United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 07-244**
	)	**Issued: October 25, 2007**
DEPARTMENT OF THE TREASURY, BUREAU OF THE MINT, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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 November 6, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' December 6, 2005 and October 3, 2006 merit decisions regarding his entitlement to 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.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he has more than a 10 percent permanent impairment of his left leg and a 0 percent permanent impairment of his right leg; and (2) whether he met his burden of proof to establish that he has more than a 36 percent permanent impairment of his penis, for which he received a schedule award.

FACTUAL HISTORY

On July 7, 1998 appellant, then a 50-year-old mechanic, filed a traumatic injury claim alleging that he injured his back at work on July 6, 1998 when he was baring down with his arms

on a die press. He stopped work on July 7, 1998.[1] The Office accepted that appellant sustained a lumbosacral strain, dislocated thoracic vertebra and lumbar stenosis at L4-5.

The findings of a July 22, 1998 magnetic resonance imaging scan showed a disc bulge at L4-5 with a superimposed broad-based paracentral disc herniation which compromised both neural foramin. The findings of a January 14, 2000 computerized tomography scan revealed a bulge of the annulus at L3-4 with mild acquired narrowing of the canal. On October 31, 2000 appellant underwent a laminectomy at L4-5 and a hemilaminectomy at L3. On April 3, 2002 he underwent a revision laminectomy and fusion at L4-5 and L5-S1 with posterior supplemental hardware and, on October 15, 2002, the hardware was surgically removed. These procedures were authorized by the Office.

On June 2, 2003 Dr. Daryl Antonacci, an attending Board-certified orthopedic surgeon, stated that appellant had pain over the ileac crest area of his back but had full strength in both legs with negative findings upon straight leg raise testing. On August 1, 2003 appellant filed a claim for a schedule award for permanent impairment to his legs due to his accepted employment injury.

In an August 11, 2003 decision, the Office denied his claim on the grounds that he did not submit sufficient medical evidence to establish any permanent impairment.

On October 16, 2003 Dr. George L. Rodriguez, Board-certified in physical medicine and rehabilitation, stated that appellant had 4/5 strength in his left gluteus maximus, medius maximus, quadriceps and biceps femoris muscles and 3/5 strength in his left anterior tibialis and soleus muscles. He indicated that he was "suffering significantly from his low back pain with radiation into the bilateral lower extremities and sexual dysfunction." Dr. Rodrigeuz stated that appellant reached maximum medical improvement on July 3, 2002. He provided calculations of impairments due to leg weakness associated with the superior gluteal, inferior gluteal and sciatic nerves on the right and the femoral, superior gluteal, inferior gluteal and sciatic nerves on the left. Dr. Rodriguez indicated that, in performing his calculations, he made reference to Tables 15-16 and 17-37 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He concluded that using the Combined Values Chart of the A.M.A., *Guides* to combine the impairment ratings for weakness associated with the implicated nerves yielded a 30 percent permanent impairment in each leg.[2] Dr. Rodriguez determined that under Table 13-21 of the A.M.A., *Guides* appellant had a 20 percent permanent impairment of his whole person due to erectile dysfunction. He indicated that he believed his impairments were related to the July 6, 1998 employment injury.

In a June 29, 2004 decision, an Office hearing representative set aside the Office's August 11, 2003 decision and remanded the case to the Office for further development of the

[1] Appellant retired and began to receive Office of Personnel Management benefits effective August 1, 2003.

[2] It should be noted that combining the impairment ratings for weakness associated with the implicated nerves on the right actually equals 31 percent and that combining the ratings for weakness associated with the implicated nerves on the left actually equals 57 percent. *See* A.M.A., *Guides* 604-05, Combined Values Chart.

medical evidence. He found that there was sufficient evidence of lower extremity symptoms and possible erectile dysfunction to require referral of appellant for a second opinion examination.

In August 2004, the Office referred appellant to Dr. Robert Smith, a Board-certified orthopedic surgeon, and Dr. Stanford Feinberg, a Board-certified neurologist, for second opinion examinations concerning his permanent impairment.

