

percutaneous discectomy at L3-4 on November 19, 1999; and a discectomy at L3-4 on December 7, 1999.

Appellant submitted a report dated February 6, 2002 from Dr. George L. Rodriguez, a Board-certified physiatrist, who examined appellant for the purpose of evaluating the extent of permanent injury to the lower extremities. Dr. Rodriguez provided a history of injury and medical treatment related to appellant's September 17, 1987 injury, as well as findings of his examination of appellant. He performed an impairment rating evaluation, applying the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). Dr. Rodriguez determined that the involved sensory roots on the right side were L5 and S1, and the involved motor roots on the right side were L4, L5 and S1. Referring to Tables 15-15, 15-16 and 15-18 at page 424, he noted that the maximum impairment due to a sensory deficit for each nerve was five percent, and that the maximum impairment due to a motor deficit was 34 percent for L4; 37 percent for L5; and 20 percent for L3 and S1. He asserted that appellant had a Grade 4 sensory impairment. For the L5 sensory root, he attributed a 10 percent sensory deficit, which he multiplied by the five percent maximum to find a .5 percent sensory impairment. For the S1 sensory root, he attributed a 25 percent deficit, which he multiplied by the five percent maximum to find a 1.25 percent sensory impairment. For the L4, L5 and S1 motor roots, he attributed a 25 percent deficit, which he multiplied by the applicable maximum percentage of impairment allowed.

His calculation resulted in motor impairment ratings of 9 percent for L4 and L5 and 5 percent for S1, for a combined right lower extremity impairment of 23 percent. Dr. Rodriguez determined that the involved sensory roots on the left side were L5 and S1, and the involved motor roots on the left side were L3, L4, L5 and S1. For the L5 and S1 sensory root, he attributed a 25 percent deficit, which he multiplied by the 5 percent maximum. His calculations resulted in a .5 percent impairment for L5 sensory loss and a 1.25 percent impairment for S1 sensory loss.¹ For the L4, L5 and S1 motor roots, he attributed a 25 percent deficit, which he multiplied by the applicable maximum percentage of impairment allowed. His calculation resulted in motor impairment ratings of 9 percent for L4 and L5, and 5 percent for S1, for a combined left lower extremity impairment of 27 percent.

The record contains a July 29, 2002 report of a second opinion examination by Dr. Richard Bennett, a Board-certified neurologist, who provided a history of injury and treatment and results on examination. Dr. Bennett found appellant's left knee reflex to be absent. Sensory testing revealed diminished sensation over the entire left leg. Sensation elsewhere appeared to be intact. Straight leg raising maneuver was performed in a seated position without difficulty. Dr. Bennett provided an impression of HNP L4-5, status post discectomy at L3-4 and L4-5 and laminectomy at L4-5 with residual radiculopathy. Referring to Tables 15-15 and 15-18 of the fifth edition of the A.M.A., *Guides*, he concluded that appellant had a 1.3 percent impairment of his lower extremity. Opining that appellant had a Grade 3 sensory impairment, Dr. Bennett multiplied the maximum percent loss of function due to sensory deficit for L4 of 5 percent, by a 26 percent sensory deficit.

¹ The Board notes that Dr. Rodriguez's calculations are not accurate. Twenty-five percent of a 5 percent maximum would result in a 1.25 percent impairment for L5 sensory loss.

On February 26, 2003 the Office granted appellant a schedule award for a 71 percent permanent impairment of the penis, and a 1 percent permanent impairment of each lower extremity. Appellant, through his representative, requested a review of the written record. By decision dated July 2, 2003, the Office hearing representative remanded the case for further development of the medical evidence.

Following a review of the record by the district medical adviser, the Office found that a conflict existed between the medical opinions of Drs. Rodriguez and Bennet regarding the degree of permanent impairment of appellant's lower extremities. The Office referred appellant, together with the entire medical record and statement of accepted facts, to Dr. Dara G. Jamieson, a Board-certified neurologist, to resolve the conflict. In a March 29, 2004 report, Dr. Jamieson related appellant's history, current complaints and findings on physical examination. She found that appellant had no loss of lower extremity function and no motor or significant sensory deficit. Dr. Jamieson concluded that appellant had degenerative disc and joint disease of the lumbar spine that was exacerbated, but not caused, by his work activities. She stated that appellant's degenerative condition continued to be chronic, preexisting and ongoing, and that his current complaints were consistent with chronic degenerative disease expected in an older man but did not represent ongoing impairment from work-related injuries. Dr. Jamieson found that appellant had a minor sensory deficit in the left S1 nerve root and an absent left knee reflex, which was consistent with L3-4 nerve root injury. The Office referred Dr. Jamieson's report to the district medical adviser for review and an impairment rating under the A.M.A., *Guides*. On April 20, 2004 the medical adviser concluded that appellant was entitled to a schedule award for a one percent impairment of each lower extremity, due primarily to sensory loss.

By decision dated May 10, 2004, the Office found that appellant had one percent impairment of each lower extremity.

