United States Department of Labor
Employees' Compensation Appeals Board

T.P., Appellant	)	
and	)	**Docket No. 09-1151**
	)	**Issued: March 17, 2010**
U.S. POSTAL SERVICE, DOMINICK V. DANIELS PROCESSING & DISTRIBUTION CENTER, Kearny, NJ, 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
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 25, 2009 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated May 30, 2008 and February 2, 2009. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 24 percent impairment of the right lower extremity for which he received schedule awards.

On appeal, appellant's attorney contends that the opinion of the impartial examiner, Dr. Thomas E. Helbig, a Board-certified orthopedic surgeon, is not sufficient to carry the weight of the medical evidence.

FACTUAL HISTORY

On September 12, 2001 appellant, then a 48-year-old mechanic sustained an employment-related lumbar contusion, cervical sprain and sciatica when he fell from a ladder at

work. He returned to limited duty on October 16, 2001. A November 26, 2001 magnetic resonance imaging (MRI) scan of the lumbar spine demonstrated degenerative changes at L4-5 and L5-S1 and a disc herniation with nerve root indentation at L5-S1. Appellant filed a schedule award claim on September 4, 2002. In a July 16, 2002 report, Dr. David Weiss, an osteopath, advised that he had 30 percent right lower extremity impairment.

The Office referred appellant to Dr. Iqbal Ahmad, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a February 24, 2004 report, Dr. Ahmad advised that appellant had no impairment of his legs. The Office subsequently determined that a conflict in medical opinion arose between Drs. Weiss and Ahmad regarding appellant's diagnoses and degree of impairment and referred him to Dr. Thomas Helbig.

In a September 2, 2004 report, Dr. Helbig noted his review of the medical record and appellant's complaint of radiating low back pain and provided physical examination findings, stating that neurological examination revealed no motor deficits in the lower extremities with decreased sensation in the lateral border of the right foot and in the first dorsal web space on the right side compared with the left. He diagnosed herniated disc, right L5-S1, with right sciatica and status post selective nerve root block, right L5. Dr. Helbig advised that, as appellant had elected not to proceed with surgical intervention, he had reached maximum medical improvement. He advised that appellant had no right lower extremity motor deficit and a sensory deficit in the L4, L5 and S1 dermatome which, under Table 15-18 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[1] yielded a 5 percent sensory loss at each level for a 15 percent right lower extremity impairment with an additional 3 percent impairment for pain as found in Figure 18-1.

By report dated July 28, 2004, an Office medical adviser advised that maximum medical improvement was reached on September 4, 2004. He agreed with Dr. Helbig's impairment rating of 15 percent for right lower extremity sensory loss and advised that appellant was not entitled to an additional 3 percent for pain because Dr. Helbig did not provide a pain questionnaire.

On August 9, 2005 appellant was granted a schedule award for a 15 percent impairment of the right lower extremity, for a period of 43.2 weeks, to run from September 2, 2004 to July 1, 2005. He timely requested a hearing that was held on December 19, 2005. By decision dated March 1, 2006, an Office hearing representative remanded the case to the Office to request a supplemental report from Dr. Helbig and ask him to provide a completed pain questionnaire to support the additional thee percent impairment for pain. In an April 11, 2006 report, an Office medical adviser stated that the documentation provided in Dr. Helbig's report supported the 3 percent pain impairment, and advised that appellant had 18 percent impairment of his right lower extremity.

On April 13, 2006 appellant was granted a schedule award for an additional three percent right lower extremity impairment. He again requested a hearing. By decision dated June 23, 2006, an Office hearing representative determined that the case was not in posture for decision, finding that Dr. Helbig's September 2, 2004 report was insufficient to establish the percentage of

[1] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

impairment of appellant's right lower extremity. On remand the Office was to obtain a supplementary report from Dr. Helbig, in accordance with the A.M.A., *Guides*.