On August 19, 2004 Dr. Smith stated that appellant had no back spasms and noted that neurological examination of the lower extremities was entirely normal with no atrophy and no motor, sensory or reflex deficits. He indicated the straight leg raising maneuvers were negative on both sides and that appellant had reached maximum medical improvement in November 2003. Dr. Smith indicated that, under the standards of the A.M.A., *Guides* appellant did not have any permanent impairment to his lower extremities. He stated that appellant's claimed penile dysfunction would have to be evaluated by an urologist as the condition was outside his scope of practice.

On August 26, 2004 Dr. Feinberg stated that appellant reported that he had constant low back pain which radiated into both thighs to the knees, that the pain was made worse by activity and prevented running and that he had weakness in his left leg. He stated that on examination appellant had 4/5 strength in the left quadriceps upon dorsiflexion of the left foot and indicated that he had lumbar discogenic disease, mostly at L4-5 and a lumbar radiculopathy. Dr. Feinberg stated that it was outside his level of expertise to comment on appellant's penile dysfunction but noted that it was unusual for an L4-5 radiculopathy to affect sexual dysfunction. He further stated:

> "According to the fifth [edition] to the [A.M.A., *Guides*], [appellant] meets the [diagnosis-based estimate] lumbar category of 10 percent. This was derived from Tables 15-16 and 15-18. [Appellant] demonstrated motor weakness which was able to move against gravity and resistance in the L3, L4 and L5 lumbar dermatones on the left. The maximum loss would be 37 percent with a 1 [to] 25 percent motor deficit. This would, therefore, lead to a 10 percent permanent disability radiating from the left lower extremity."

The Office referred appellant to Dr. Marvin H. Marx, a Board-certified urologist, for a second opinion regarding the nature and extent of any penile dysfunction. On December 1, 2004 Dr. Marx discussed appellant's reported sexual dysfunction and determined that under Table 13-21 of the A.M.A., *Guides* he had a 10 percent permanent impairment of his whole person due to a Class 3 erectile dysfunction which was employment related. He indicated that appellant reported that he had a sudden loss of function after his July 6, 1998 injury and that the frequency of sexual intercourse had diminished from twice per week to no more once a month.[3] Dr. Marx stated that appellant had reached maximum medical improvement, although all avenues of sexual dysfunction treatment had not been attempted.

In an October 19, 2004 report, Dr. Feinberg stated that appellant had no deficits in his right leg and, therefore, he did not have any impairment of the right leg.

[3] Dr. Marx stated that appellant reported that he was able to maintain his ability to ejaculate.

In a November 3, 2004 decision, the Office determined that appellant did not establish that he had permanent impairment of his right leg which entitled him to schedule award compensation.

In a November 8, 2004 decision, the Office granted appellant a schedule award for a 10 percent permanent impairment of his left leg. The award ran for 28.8 weeks from November 1, 2003 to May 20, 2004.

Dr. Rodriguez examined appellant up through 2005 and reported findings similar to those listed in his October 16, 2003 report. He indicated that appellant had erectile dysfunction of a "high severity."

In August 4 and October 12, 2005 reports, Dr. Willie E. Thompson, a Board-certified orthopedic surgeon and an Office medical adviser, determined that appellant had a 10 percent impairment of his whole person due to penile dysfunction under the standards found in Table 13-21 of the A.M.A., *Guides*. He indicated that this impairment rating was based on the opinion of Dr. Marx. Dr. Thompson found that, according to a formula dictated by Office procedure, this whole person impairment equaled a 36 percent impairment of the penis.

In an October 20, 2005 decision, an Office hearing representative set aside the Office's November 3 and 8, 2004 decisions and remanded the case for further development. The hearing representative found that there was a conflict in the medical evidence between Dr. Gonzalez and Dr. Feinberg regarding whether appellant had more than a 10 percent permanent impairment to his left leg and no impairment of his right leg.[4] He determined that appellant should be referred to an impartial medical specialist for examination and an opinion regarding the extent of the impairment of his legs.

In a December 6, 2005decision, the Office granted appellant a schedule award for a 36 percent permanent impairment of his penis. The award ran for 73.8 weeks from December 1, 2004 to May 1, 2005.

On January 25, 2006 Dr. Rodriguez stated that electromyogram (EMG) and nerve conduction studies obtained on that date suggested L4, L5 and S1 radiculopathies on the left and a L4 radiculopathy on the right.

