing establishment on November 30, 2002.

with radiculopathy.[2] An electromyogram (EMG) obtained on October 26, 2001 showed bilateral S1 irritation and left-sided L5 dysfunction.

On April 30, 2003 appellant filed a claim for a schedule award. In support of his claim, he submitted an impairment evaluation dated February 13, 2003 from Dr. Nicholas Diamond, an osteopath, who noted appellant's complaints of right leg pain at night and left leg pain during the day and at night. On physical examination, he stated:

> "Manual muscle strength testing of the anterior quadriceps and biceps femoris reveals a grade of 4-4+/5 bilaterally.
>
> "Sensory examination reveals decreased sensation to light touch and pinprick over the S1 dermatome involving the right lower extremity and over the L5-S1 dermatone involving the left lower extremity."

Dr. Diamond found that appellant's quadriceps circumference was 47 centimeters bilaterally and his gastrocnemius circumference was 43 centimeters on the right and 42 centimeters on the left. He diagnosed discogenic disease of the lumbar spine, chronic lumbosacral strain and sprain, chronic myofascial pain syndrome, bilaterally S1 radiculopathy by EMG and left L5 dysfunction by EMG. He found that appellant had a 4 percent impairment of the right S1 nerve root pursuant to Tables 15-15 and 15-18 on page 424 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). Dr. Diamond further found that appellant had a 12 percent impairment due to loss of strength in the right anterior quadriceps and biceps femoris for a combined right lower extremity impairment of 16 percent.[3] He added a three percent impairment due to pain and concluded that appellant had a 19 percent permanent impairment of the right lower extremity.[4] For the left lower extremity, Dr. Diamond found that he had a 4 percent impairment due to a sensory deficit of the L5 nerve root and a 4 percent impairment due to a sensory deficit of the S1 nerve root.[5] He further determined that appellant had a 12 percent impairment due to loss of strength in the anterior quadriceps and biceps femoris for a combined right lower extremity impairment of 19 percent.[6] Dr. Diamond added three percent due to pain for a total left lower extremity impairment of 22 percent.[7] He opined that appellant reached maximum medical improvement on February 13, 2002.

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[2] Appellant initially filed a claim for an occupational disease. By decision dated November 20, 2001, the Office denied his occupational disease claim. Appellant subsequently filed a claim for a traumatic injury. By decision dated April 10, 2002, the Office determined that he sustained lumbar strain with radiculopathy due to a traumatic injury on July 12, 2001.

[3] A.M.A., *Guides* at 532, Table 17-8.

[4] *Id*. at 574, Figure 18-1.

[5] *Id*. at 424, Tables 15-15, 15-18.

[6] *Id*. at 532, Table 17-8.

[7] *Id*. at 574, Figure 18-1.

On April 22, 2003 Dr. Mark J. Reiner, an attending osteopathic physician, indicated that he concurred with Dr. Diamond's finding of a 19 percent permanent impairment of the right lower extremity and a 22 percent impairment of the left lower extremity.

An Office medical adviser reviewed Dr. Diamond's report on May 16, 2003 and noted that appellant had preexisting degenerative joint disease and spinal stenosis. He recommended a second opinion examination.

By letter dated October 23, 2003, the Office referred appellant, together with a statement of accepted facts, to Dr. Jatinkumar Gandhi, a Board-certified orthopedic surgeon, for a second opinion examination regarding the extent of permanent impairment to his lower extremities.

In a report dated November 10, 2003, Dr. Gandhi discussed appellant's July 12, 2001 employment injury and complaints of low back pain with radiculopathy bilaterally. He further noted that appellant had a prior work injury to his back in January 2001. Dr. Gandhi performed a physical examination of the spine and listed range of motion findings for the spine. He diagnosed chronic lumbar sprain with nerve root irritation due to appellant's employment injury. Dr. Gandhi opined that appellant had reached maximum medical improvement and had a five percent permanent impairment according to Table 15-3 on page 384 of the A.M.A., *Guides*.

In a supplemental report dated December 20, 2003, Dr. Gandhi indicated that he had reviewed his prior report and the A.M.A., *Guides*.[8] He stated, "Based on the fact that [appellant] has bilateral radicular pain along the L4-5 roots, he will have permanency of 2.5 percent of each lower extremity" and cited Table 15-15 on page 424.

On January 13, 2004 an Office medical adviser reviewed the medical evidence of record. He found that the maximum impairment of the L5 nerve was 5 percent which he multiplied by 60 percent for Grade 3 pain which interfered with activity, to find that appellant had a 2.5 percent impairment of both the right and left leg.[9] The Office medical adviser rounded the 2.5 percent to 3 percent in accordance with Office procedures.

By decision dated February 2, 2004, the Office granted appellant a schedule award for a three percent permanent impairment of the right lower extremity and a three percent permanent impairment of the left lower extremity. The period of the award ran for 17.28 weeks from December 20, 2003 to April 18, 2004.

On February 6, 2004 appellant, through his attorney, requested an oral hearing. At the hearing held on December 1, 2004, counsel attorney argued that Dr. Ghandi did not perform muscle strength or sensory examination testing or obtain measurements of the lower extremities.[10]

[8] The inquiry from the Office is not contained in the case record.

[9] A.M.A., *Guides* 424, Tables 15-15, 15-18.

[10] An EMG dated January 29, 2004 showed chronic left S1 radiculopathy.