On August 24, 2006 the Office referred appellant to Dr. David I. Rubinfeld, Board-certified in orthopedic surgery, for a second opinion evaluation. In a September 18, 2006 report, Dr. Rubinfeld advised that, in accordance with Tables 15-15 and 15-18 of the A.M.A., *Guides*, appellant had sensory losses of 4 percent each at L4, L5 and S1, for a 12 percent right lower extremity impairment; that under Table 17-8 he had a motor loss of 3 percent for great toe extension and a motor loss of 8 percent for ankle extension, for an 11 percent motor loss and under Figure 18-1, a 2 percent impairment for pain, for a total 25 percent right lower extremity impairment. In an August 27, 2007 report, an Office medical adviser reviewed Dr. Rubinfeld's report and found that appellant had a 14 percent impairment for motor loss under Tables 17-8 and 17-9, and a 12 percent impairment for sensory loss under Tables 15-15 and 15-18, which he combined to yield a 24 percent right lower extremity impairment. He noted that appellant would not be entitled to an additional two percent for pain since the sensory loss also covered pain.

On October 25, 2007 appellant was granted a schedule award for an additional 6 percent impairment of the right lower extremity, or a total impairment of 24 percent. He timely requested a hearing. By decision dated January 8, 2008, an Office hearing representative remanded the case to the Office. The hearing representative found that the Office failed to undertake proper development of the medical evidence by not requesting a supplemental report from Dr. Helbig. It failed to explain the basis for referring appellant for a second opinion evaluation rather than resolving the conflict between the opinions of Drs. Weiss and Ahmad. The Office was directed to refer appellant to Dr. Helbig for reevaluation, including an impairment rating of appellant's right lower extremity in accordance with the A.M.A., *Guides*.

The Office referred appellant to Dr. Helbig for an impartial evaluation regarding the degree of permanent impairment. In a March 25, 2008 report, Dr. Helbig noted the history of injury, his review of the medical record, and appellant's complaints of constant low back pain with radiation to the right lower extremity and right foot numbness. Lumbosacral spine examination demonstrated limited, painful range of motion. The right lower extremity demonstrated a Grade 4/5 weakness of the extensor hallucis longus (EHL) and diminished sensation to light touch and painful stimuli in the lateral border of the right foot, the first dorsal web space, the medial border and the sole of the right foot, as noted with the tip of a paperclip. Dr. Helbig's impression was herniated disc at L5-S1 with right sciatica, status post selective nerve root block on the right at L5. He provided an impairment analysis, rating appellant's sensory deficits at the L4, L5 and S1 dermatomes in accordance with Table 15-15 of the A.M.A., *Guides*,[2] and classified the sensory impairment as falling between Grades 2 and 3, or a 60 percent sensory deficit which, when multiplied by the maximum 5 percent impairment identified under Table 15-18, yielded a 3 percent impairment at each dermatome, for a total 9 percent sensory impairment of the right lower extremity. Dr. Helbig classified appellant's motor weakness of the EHL in the L5 dermatome under Table 15-16 at Grade 4 or 15 percent which, when multiplied by the maximum loss found under Table 15-18, yielded a 5.6 percent motor

[2] The Board notes that the report contains a typographical error identifying the table that determines impairment due to sensory loss as Table 15-5 rather than Table 15-15.

impairment of the right lower extremity. He then advised that, in accordance with Box 3 of Figure 18, appellant would be entitled to an additional 3 percent impairment for pain that increased the burden of his condition slightly and concluded that appellant had a 17.6 percent right lower extremity impairment.

By report dated May 21, 2008, an Office medical adviser reviewed Dr. Helbig's impairment rating and advised that maximum medical improvement was reached on March 25, 2008 and that appellant had a nine percent right lower extremity impairment. He agreed with Dr. Helbig's finding that appellant had a Grade 4 motor deficit of the L5 nerve root, that yielded a 5.55 percent or, rounded up, a 6 percent right lower extremity motor impairment. The medical adviser, however, opined that Dr. Helbig did not perform the sensory examination properly and should have performed two-point discrimination testing, finding that Dr. Helbig's evaluation demonstrated a Grade 4 sensory loss, which yielded a 1.25 percent impairment at the L4, L5 and S1 dermatomes on the right, for a total 3 percent right lower extremity sensory impairment, and that, in accordance with Office procedures, appellant would not be entitled to an additional rating for pain because Table 15-15 provided a rating for nerve root pain.