On remand the Office referred appellant to Dr. Howard Levin, a Board-certified neurologist, for an impartial medical examination and opinion regarding the extent of the impairment to his legs. On March 9, 2006 Dr. Levin described appellant's medical history and noted that he currently complained of pain that went down the front and back of both legs but stopped at his knees. He indicated that he exhibited 5/5 strength throughout his legs but had 4/5 strength in his foot and ankle. Dr. Levin stated that he agreed with Dr. Feinberg that appellant had weakness in his left foot and ankle but did not have any weakness in his right leg. He indicated that because appellant consistently complained of pain that went down both legs but

[4] The hearing representative stated that Dr. Gonzalez determined that appellant had 30 percent permanent impairment of each leg and that Dr. Feinberg had determined that he had a 10 percent permanent impairment of his left leg and a 0 percent permanent impairment of his right leg

stopped at his knees it was not felt that there was involvement of the L4, L5 or S1 nerve roots, despite recent EMG and nerve conduction studies which suggested otherwise. Dr. Levin concluded that appellant had a "permanent impairment disability of 10 percent whole person due to the weakness he is experiencing in his left lower extremity as a result of the injury he reportedly sustained to his lumbar spine on July 6, 1998" and that there "was no evidence that he is suffering from any permanent impairment in his right lower extremity."[5]

On June 5, 2006 Dr. Morley Slutsky, Board-certified in occupational medicine and an Office medical adviser, stated that the basis for Dr. Levin's impairment rating of the left leg was unclear. On September 8, 2006 Dr. Levin indicated that he applied Table 15-3 on page 384 of the A.M.A., *Guides* which is entitled "Criteria for Rating Impairment Due to Lumbar Spine Injury." He indicated that appellant fell under Category 3 for diagnosis-related estimates and, therefore, had a 10 percent whole person impairment. On September 19, 2006 Dr. Slutsky indicated that it was inappropriate for Dr. Levin to apply Table 15-3.

In an October 3, 2006 decision, the Office found that appellant had no more than a 10 percent permanent impairment of his left leg and no permanent impairment of his right leg. The Office based its determination on the opinions of Dr. Levin and Dr. Slutsky.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulation[7] 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 regulation as the appropriate standard for evaluating schedule losses.[8]

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."[9] 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

[5] Dr. Levin also questioned whether appellant's erectile dysfunction was related to his employment injuries and suggested that this dysfunction might be related to the medications he was taking.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id*.

[9] 5 U.S.C. § 8123(a).

such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[10]

It is well established that proceedings under the Act are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[11]

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained lumbar and thoracic strains and lumbar stenosis at L4-5 on July 6, 1998 when he was baring down with his arms on a die press. It authorized multiple surgeries for bulging or herniated discs at L3-4, L4-5 and L5-S1. The Office awarded appellant a schedule award for a 10 percent permanent impairment of his left leg and determined that he had a 0 percent permanent impairment of his right leg. It indicated that it based on its determination that appellant did not have a greater impairment on the opinions of Dr. Levin, a Board-certified neurologist, who served as an impartial medical specialist, and Dr. Slutsky, a Board-certified occupational medicine physician, who served as an Office medical adviser.

The Office had determined that there was a conflict in the medical evidence between the October 16, 2003 opinion of Dr. Rodriguez, an attending Board-certified physical medicine and rehabilitation physician, and the August 26, 2004 opinion of Dr. Feinberg, a Board-certified neurologist, who served as an Office referral physician, which necessitated a referral to Dr. Levin for an impartial medical examination. On October 16, 2003 Dr. Rodriguez stated that appellant had a 30 percent impairment due to leg weakness associated with the superior gluteal, inferior gluteal and sciatic nerves on the right and that he had a 30 percent impairment due to leg weakness associated with the femoral, superior gluteal, inferior gluteal and sciatic nerves on the left.[12] On August 26, 2004 Dr. Feinberg determined that appellant had a 10 percent impairment of his left leg due to weakness which was based on a "maximum loss" of 37 percent and "a 1 [to] 25 percent motor deficit" derived from Tables 15-16 and 15-18 of the A.M.A., *Guides*. Dr. Feinberg also found that appellant did not have any impairment of his right leg.