By decision dated February 17, 2005, the hearing representative affirmed the Office's February 2, 2004 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act,[11] and its implementing regulation,[12] sets forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standards applicable to all claimants.[13] The Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[14]

Chapter 17 of the A.M.A., *Guides*, relevant to determining a lower extremity impairment, provides:

> "It is important to ensure that lower extremity impairment discussed in this chapter is not due to underlying spine pathology. If lower extremity impairment is due to an underlying spine disorder, the lower extremity impairment would, in most cases, be accounted for in the spine impairment rating."[15]

When the Office refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, the Office should secure an appropriate report on the relevant issues.[16]

ANALYSIS

The Office accepted appellant's claim for lumbar strain with radiculopathy. An EMG obtained on October 26, 2001 revealed bilateral S1 irritation and dysfunction at L5 on the left side. Appellant filed a claim for a schedule award and submitted a report dated February 13, 2003 from Dr. Diamond, who diagnosed discogenic disease of the lumbar spine, chronic lumbosacral strain and sprain, chronic myofascial pain syndrome, bilaterally S1 radiculopathy and left-sided dysfunction at L5 by EMG. For the right side, Dr. Diamond concluded that appellant had a 4 percent impairment of the right S1 nerve root due to sensory deficit,[17] and a 12

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] 20 C.F.R. § 10.404(a).

[14] *See* FECA Bulletin No. 01-05 (issued January 20, 2001).

[15] A.M.A., *Guides* 524.

[16] *See Robert Kirby*, 51 ECAB 474 (2000); *Mae Z. Hackett*, 34 ECAB 1421 (1983).

[17] A.M.A., *Guides* 424, Tables 15-15 and 15-18.

percent impairment due to loss of strength in the right anterior quadriceps and biceps femoris for a combined impairment of 16 percent of the right lower extremity.[18] For the left side, Dr. Diamond determined that appellant had a 4 percent impairment due to sensory deficit of the S1 nerve root, a 4 percent impairment due to sensory deficit of the L5 nerve root[19] and a 12 percent impairment due to loss of strength in the right anterior quadriceps and biceps femoris for a combined impairment of 19 percent of the left lower extremity.[20] He added an additional 3 percent impairment due to pain for both the right and left lower extremities[21] and concluded that appellant had a 19 percent permanent impairment of the right lower extremity and a 22 percent permanent impairment of the left lower extremity. In reaching his conclusions, Dr. Diamond included loss of strength findings pertinent to determining an impairment of the lower extremities under Chapter 17 of the A.M.A., *Guides*. Chapter 17 of the A.M.A., *Guides,* however, is relevant to evaluating the lower extremities and specifically excludes lower extremity impairments due to underlying spine pathology.[22] He further included an additional three percent impairment of both the right and left lower extremity due to pain according to Chapter 18 of the A.M.A., *Guides*. The Board notes, however, that examiners should not use this chapter to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[23] Additionally, Office procedures provide that Chapter 18 is not to be used in combination with other methods to measure impairment due to sensory pain.[24] As Dr. Diamond's impairment evaluation did not conform to the Office's procedures or the A.M.A., *Guides*, the Office properly referred appellant to Dr. Gandhi for a second opinion evaluation.

In a report dated November 10, 2003, Dr. Gandhi listed range of motion findings for the spine and diagnosed chronic lumbar sprain with nerve root irritation. He opined that appellant had a 5 percent permanent impairment according to Table 15-3 on pages 384 of the A.M.A., *Guides*. Table 15-3, however, is relevant to determining impairments of the spine rather than the lower extremities. Schedule awards under the Act, however, are not payable for impairments of the spine.[25] In a supplemental report dated December 20, 2003, Dr. Gandhi stated that appellant had a 2.5 percent impairment of the bilateral lower extremities due to L4-5 radicular pain according to Table 15-15 on page 424.

[18] *Id*. at 532, Table 17-8.

[19] *Id*. at 424, Tables 15-15 and 15-18.

[20] *Id*. at 532, Table 17-8.

[21] *Id*. at 574, Figure 18-1.

[22] *Id*. at 524; *see also Vanessa Young*, 55 ECAB ___ (Docket No. 04-562, issued June 22, 2004).

[23] *Id*. at 517, section 18.3b.

[24] *See* FECA Bulletin No. 01-05 (issued January 31, 2001); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[25] The Act itself specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

An Office medical adviser reviewed Dr. Gandhi's report and found that the affected spinal nerve was L5. He determined that the maximum sensory deficit of the lower extremities caused by an impairment of the L5 nerve root was 5 percent which he then multiplied by an assessed Grade 3, or 60 percent, sensory deficit to find a 2.5 percent impairment for each lower extremity, which he rounded up to 3 percent.[26] The Office medical adviser, however, did not explain how he selected L5 as the affected spinal nerve given that Dr. Gandhi found radicular pain along L4 and L5. Table 15-18, relevant to determining spinal nerve root impairments affecting the lower extremities, provides for separate impairment determinations for L4 and L5. Additionally, it is unclear why Dr. Gandhi found that appellant experienced radicular pain at L4-5 in view of the fact that the objective studies at the time revealed a bilateral impairment at S1 and a left-sided impairment at L5. Dr. Gandhi did not provide any explanation in support of his conclusion that appellant had radicular pain at L4-5. While an Office medical adviser may review the findings of a second opinion physician and offer his or her opinion, the referral physician's medical report must provide adequate findings on which to base a schedule award determination. As Dr. Gandhi fails to explain the basis for his findings, it is insufficient to support the proper application of the A.M.A., *Guides*. As the Office referred appellant to Dr. Gandhi, it has the responsibility to obtain an evaluation that will resolve the issue of the degree of appellant's permanent impairment of the lower extremities.[27] The Board, therefore, will remand the case for such further development as may be necessary, followed by an appropriate decision by the Office on appellant's entitlement to a schedule award.

CONCLUSION

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

[26] A.M.A., *Guides* 424, Tables 15-15, 15-18.

[27] *See Robert Kirby*, *supra* note 16.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 17, 2005 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: February 8, 2006
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board