Appellant again requested review of the written record. By decision dated September 9, 2004, the Office hearing representative remanded the case to the Office for further development of the medical evidence. The Office was instructed to obtain clarification from Dr. Jamieson as to whether appellant's preexisting lumbar condition contributed to or permanently exacerbated his accepted work-related condition. In a February 15, 2005 supplemental report, Dr. Jamieson reiterated that appellant had degenerative disc and joint disease of the lumbar spine that was exacerbated, but not caused, by his work activities. She stated that appellant's degenerative condition continued to be chronic, preexisting and ongoing, and that his current complaints were consistent with chronic degenerative disease expected in an older man and did not represent ongoing impairment from work-related injuries. Dr. Jamieson indicated that appellant's preexisting lumbar degenerative disease was not permanently exacerbated by his work conditions.

By decision dated February 16, 2005, the Office denied appellant's request for an increased schedule award. The Office found that Dr. Jamieson's February 15, 2005 supplemental report clarified that appellant's current condition did not represent ongoing impairment from work-related injuries.

On February 18, 2005 appellant's representative again requested review of the written record, contending that Dr. Jamieson had not provided clarification as to whether appellant's preexisting lumbar condition contributed to or permanently exacerbated his accepted work-related condition. By decision dated November 14, 2005, the Office hearing representative set aside the February 16, 2005 decision and remanded the case to the Office for referral to a different impartial medical examiner. The hearing representative found that Dr. Jamieson's report was merely a restatement of her March 29, 2004 report, and did not contain a rationalized opinion as to whether appellant had experienced an exacerbation of his lumbar degenerative disease, whether it had been resolved and whether it was permanent or temporary.

The record contains ESAFEC reports reflecting that the Office used the Physicians Directory System (PDS) in conjunction with the Marquis Directory of Medical Specialists to select the new referee physician. The Office attempted to schedule appointments with Drs. Dirk Skinner, Stanley Leonberg and Scott Sharets, all Board-certified neurologists. The reports reflect that these doctors were too busy to perform an examination of appellant. A July 14, 2004 PDS report shows that, after the above-referenced bypasses, an appointment was scheduled with Dr. Stephen C. Vanna, a Board-certified neurologist, on April 27, 2006. An Office appointment schedule notification form reflects that appellant's appointment for a referee examination with Dr. Vanna was scheduled for April 27, 2006 at 11:00 a.m. The following handwritten notation appeared at the bottom of the form: "Dr. Maria Carter will be the doctor who will do the [e]xam[ination]."

On May 1, 2006 Dr. Maria C. Carta, a Board-certified neurologist, reported the results of her April 27, 2006 examination of appellant. Dr. Vanna's letterhead reflects that she is an associate of his. Dr. Carta reviewed appellant's history of injury and treatment and stated that she had reviewed the entire medical record. Sensory examination revealed slight hypesthesia to light touch and pinprick in the L4 and L5 dermatomes in the left leg. A constant sensory deficit could not be demonstrated in the right leg. Reflexes were normoactive and symmetrical in the upper extremities. Plantar responses were downgoing bilaterally. There was no clonus at the ankle. Left knee jerk was absent. Dr. Carta diagnosed failed back syndrome with status post L4-5 and L3-4 laminectomy. She indicated that appellant had clinical findings consistent with radiculopathy. Motor examination revealed no hemiparesis, drift or focal strength deficit. Dr. Carta opined that appellant's left leg symptoms were permanent and related to his September 17, 1987 injury. She found no permanent partial disability of the right lower extremity. Dr. Carta concluded that appellant had a five percent impairment of his left lower extremity attributable to a sensory deficit in the L4-5 dermatome. She opined that appellant's symptoms were more consistent with degenerative joint disease of the lumbar spine than to any injury-related pathology.

On May 26, 2006 the Office asked the district medical adviser to review Dr. Carta's report and to provide a recommendation as to the degree of permanent impairment of appellant's lower extremities. On May 30, 2006 the medical adviser concluded that appellant had no impairment of his right lower extremity, as there was no consistent sensory deficit and no muscle strength loss. For the left lower extremity, he allocated a four percent rating due to slight hypesthesia to light touch and pinprick at the L4-5 area (25 percent x 5 for each root, rounded off to 2 percent), and a 1 percent rating, due to the absence of a knee jerk for a combined 5 percent

deficit of the left lower extremity. The medical adviser opined that maximum medical improvement was probably on March 1, 2004, when the last RME was done. He indicated that he had not seen the report.

By decision dated August 4, 2006, the Office granted appellant a schedule award for an additional three percent impairment of his lower extremities. The Office indicated that the award represented the difference between the total impairment rating of five percent and the two percent previously awarded. The Office found that the date of maximum medical improvement was March 1, 2004, and the period of the award was from March 1, through April 30, 2004.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act² and its implementing regulation³ 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. The Act, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of the Office.⁴ 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 regulation as the appropriate standard for evaluating schedule losses.⁵

In situations where there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist for the purpose of resolving the conflict, pursuant to section 8123(a) of the Act.⁶ Impartial medical specialists are selected by a strict rotational system to eliminate any inference of bias or partiality.⁷

A physician selected by the Office to serve as an impartial medical specialist should be one wholly free to make a completely independent evaluation and judgment. In order to achieve this, the Office has developed specific procedures for the selection of impartial medical

² 5 U.S.C. § 8101 *et seq.*

³ 20 C.F.R. § 10.404.