By decision dated May 25, 2008, the Office found that appellant was not entitled to a schedule award greater than the 24 percent previously paid.

On June 6, 2008 appellant, through his attorney, requested a hearing that was held on October 27, 2008. Appellant was not present at the hearing. On November 3, 2008 counsel contended that Dr. Rubinfeld's impairment rating should be adopted. In a February 2, 2009 decision, an Office hearing representative affirmed the May 25, 2008 decision.

LEGAL PRECEDENT

Under section 8107 of the Federal Employees' Compensation Act[3] and section 10.404 of the implementing federal regulations,[4] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[5] has been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[6]

Although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[7] In

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] A.M.A., *Guides*, *supra* note 1.

[6] *See Joseph Lawrence, Jr., supra* note 1.

[7] *Pamela J. Darling*, 49 ECAB 286 (1998).

1960, amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[8] An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized,[9] and schedule awards for permanent impairment of the whole person are not authorized under the Act.[10]

Section 15.12 of the fifth edition of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities. The nerves involved are first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction identified in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity. The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve.[11]

The fifth edition of the A.M.A., *Guides* allows for an impairment percentage to be increased by up to three percent for pain by using Chapter 18, which provides a qualitative method for evaluating impairment due to chronic pain. If an individual appears to have a pain-related impairment that has increased the burden on his or her condition slightly, the examiner may increase the percentage up to three percent. Section 18.3(b) of the A.M.A., *Guides* provides, however, that examiners should not use Chapter 18 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*.[12] Office procedures provide that it is not to be used in combination with other methods to measure impairment due to sensory pain.[13]

Section 8123(a) of the Act provides that, 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.[14] When 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 on a proper factual background, must be

[8] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[9] *Patricia J. Penney-Guzman*, 55 ECAB 757 (2004).

[10] *D.J.*, 59 ECAB ___ (Docket No. 08-725, issued July 9, 2008).

[11] A.M.A., *Guides*, *supra* note 1 at 423; *see T.H.*, 58 ECAB 334 (2007).

[12] *Id*. at 571.

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2, Exhibit 4 (June 2003); *see T.H., supra* note 11.

[14] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

given special weight.[15] Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained. Where a medical conflict is present, to properly resolve the conflict, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[16]

ANALYSIS

The Office accepted that appellant sustained a lumbar contusion, cervical sprain and sciatica when he fell from a ladder at work on September 12, 2001. Appellant subsequently received schedule awards totaling a 24 percent impairment of the right lower extremity. As noted, following the October 25, 2007 schedule award that brought his total right lower extremity impairment to 24 percent, he timely requested a hearing. In a decision dated January 8, 2008, an Office hearing representative determined that the Office failed to undertake proper development of the medical evidence and should have obtained a supplemental report from Dr. Helbig, who initially saw appellant in September 2004, to resolve a conflict created between the opinions of Dr. Weiss, an attending osteopath, and Dr. Ahmad, an Office referral physician, regarding the degree of appellant's right lower extremity impairment. The Office referred appellant to Dr. Helbig for reexamination and an opinion on permanent impairment.

The impairment rating of 24 percent granted in this case was based on the report of Dr. Rubinfeld, a second opinion specialist, rather than the opinion of Dr. Helbig, the physician selected to resolve the conflict in medical opinion found between Dr. Weiss and Dr. Ahmad.

Dr. Helbig's initial report dated September 2, 2004 did not comport with the A.M.A., *Guides*. He found no motor deficit. In rating pain, Dr. Helbig identified sensory deficits to the L4, L5 and S1 dermatomes, noting that Table 15-18 allowed a maximum 5 percent loss at each level, which he then added to total 15 percent. In this regard, he failed to grade the extent of sensory deficit under Table 15-15. Dr. Helbig allowed an additional 3 percent for pain under Figure 18-1, for a total 18 percent impairment of the right leg. He did not provide any explanation for allowing the additional pain rating under Chapter 18 in light of the sensory loss scheme at Chapter 15, and he did not address the Combined Values Chart.

