U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LUIS E. COLON and U.S. POSTAL SERVICE,
POST OFFICE, Stamford, Conn.

Docket No. 96-988; Submitted on the Record;
Issued July 1, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant is entitled to a schedule award.

The Board has duly reviewed the record on appeal and finds that this case is not in posture for a determination of whether appellant is entitled to a schedule award. Further development of the medical evidence is warranted.

Appellant's attending physician, Dr. Daniel E. Nijensohn, a Board-certified neurological surgeon, reported on June 30, 1994 that it was his medical opinion, based on reasonable medical probability, that appellant had reached maximum medical improvement; that appellant suffered from a 15 percent permanent disability rating of his lower back; that appellant suffered from a 15 percent permanent disability rating of his left lower extremity, based on the intermittent sciatica he suffers involving the leg; and that appellant suffered a 5 percent permanent disability rating of his right lower extremity, which also ached and was numb and weak on occasion. On August 31, 1994 Dr. Nijensohn reported that these disability ratings were the result of the disc herniation that occurred as a result of appellant's work-related injury.[1]

On December 7, 1994 Dr. Robert Y. Pick, an orthopedic surgeon and medical adviser to the Office reviewed the medical evidence of record and reported that the only detailed medical report provided by Dr. Nijensohn was a December 15, 1992 office visit note, "which has a brief paragraph and a half description of a physical examination." The only comprehensive detailed narrative medical report of record, Dr. Pick stated, was a September 2, 1993 initial consultation report of a Dr. Lustgarten, who described no objective findings in the lower extremities. Dr. Pick reported:

> "Again, with all due respect to Dr. Nijensohn, I will emphasize that his description of findings in this operative report are [sic] strictly of a subjective nature. Thus, based on the entire medical evidence of record, along with the

[1] The Office of Workers' Compensation Programs accepted that on November 30, 1992 appellant sustained a lumbar strain and an aggravation of his L5-S1 herniated disc while in the performance of duty.

> *Guides to the Evaluation of Permanent Impairment*, fourth edition, as published by the American Medical Association, that there is no documentation of any objective lower extremity impairment. Hence, there is no permanent partial impairment of either lower extremity."

The Office referred appellant, together with copies of medical reports and a statement of accepted facts, to Dr. Eric M. Garver, a Board-certified orthopedic surgeon, for a second opinion. On March 15, 1995, after relating appellant's history of injury, Dr. Garver reported his findings on examination, which follow in their entirety: "The patient has mild restricted motion of the lumbar spine on flexion and lateral bending. The patient's straight leg raising is essentially negative. His reflexes and motor strength examination are normal." After a review of previous scans and medical records, Dr. Garver reported that appellant's diagnosis was that of herniated disc at the L5-S1 level as a preexisting condition to the work-related injury of November 30, 1992, which episode exacerbated his preexisting condition. Stating that appellant had reached maximum medical improvement, Dr. Garver reported: "I believe the patient has a ten (10%) percent permanent disability on the basis of the patient's low back condition which takes into account the preexisting injury as well as the patient's November 30, 1992 exacerbation." He added that based on the history and especially the timing, it did appear that the incident of November 30, 1992 was the final triggering episode leading to appellant's surgery, though this episode in and of itself did not cause the disc herniation or directly and totally lead to the surgery but was an exacerbating factor of the preexisting condition that necessitated the surgery. On a form provided by the Office, Dr. Garver marked as "not applicable" the nerve root origin and specific nerve branches affected, the degree of permanent impairment of the lower extremity due to loss of function from sensory deficit, pain or discomfort, or strength.

On May 31, 1995 Dr. Barry W. Levine, a second Office medical adviser, reviewed Dr. Garver's report and found that the A.M.A., *Guides*[2] allowed an eight percent whole-person impairment for a surgically treated disc lesion without residual signs and symptoms. As Dr. Garver concluded that the accepted injury precipitated the need for surgery, Dr. Levine stated that an eight percent impairment of the whole person was fair. On June 21, 1995 Dr. Levine stated that there was no evidence of any residual lower extremity impairment, and therefore there was no ratable impairment under the A.M.A., *Guides*.

In a decision dated July 25, 1995, the Office denied appellant's claim for a schedule award. The Office found that the weight of the medical evidence rested with Dr. Garver and Dr. Levine. Dr. Garver's report, the Office stated, gave a complete and accurate history, his examination was comprehensive, and his findings were detailed in his report of March 15, 1995.

The Board finds that the medical evidence developed by the Office in this case is insufficient to establish whether appellant is entitled to a schedule award.

The schedule award provisions of the Federal Employees' Compensation Act[3] and its implementing federal regulations[4] provide for payment of compensation for the permanent loss

[2] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993).

