United States Department of Labor
Employees' Compensation Appeals Board

A.A., Appellant	)	
and	)	**Docket No. 09-1121**
	)	**Issued: March 18, 2010**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Tucson, AZ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 20, 2009 appellant filed a timely appeal from the January 29, 2009 decision of the Office of Workers' Compensation Programs concerning schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a three percent permanent impairment of her right and left leg for which she received schedule awards.

FACTUAL HISTORY

The Office accepted that on May 2, 2006 appellant, then a 52-year-old agriculture specialist, sustained thoracic and lumbosacral neuritis and displacement of a lumbar intervertebral disc without myelopathy due to climbing, lifting and bending in order to inspect fruit containers. Appellant stopped work on May 19, 2006 and the Office paid compensation for

periods of disability. She returned to limited-duty work for the employing establishment on a full-time basis in July 2006.

On July 13, 2006 appellant was first examined by Dr. Robert I. Winer, an attending Board-certified neurologist, who noted that she complained of back pain which radiated down her buttocks and lateral thighs and that she reported an April 2004 left foot fracture which caused her to miss work for 18 weeks and resulted in continuing foot swelling and pain. Dr. Winer advised that the findings of the May 16, 2006 magnetic resonance imaging (MRI) scan testing showed a left disc herniation at L4-5 and a central disc herniation at L5-S1, more significant at L4-5. There was chronic disc desiccation at multiple lumbar levels. Dr. Winer obtained electromyogram (EMG) and nerve conduction velocity testing on July 14, 2006 which showed bilateral radiculopathy at L3-4 and S1, left radiculopathy at L5 and probable axonal neuropathy.

On June 19, 2007 Dr. Steven J. Valentino, an osteopath serving as an Office referral physician, indicated that his evaluation showed that appellant continued to have residuals of her work-related injury in the form of spasms and diminished range of motion. The motor examination of appellant's legs was normal. Dr. Valentino noted that she suffered a fracture of her right great toe three weeks prior.[1]

On July 9, 2007 Dr. Winer stated that physical examination revealed limited back motion with pain; normal proximal and distal leg strength, bulk and mass; and normal sensory findings in all four extremities to pinprick, pain sensation, vibration, temperature sensation and position sense. He found that appellant had continued pain and limitation of activities related to her lumbosacral conditions. The findings of August 2, 2007 EMG and nerve conduction velocity testing showed bilateral radiculopathy at L3-4 and L5-S1, worse at L3-4 and possible axonal neuropathy.

On September 7, 2007 appellant filed a claim for a schedule award due to her May 2, 2006 work injury.

In October 1, 2007 reports, Dr. Winer noted that appellant reported low back pain which radiated into her legs and intermittent numbness in her feet. He found that appellant's L5-S1 nerve roots were affected bilaterally and that there was L5-S1 sensory loss with activity despite normal pinprick, touch and proprioception on resting neurological examination. Dr. Winer indicated that lumbar range of motion was restricted on flexion to 80 degrees, extension to 20 degrees, right lateral bending to 20 degrees and left lateral bending to 20 degrees. He noted functional leg weakness with walking or standing despite the normal tone, bulk and strength on gross neurological testing.[2] Dr. Winer determined that appellant had a 36 percent permanent impairment of each leg. This impairment was comprised of an 11 percent impairment due to sensory loss,[3] a 5 percent impairment due to weakness manifested by station and gait

[1] In June 2007 appellant began performing full-duty work as a supervisory agriculture specialist.

[2] Dr. Winer referenced Table 13-15 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) concerning impairment due to station and gait disorders.

