U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RAYMOND SINGLETON and U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Dallas, TX

Docket No. 00-1157; Submitted on the Record;
Issued September 21, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, BRADLEY T. KNOTT,
PRISCILLA ANNE SCHWAB

The issue is whether appellant is entitled to a schedule award for a permanent impairment related to his accepted employment injury.

On August 11, 1995 appellant, then a 49-year-old mail processor performing modified duties, filed a claim for an injury to his low back sustained while getting up from a chair. Appellant received compensation until his return to full-time limited duty on September 3, 1996.

On April 15, 1996 appellant filed a claim for a schedule award. By decision dated December 27, 1996, the Office of Workers' Compensation Programs found that the evidence failed to demonstrate a permanent impairment to a scheduled member of the body.

By letter dated January 13, 1997, appellant requested a hearing. By decision dated August 20, 1997, an Office hearing representative found that a schedule award was not payable for an impairment of the spine, but newly submitted medical evidence indicated that appellant had reflex abnormalities and loss of strength in his lower extremities as a result of his back condition. The case was remanded to the Office for referral to an appropriate Board-certified specialist for a thorough evaluation and opinion on whether appellant sustained a permanent impairment to his legs as a result of his accepted injury.

The Office referred appellant, prior medical reports and a statement of accepted facts to Dr. George Wharton, a Board-certified orthopedic surgeon. In a report dated November 7, 1997, Dr. Wharton stated that rating appellant's permanent impairment on the basis of his lumbosacral spine impairment was "far more rational" than rating him for impairment of his leg, which, in my opinion, is primarily due to extreme obesity, deconditioning, inactivity and age-related arthritic changes." An Office medical adviser reviewed Dr. Wharton's reports and found no permanent impairment of appellant's lower extremities as a result of the accepted conditions of lumbar strain and permanent aggravation of degenerative disc disease of the lumbar spine.

By decision dated December 4, 1997, the Office found that the weight of the medical evidence established that appellant had no permanent impairment of a scheduled member of the body.

By letter received by the Office on January 7, 1998, appellant requested a hearing. By decision dated December 22, 1998, an Office hearing representative found a conflict of medical opinion between Dr. Wharton, who examined appellant for the Office, and appellant's attending physician, Dr. Kenneth S. Bayles, an osteopath specializing in orthopedic surgery, regarding whether appellant had an injury-related sensory impairment of his legs.

To resolve this conflict of medical opinion, the Office referred appellant, the case record and a statement of accepted facts to Dr. Audrey Stein-Goldings, a Board-certified neurologist. In a report dated May 13, 1999, she set forth appellant's history and findings on physical examination and reviewed prior medical reports. She stated:

> "On examination, [appellant] is malignantly obese. He had several Waddell signs, which are felt to be consistent with symptom magnification. Low back pain was reported on vertical loading over [appellant's] skull. Back pain was also reported when shoulders and pelvis were passively rotated at the same plane. There was a difference of more than 30 degrees between straight leg raising performed in the sitting and supine positions. In fact, straight leg raising was less than that required for walking. In other words [appellant] actually did have that degree of abnormal straight leg raising they would not be able to walk into the office. There was also a disproportionate verbalization, facial expression and pain behavior associated with all maneuvers.
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> "Also on this examination performed today [appellant] complained of decreased sensation in his lower extremities up to the level of his groin region symmetrically over the anterior aspect of his legs, posteriorly, [his] numbness was up to the area of his waist. This is not anatomically likely to be on an organic basis. Additionally, it is different from [appellant's] previous examination by Dr. Bayles performed recently. [Appellant] also has absent deep tendon reflexes throughout. This would suggest that he has a more severe peripheral neuropathy than initially. This would go along with his having a known peripheral neuropathy. The peripheral neuropathy would be secondary most likely to appellant's known diabetes mellitus. However, his symptom magnification is very difficult for me to know his exact disability based on his physical examination. However, it is likely based on the magnetic resonance imaging (MRI) findings that he does have significant pain in his legs related to spinal stenosis and neural foraminal narrowing. In addition, there would be loss of sensation in his lower extremities related to the diabetes. He also has impairment of motion of his right foot related to a previous surgery of his right ankle.
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> "In my opinion this is a complicated case. [Appellant] undoubtedly has preexisting lumbar degenerative changes that predate his injury. The injury by its description does not sound like a severe impact or trauma to lumbar spine. I have noted [that he] had preexisting back surgery reportedly in 1966. It is my belief

that [appellant's] malignant obesity probably has caused more cumulative wear and tear type injury to his back than the work-related injury described.