⁴ *Linda R. Sherman*, 56 ECAB ___ (Docket No. 04-1510, issued October 14, 2004); *Daniel C. Goings*, 37 ECAB 781, 783-84 (1986).

⁵ *Ronald R. Kraynak*, 53 ECAB 130, 132 (2001).

⁶ 5 U.S.C. § 8123(a) states in pertinent part: "If there is a 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."

⁷ *LaDonna M. Andrews*, 55 ECAB 301 (2004); *Miguel A. Muniz*, 54 ECAB 217 (2002); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (March 2005).

specialists designed to provide adequate safeguards against any possible appearance that the selected physician's opinion was biased or prejudiced. These procedures, set forth in the Federal (FECA) Procedure Manual provide, in pertinent part, as follows:

“b. Selection of Physician. The CE [claims examiner] may use Form CA-19, Request for Specialists Referral (Exhibit 1), to initiate the referral. Unlike selection of second opinion examining physicians, selection of referee physicians is made by a strict rotational system using appropriate medical directories....

“(1) The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality. This is accomplished by selecting specialists in alphabetical order as listed in the roster chosen under the specialty and/or subspecialty heading in the appropriate geographic area and repeating the process when the list is exhausted....”⁸

ANALYSIS

In order to resolve a conflict of medical opinion regarding the degree of permanent impairment of his accepted condition, the Office properly referred appellant to Dr. Jamieson, selected as the impartial medical specialist.⁹ In a November 14, 2005 decision, finding that Dr. Jamieson's report had failed to resolve the conflict, the Branch of Hearings and Review instructed the Office to refer appellant to a different impartial medical examiner. Accordingly, the Office utilized the PDS and referred appellant to Dr. Vanna for an impartial medical examination. However, the record reflects that the Office actually scheduled the appointment with Dr. Vanna's associate, Dr. Carta, who performed the examination on April 27, 2006. Stating that Dr. Carta's May 1, 2006 report was entitled to special weight because she was acting as an impartial medical specialist, the Office found that her opinion represented the weight of the medical evidence and was sufficient to resolve the conflict in the medical evidence. The Board finds, however, that Dr. Carter may not be considered an impartial medical specialist because she was not appointed by the Office in accordance with procedures established by the Office for the selection of such specialists.

A physician selected by the Office to serve as an impartial medical specialist should be one wholly free to make a completely independent evaluation and judgment. In order to achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide adequate safeguards against any possible appearance that the selected physician's opinion was biased or prejudiced. As noted above, the procedures contemplate that impartial medical specialists will be selected on a strict rotating basis in order to

⁸ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (March 2005).

⁹ Section 8123 of the Federal Employees' Compensation Act provides: "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 U.S.C. § 8123; *see e.g., William C. Bush*, 40 ECAB 1064 (1989).

negate any appearance that preferential treatment exists between a particular physician and the Office.¹⁰ Because Dr. Carta was not selected by the Office in accordance with its rotating selection procedures, her opinion was improperly obtained and cannot be awarded special weight.¹¹

Although Dr. Carta is Dr. Vanna's associate, the record does not demonstrate that she would have been the next physician on the rotation list after Dr. Vanna. Therefore, to permit the use of Dr. Carta's medical opinion would undermine the appearance of impartiality or would appear to compromise the integrity of the system for selecting impartial medical specialists.¹² As Dr. Carta cannot be considered to be an impartial medical specialist in this case, her report may not receive any special weight. As such, the Board finds that there remains an unresolved conflict in medical opinion regarding the degree of permanent impairment of appellant's lower extremities. This case is remanded to the Office for referral of appellant, the case record and a statement of accepted facts to an appropriate impartial medical specialist, selected in accordance with the Office's procedures. After such further development of the record as it deems necessary, the Office shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision, as the impartial medical specialist was not selected according to Office procedures. This case must be remanded for additional development of the medical evidence.

¹⁰ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4(b) (March 2005).

¹¹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(b) (1) (March 1994), which provides in pertinent part: "If someone other than the selected physician examined the claimant, the report cannot be used to resolve a conflict in medical opinion and cannot be afforded special weight. It should be annotated accordingly, and another referee examination must be arranged."

¹² See *Raymond J. Brown*, 52 ECAB 192 (2001); *Shirley L. Steib*, 46 ECAB 309 (1994) (In each case, an associate of the physician selected by the Office to serve as an impartial medical specialist examined the claimant and provided an opinion to resolve a conflict in the medical opinion. In each case, the Board found that the associate's opinion could not represent the weight of the medical evidence, as the associate was not selected as an impartial medical specialist according to Office procedures); see also *Vernon E. Gaskins*, 39 ECAB 746 (1988); *William C. Iadipaolo*, 39 ECAB 530 (1988); *Leonard W. Waggoner*, 37 ECAB 676 (1988).

ORDER

IT IS HEREBY ORDERED THAT the August 4, 2006 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision.

Issued: May 2, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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