[3] Dr. Winer determined that appellant had a Class 3 sensory loss under Table 13-23 of the A.M.A., *Guides* for evaluating pain or sensory loss from peripheral nerve disorders.

deficiencies and a 20 percent impairment due to limited motion on flexion, extension, right lateral bending and left lateral bending.[4]

In a November 7, 2007 report, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon serving as an Office medical adviser, determined that appellant had a three percent permanent impairment of her right leg and a three percent permanent impairment of her left leg. He stated that, under Table 15-18 of the A.M.A., *Guides*, the maximum loss of function due to sensory deficit or pain associated with the S1 nerve root was five percent. Under Table 15-15, appellant had a Grade 3 or 60 percent sensory loss in each leg which multiplied by the 5 percent maximum value equaled 3 percent impairment in each leg.[5] Dr. Berman indicated that none of the examining physicians, other than Dr. Winer, noted any muscle loss or decreased strength in appellant's legs and therefore he was not including an impairment value for strength loss.

In a November 27, 2007 decision, the Office granted appellant schedule awards for three percent permanent impairment of her right and left legs. The awards ran for 17.28 weeks from July 9 to November 6, 2007.

In a December 6, 2007 report, Dr. Winer provided further explanation of his opinion that appellant had a 36 percent permanent impairment of each leg. He expressed disagreement with the impairment rating of Dr. Berman. Dr. Winer felt that it was more appropriate to evaluate sensory loss under Table 13-23 of the A.M.A., *Guides* than under Table 15-15 as had been carried out by Dr. Berman. He also believed that Dr. Berman improperly discounted appellant's station and gait abnormalities.

The Office determined that there was a conflict in the medical opinion between Dr. Winer and Dr. Berman regarding the extent of the permanent impairment to appellant's legs. It referred appellant, pursuant to section 8123(a) of the Act, to Dr. Michael Okin, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.

In a February 12, 2008 report,[6] Dr. Okin described appellant's work injury and detailed her medical history, including findings on examination and diagnostic testing. He noted that on physical examination appellant's gait and station were within normal limits and she had no palpable spinal tenderness. Range of motion of the lumbar spine was limited on flexion and extension with pain complaints and right and left lateral bending was to 20 degrees without discomfort. Appellant had 5/5 strength upon dorsiflexion of the feet and ankles as well as 5/5 strength in the extensors and flexors of her knees and the abductors, adductors, flexors and extensors of her hips. Dr. Okin indicated that the sensory examination in both legs was intact. Appellant was able to sit on the examining table with her knees fully extended and her feet completely dorsiflexed under resistance in both areas without any complaints of discomfort in the low back or down the posterior thighs. She went from the seated to supine position and from

[4] Dr. Winer applied Tables 15-8 and 15-9 of the A.M.A., *Guides* detailing impairment for limited flexion, extension and lateral bending of the lumbar spine.

[5] Dr. Berman stated that appellant's sensory loss was manifested by pain rather than abnormal sensation patterns.

[6] The first page of the report contains the date February 12, 2008 but the remaining pages are dated February 12, 2008, the date of Dr. Okin's examination.

the supine to seated position with some discomfort, but she did not really exhibit symptom magnification. Dr. Okin diagnosed degenerative disc disease of the lumbar spine and resolved lumbosacral spine sprain and stated:

> "Based on my review of the records, evaluating the patient, seeing the patient, examining the patient, I have made the following conclusions within a reasonable degree of medical certainty. The patient has underlying disc degenerative disease of the lumbar spine prior to the date of so-called injury on May 2, 2006. Her EMGs and nerve conduction studies performed by Dr. Winer revealed that she had chronic radicular changes at L3-4 and L5-S1 by EMG. Not acute. Also, her examination does not carry out any neurologic deficit whatsoever. On clinical examination all her motor function was intact. Sensory function intact. Reflexes were intact and her only deficit was range of motion causing back pain which is a disc degenerative process and this is not a compensable or an impairment rated issue.
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> "I disagree with Dr. Berman and I disagree with Dr. Winer and this patient is left with no impairment as result of injury, but she does have disc degenerative disease of the lumbar spine, which I feel does limit her ability to do lifting, bending, or stooping, and she should remain at her present job position."