"Although it is not demanded that I respond to the following questions I will to clarify an[y] further questions that might arise regarding my evaluation. The American Medical Association (A.M.A.), *Guides* [*to the Evaluation of Permanent Impairment*], Fourth Edition is utilized on page 102. [Appellant] falls into DRE lumbosacral category for loss of motion segment integrity. Based on the fact that [he] does have loss of motion segment or structural integrity and there is a documented history of muscle pain. [Appellant] has multi level spine segment structural compromise with residual neurological motor compromise and yet there does not appear to be any residual neurological motor compromise. Impairment given to this category is 20 percent whole person impairment. I am asked to refer to Table 11 on page 48 and Table 12 on page 49 with further determining the impairment due to sensory and motor involvement. Unfortunately, the [appellant] has a nonanatomically sensory examination today with symptom magnification. As mentioned he has seen other physicians and these symptoms and findings were not present. The signs described by other physicians are nondermatomal sensory loss. This would more likely be related to his diabetes mellitus and not at all related to the back injury. In addition, I am not able to document any motor abnormalities on today's examination]. Although [appellant] is not able to toe or heel walk he does appear to have good function of his right foot. As mentioned he does walk in an everted posture and has limited ability to toe and heel walk related to a previous ankle surgery. Question number three, I believe that MMI [maximum medical improvement] has occurred and if we go by the date of injury it would be the statutory MMI, which would be awarded. I believe I have stated the objective findings on examination with subjective complaints in the previous responses. The diagnosis of conditions affecting the lower extremities include peripheral neuropathy, symptom magnification, presumed spinal stenosis (this would be better evaluated by a myelogram), neural foraminal narrowing without clear motor or sensory loss at L4-5, L5-S1, spondylolysis L4-5, the accepted facts by your office include lumbar sprain as a result of this injury, preexisting conditions of diabetes, hypertension, right ankle injury, degenerative disc disease and facet arthritis at the lumbar spine, L4-5 stenosis and spondylolysis L5-S1, stenosis and obesity are not accepted as work related. The impairment that I rated for not being related to the work incident as described above."

An Office medical adviser reviewed Dr. Stein-Goldings' report on June 18, 1999 and found "no valid medical evidence on which to base a PPI [permanent partial impairment] of either lower extremity that can be attributed to the accepted work-related condition."

By decision dated June 28, 1999, the Office found that the medical evidence failed to demonstrate that appellant sustained any permanent impairment of a member or function of the body listed under the schedule award provision of the Federal Employees' Compensation Act.[1]

[1] 5 U.S.C. §§ 8101-8193.

The Board finds that the weight of the medical evidence establishes that appellant does not have a permanent impairment that would entitle him to a schedule award under the Act.

The schedule award provision of the Act[2] and its implementing regulation[3] 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.

As found by an Office hearing representative in a December 22, 1998 decision, there was a conflict of medical opinion on whether appellant had a permanent impairment of the legs related to his August 11, 1995 employment injury to his back. His attending physician, Dr. Bayles stated in a December 22, 1997 report that appellant's "leg symptoms are stemming from his back injury and back complaints." Dr. Wharton, to whom the Office referred appellant for a second opinion, attributed his leg condition to his obesity, deconditioning and age-related arthritic condition.

To resolve this conflict of medical opinion, the Office, pursuant to section 8123(a) of the Act,[4] referred appellant, the case record and a statement of accepted facts to Dr. Stein-Goldings. In a report dated May 13, 1999, she attributed appellant's sensory loss in the lower extremities to his diabetes and attributed the pain in his legs to spinal stenosis and neural foraminal narrowing. Dr. Stein-Goldings was unable to document any motor abnormalities and concluded that the impairment of appellant's spine was not related to his employment injury.

In situations where there are 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 on a proper factual background, must be given special weight.[5] The report of Dr. Stein-Goldings, as that of an impartial medical specialist, is given special weight and establishes that appellant has no permanent impairment of the legs related to his August 11, 1995 employment injury. Although Dr. Stein-Goldings indicated that appellant had a permanent impairment of the back, a schedule award is not payable under the Act for a permanent impairment of the back or for an impairment to the body as a whole.[6]

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] 5 U.S.C. § 8123(a) states 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."

[5] *James P. Roberts*, 31 ECAB 1010 (1980).

[6] *Rozella L. Skinner*, 37 ECAB 398 (1986). 5 U.S.C. § 8101(2) specifically excludes the back from the definition of "organ" under the Act.

The June 28, 1999 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
September 21, 2001

Michael J. Walsh
Chairman

Bradley T. Knott
Alternate Member

Priscilla Anne Schwab
Alternate Member