On March 1, 2006 an Office hearing representative properly remanded the case for a supplemental report from Dr. Helbig pertaining to the extent of impairment and the additional three percent rating for pain found under Chapter 18. However, an Office medical adviser intervened and allowed this percentage of impairment. On April 13, 2006 the Office amended the award to total 18 percent. On further review, the case was again remanded by the Branch of Hearings and Review. The case was referred to Dr. Rubinfeld, for a second opinion evaluation, and not back to Dr. Helbig for a supplemental report.

[15] *Manuel Gill*, 52 ECAB 282 (2001).

[16] *Thomas J. Fragale*, 55 ECAB 619 (2004).

Dr. Rubinfeld agreed with the sensory loss to the L4, L5 and S1 dermatomes, finding a 12 percent impairment. This would be based on an 80 percent (Grade 2) sensory deficit under Table 15-15,[17] multiplied by the 5 percent maximum values for each level under Table 15-18.[18] Dr. Rubinfeld, however, also allowed an 11 percent motor loss under Table 17-8 for great toe extension weakness of 3 percent (Grade 3) and ankle extension weakness of 8 percent (Grade 4).[19] It is not readily apparent, however, that the cross-usage chart at Table 17-2[20] permits combining sensory loss for nerve root dysfunction with manual muscle testing under Chapter 17-2e.[21] The text accompanying this section notes that individuals whose performance is inhibited by pain are not good candidates for manual muscle testing, and other evaluation criteria should be considered.[22] This caution was not addressed by Dr. Rubinfeld who also allowed an additional two percent impairment for pain under Figure 18-2 without explanation.

The Office finally referred appellant back to Dr. Helbig. In a March 25, 2008 report, Dr. Helbig found both motor and sensory deficits on reexamination of appellant. He utilized Table 15-15 to identify that extent of sensory deficit at 60 percent (Grade 3) which he then multiplied by the maximum 5 percent impairment allowed at each level at Table 15-18 to find a 9 percent total sensory impairment. In rating loss of strength, Dr. Helbig utilized Table 15-18 to note that maximum impairment for loss of strength at L5 was 37 percent. He graded the extent of strength deficit as 15 percent (Grade 4) to find a 5.6 percent impairment, which is rounded up to 6 percent. Under the Combined Values Chart,[23] the impairments (9 combined with 6) result in a 14 percent impairment. Dr. Helbig addressed Figure 18-1 of the A.M.A., *Guides*,[24] stating that a three percent additional impairment was allowed in this case as he found that pain increased the burden of appellant's condition slightly. Under the Combined Values Chart, 14 combined with 3 yields a 17 percent impairment.[25]

It is noted that rating impairment for motor and sensory loss to the lower limbs under Table 15-18, and the grading tables at 15-15 and 15-16 does not result in any conflict in combining the impairment values as noted under Chapter 17 at Table 17-2. The Board finds that the March 25, 2008 report of Dr. Helbig is the most probative report of record regarding the degree of impairment of appellant's right lower extremity. Dr. Helbig clearly explained the method for rating loss under the protocols of Chapter 15 and provided an explanation for

[17] A.M.A., *Guides*, *supra* note 1 at 424.

[18] *Id*.

[19] *Id*. at 532.

[20] *Id*. at 526.

[21] *Id*. at 531-33.

[22] *Id*. This method was also utilized Dr. Weiss in rating impairments of appellant's right lower extremity at 30 percent.

[23] A.M.A., *Guides* 604-06.

[24] *Id*. at 574.

[25] *Id*. at 604.

allowing an additional three percent impairment for pain under Figure 18-1. As the impartial medical specialist, his rating is entitled to special weight. The 24 percent previously awarded appears to be based on an erroneous application of the A.M.A., *Guides* by Dr. Rubinfeld. There is no well-rationalized medical evidence establishing greater than a 17 percent impairment based on a proper application of the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has not established that he is entitled to a schedule award greater than the 24 percent awarded.

ORDER

IT IS HEREBY ORDERED THAT the February 2, 2009 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: March 17, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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