In an April 7, 2008 decision, the Office affirmed its November 27, 2007 decision. It found that the opinion of Dr. Okin did not establish that appellant had more than a three percent permanent impairment of her right leg and a three percent permanent impairment of her left leg.

On September 16, 2008 Dr. Steven M. Allon, an attending orthopedic surgeon, indicated that sensory examination revealed that appellant had a perceived sensory deficit over the L4, L5 and S1 dermatomes involving the right and left lower extremity. He stated that she sustained a left foot crush injury in 2004 and reported that manual muscle strength testing revealed left ankle dorsiflexion, inversion and eversion of 4/5. Dr. Allon determined that, under the standards of the A.M.A., *Guides*, appellant had a 29 percent permanent impairment of her left leg based on a 4 percent impairment for a Grade 2 sensory deficit of the left L4 nerve root; a 4 percent impairment for a Grade 2 sensory deficit of the left L5 nerve root; a 4 percent impairment for a Grade 2 sensory deficit of the left S1 nerve root; a 5 percent impairment for 4/5 motor strength deficit on left ankle inversion; a 5 percent impairment for 4/5 motor strength deficit on left ankle eversion and a 12 percent impairment for 4/5 motor strength deficit on left ankle dorsiflexion.[7] Appellant had a 12 percent permanent impairment of her right leg based on a 4 percent impairment for a Grade 2 sensory deficit of the right L4 nerve root; a 4 percent impairment for a Grade 2 sensory deficit of the right L5 nerve root; and a 4 percent impairment for a Grade 2 sensory deficit of the right S1 nerve root.

On January 27, 2009 Dr. Berman indicated that Dr. Allon had not adequately explained his opinion that appellant had permanent impairment due to sensory and strength deficits in her legs. He determined that appellant only had a three percent permanent impairment of her right

[7] Dr. Allon used the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine these values. He used Tables 15-15 and 15-18 to evaluate sensory loss and Table 17-8 to evaluate strength loss.

leg and a three percent permanent impairment of her left leg due to pain impairment as calculated under Chapter 18.3 of the A.M.A., *Guides*. In a January 29, 2009 decision, the Office affirmed its April 7, 2008 decision.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[8] and its implementing regulations[9] set 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[11] Neither the Act nor its implementing regulations provide for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is specifically excluded from the definition of organ under the Act.[12]

Section 8123(a) of the Act provides in pertinent 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."[13] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[14] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[15] Office procedures provide that selection of

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404 (1999).

[10] *Id*.

[11] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b (June 1993). This portion of Office procedure provides that the impairment rating of a given scheduled member should include "any preexisting permanent impairment of the same member or function."

[12] *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

[13] 5 U.S.C. § 8123(a).

[14] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[15] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

impartial medical specialists is made by a rotational system using the Physician's Directory System, whenever possible, to ensure consistent rotation among physicians.[16]

In a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[17]

ANALYSIS

The Office accepted that on May 2, 2006 appellant sustained thoracic and lumbosacral neuritis and displacement of a lumbar intervertebral disc without myelopathy. On November 27, 2007 it granted appellant a schedule award for a three percent permanent impairment of her right leg and a three percent permanent impairment of her left leg.

After granting appellant a schedule award, the Office determined that there was a conflict in the medical opinion between Dr. Winer, an attending Board-certified neurologist, and Dr. Berman, a Board-certified orthopedic surgeon serving as an Office medical adviser, regarding the extent of the permanent impairment of appellant's legs.

In October 1, 2007 reports, Dr. Winer determined that appellant had a 36 percent permanent impairment of each leg. This impairment was comprised of 11 percent impairment due to sensory loss,[18] a 5 percent impairment due to weakness manifested by station and gait deficiencies[19] and a 20 percent impairment due to limited motion on flexion, extension, right lateral bending and left lateral bending.[20] In contrast, Dr. Berman found on November 7, 2007 that appellant only had a three percent permanent impairment of her right leg and a three percent permanent impairment of her left leg due to sensory loss associated with the S1 nerve root.[21]

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4, 7 (March 1994, May 2003); FECA Bulletin No. 00-01 (issued November 5, 1999).