[3] 5 U.S.C. § 8107(a).

or loss of use of specified members, functions and organs of the body. No schedule award is payable for a member, function or organ of the body not specified in the Act or in the regulations.[5] Because neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[6] no claimant is entitled to such an award.[7] Amendments to the Act, however, 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. 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 upper or lower extremity even though the cause of the impairment originated in the spine.[8]

The fourth edition of the A.M.A., *Guides* became effective November 1, 1993.[9] With the rapid pace and advance of medicine, the fourth edition takes a new look at the impairment criteria for all organ systems.[10] In previous editions, the standards for evaluating the permanent impairment of extremities were based primarily on loss of range of motion, with possible additional impairment caused by pain, discomfort or loss of sensation or by loss of strength.[11] The fourth edition offers alternative methods for evaluating permanent impairment:

> "Anatomic, diagnostic, and functional methods are used in evaluating permanent impairments of the lower extremity. While some impairments may be evaluated appropriately by determining the range of motion of the extremity, others are better evaluated by the use of diagnostic categories or according to test criteria. In some instances, a combination of two or three methods is required.
>
> "This section includes information on using some of the simpler, more reproducible methods of and tests for assessing function. It also includes examples illustrating how the physician selects the best approach to evaluate an impairment. Selecting the optimal approach or combining several methods

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[4] 20 C.F.R. § 10.304.

[5] *William Edwin Muir*, 27 ECAB 579 (1976) (this principle applies equally to body members that are not enumerated in the schedule provision as it read before the 1974 amendment, and to organs that are not enumerated in the regulations promulgated pursuant to the 1974 amendment); *see also Thomas E. Montgomery*, 28 ECAB 294 (1977).

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

[7] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).

[8] *Rozella L. Skinner*, 37 ECAB 398 (1986).

[9] FECA Bulletin No. 94-4 (November 1, 1993).

[10] A.M.A., *Guides* at p. v.

[11] *Id*. at 49 (3d ed. 1988); *id*. at 55 (3d ed. rev., 1990).

> requires judgment and experience. Also needed is careful testing that produces accurate and consistent results."[12]

The evaluating physician thus assumes the added responsibility of selecting the most appropriate method or combination of methods for evaluating impairment. Noting that some impairments are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination, section 3.2i of the fourth edition states:

> "The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient. The physician, in general, should decide which estimate best describes the situation and should use only one approach for each anatomic part."[13]

Consistent with previous editions, however, is the importance placed on the proper reporting of necessary clinical information. As the fourth edition states:

> "In evaluating an impairment, it is important to obtain enough clinical information to characterize it in accordance with the *Guides* requirements. Once this task is accomplished, the evaluator's findings may be compared with the clinical information already available about the individual. If the evaluator's findings are consistent with the results of previous clinical studies, the findings may be compared with the *Guides* criteria to estimate the impairment. If the findings are not consistent with those of earlier studies, there should be communication between the involved physicians and clinical studies as needed to resolve any disparities."[14]

Appellant's physician, Dr. Nijensohn, concluded that appellant had a 15 percent permanent disability of his left lower extremity based on the intermittent sciatica he suffered involving the leg, and a 5 percent permanent disability rating of his right lower extremity, which ached and was numb and weak on occasion. He did not, however, report enough clinical information to fully characterize the impairment in accordance with the A.M.A., *Guides*, nor did he explain how he compared his clinical finding with the appropriate table and pages in the A.M.A., *Guides* to arrive the percentages he reported.

Recognizing that Dr. Nijensohn's opinion on permanent impairment was lacking, the Office obtained a second opinion from Dr. Garver. Dr. Garver, however, gave no indication that his examination of appellant followed the protocols of the A.M.A., *Guides*, and the few findings he did report (relating to straight leg raising, reflexes and strength) failed to provide enough clinical information to fully characterize the impairment in accordance with the A.M.A., *Guides*. Although he indicated that nerve root origin was "not applicable," he made no attempt to account for the intermittent sciatica and occasional ache, numbness and weakness reported by appellant's attending physician. Further, although the statement of accepts facts accurately reflected that the Office accepted appellant's claim for the additional condition of aggravation of L5-S1 disc

[12] *Id.* at 75 (4th ed. 1993).

[13] *Id.* at 84.

[14] *Id*. at 3.

herniation, the Office advised Dr. Garver that it had accepted only a temporary aggravation. This is significant because by definition no permanent impairment can be expected to result from an aggravation that is itself only temporary.

Proceedings under the Act are not adversarial, nor is the Office a disinterested arbiter. Although the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence: It has the obligation to see that justice is done.[15]

Because the medical evidence developed in this case is insufficient to allow a proper determination of appellant's entitlement, the Board will set aside the Office's July 25, 1995 decision denying appellant's claim for a schedule award and remand the case for such clinical findings as are necessary to characterize the impairment of appellant's lower extremities in accordance with the requirements of the A.M.A., *Guides*. The specialist should explain whether the cause of any impairment found in the lower extremities has its origin in the accepted herniated disc condition (or in the subsequent surgery, if the employment injury helped lead to the surgery, as reported by Dr. Garver). After such further development of the medical evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to a schedule award.

The July 25, 1995 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, D.C.
July 1, 1998

George E. Rivers
Member

David S. Gerson
Member

Michael E. Groom
Alternate Member

[15] *William J. Cantrell*, 34 ECAB 1233 (1983); *Gertrude E. Evans*, 26 ECAB 195 (1974).