[17] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232, 238 (1988).

[18] Dr. Winer determined that appellant had a Class 3 sensory loss under Table 13-23 of the A.M.A., *Guides* for evaluating pain or sensory loss from peripheral nerve disorders. *See* A.M.A., *Guides* 346, Table 13-23.

[19] Dr. Winer referenced Table 13-15 of the A.M.A., *Guides* concerning impairment due to station and gait disorders. *See* A.M.A., *Guides* 336, Table 13-15.

[20] Dr. Winer applied Tables 15-8 and 15-9 of the A.M.A., *Guides* detailing impairment for limited flexion, extension and lateral bending of the lumbar spine. *See* A.M.A., *Guides* 407, 409, Tables 15-8 and 15-9. The Board notes that the Act does not allow impairment ratings for loss of back motion because neither the Act nor its implementing regulations provide for a schedule award for impairment to the back. *See supra* note 12.

[21] Dr. Berman applied Tables 15-15 and 15-18 of the A.M.A., *Guides* and found that she had a Grade 3 sensory loss associated with the S1 nerve root. *See* A.M.A., *Guides* 424, Tables 15-15 and 15-18.

In order to resolve the conflict, the Office properly referred appellant, pursuant to section 8123(a) of the Act, to Dr. Okin, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.[22]

On February 12, 2008 Dr. Okin determined that appellant did not have any permanent impairment of her legs. He noted that diagnostic testing of appellant's back showed degenerative changes at L3-4 and L5-S1 but indicated that these changes were "not acute." Dr. Okin stated that examination revealed that sensory and motor functions were intact. He indicated that appellant's "only deficit was range of motion causing back pain which is a disc degenerative process and this is not a compensable or an impairment rated issue."

The Board finds that Dr. Okin's report is in need of clarification in order to properly evaluate the permanent impairment of appellant's legs.[23] The diagnostic testing of record shows that appellant has suffered disc herniations and/or radiculopathies at the L3, L4, L5 and S1 discs. Dr. Okin did not adequately explain why these diagnostic testing results and the clinical findings of record would not show that appellant is entitled to an impairment rating for sensory loss associated with at least one of these discs and attendant nerve roots. It also is unclear whether Dr. Okin adequately evaluated appellant's impairment due to loss of strength in her legs. He indicated that appellant had 5/5 strength on dorsiflexion of the ankles, but he did not provide specific findings for manual muscle testing of her lower extremities.[24] It appears that appellant sustained a left foot crush injury in 2004 and any permanent impairment due to this preexisting injury would be included in an evaluation of the impairment of appellant's legs.[25] The Board further notes, that Dr. Okin did not provide specific findings for range of motion testing of the legs.[26]

For the above-described reasons, the opinion of Dr. Okin required clarification. The case will be remanded to the Office for referral of the case record, a statement of accepted facts, and, if necessary, appellant, to Dr. Okin for a supplemental report regarding the extent of the permanent impairment of her legs. If he is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[27] After such further development as the Office deems necessary, an appropriate decision should be issued regarding appellant's entitlement to schedule award compensation.

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[22] Appellant's attorney suggested that the Office did not select Dr. Okin on a proper rotational basis using the Physician's Directory System. However, he did not adequately explain the basis for this assertion. *See supra* note 16.

[23] *See supra* note 17.

[24] *See* A.M.A., *Guides* 531-33. For example, Dr. Okin did not provide specific findings for ankle flexion and eversion.

[25] *See supra* note 12.

[26] *See* A.M.A., *Guides* 533-34.

[27] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than a three percent permanent impairment of her right leg and a three percent permanent impairment of her left leg, for which she received a schedule award. The case is remanded to the Office for further development.

ORDER

IT IS HEREBY ORDERED THAT the January 29, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: March 18, 2010
Washington, DC

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

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

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