The Board finds, however, that there was no conflict in the medical evidence[13] at the time of appellant's referral to Dr. Levin. The opinions of Dr. Rodriguez and Dr. Feinberg were of limited probative value in that the physicians failed to provide an explanation of how their assessments of permanent impairment were derived in accordance with the A.M.A. *Guides*

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

[11] *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[12] It should be noted that combining the impairment ratings for weakness associated with the implicated nerves on the right actually equals 31 percent and that combining the ratings for weakness associated with the implicated nerves on the left actually equals 57 percent. *See* A.M.A., *Guides* 604-05, Combined Values Chart.

[13] *See supra* note 9 and accompanying text.

adopted by the Office and approved by the Board as appropriate for evaluating schedule losses.[14] Dr. Rodriguez did not provide any explanation for his opinion that appellant's leg weakness in the superior gluteal, inferior gluteal and sciatic nerves on the right and the femoral, superior gluteal, inferior gluteal and sciatic nerves on the left was related to the accepted employment-related injuries. Dr. Feinberg did not explain why he apparently felt that weakness associated with the L5 nerve on the left was the only source of impairment.[15] Although he suggested that appellant had Grade 5 weakness on the left, he did not specify where that grade fell between 1 and 25 percent.[16]

For these reasons, Dr. Levin actually served as an Office referral physician rather than an impartial medical specialist and his opinion is not entitled to special weight regarding appellant's leg impairment.[17] The Board further finds that Dr. Levin's opinion is in need of clarification and the case will be remanded to the Office.

On March 9, 2006 Dr. Levin concluded that appellant had a "permanent impairment disability of 10 percent whole person due to the weakness he is experiencing in his left lower extremity as a result of the injury he reportedly sustained to his lumbar spine on July 6, 1998" and that there "was no evidence that he is suffering from any permanent impairment in his right lower extremity." On September 8, 2006 Dr. Levin indicated that he applied Table 15-3 on page 384 of the A.M.A., *Guides* which is entitled "Criteria for Rating Impairment Due to Lumbar Spine Injury" to determine that appellant had a 10 percent whole person impairment.[18] The Board notes, however, that it was inappropriate for Dr. Levin to use Table 15-3 because neither the Act nor its implementing regulation provides for a schedule award for impairment to the back or to the body as a whole.[19] Dr. Levin indicated that appellant had left foot and ankle weakness and the A.M.A., *Guides* includes methods for measuring such deficits, such as those found in Table 17-8 which pertain to weakness upon such ankle motions as flexion, extension, inversion and eversion.[20] There is no indication that Dr. Levin attempted to apply the standards of Table 17-8 or some other part of the A.M.A., *Guides* which would adequately evaluate this aspect of appellant's condition. Moreover, it is unclear whether he adequately considered whether the pain symptoms in both appellant's legs justified impairment ratings for sensory loss.

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[14] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

[15] Dr. Feinberg indicated that he conducted his calculation under Table 15-18 using a maximum value of 37 percent. The only nerve root with a maximum value of 37 percent under Table 15-18 is the L5 nerve root. A.M.A., *Guides* 424, Table 15-18.

[16] *Id.* at Table 15-16. Even if the 25 percent weakness grade were chosen, multiplying this value times the maximum value for weakness associated with the L5 nerve would only equal a 9.25 percent impairment.

[17] *See supra* note 10 and accompanying text. The Board further notes that the reports of Dr. Slutsky would not support the Office's determination as Dr. Slutsky actually indicated that Dr. Levin's calculation was not appropriate.

[18] *See* A.M.A., *Guides* 384, Table 15-3.

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

[20] *See* A.M.A., *Guides* 532, Table 17-8.

As noted, the Office shares responsibility in the development of the evidence.[21] Therefore, the case should be remanded to the Office for clarification of the permanent impairment to appellant's legs. After such development if deems necessary, the Office should issue an appropriate decision.

LEGAL PRECEDENT -- ISSUE 2

The Act provides schedule award compensation for employment-related permanent impairment of the sexual and urinary functions of the penis, but it must be shown that a claimant's sexual or urinary difficulties are related to employment factors through the submission of rationalized medical evidence establishing such a causal relationship.[22] Permanent impairment must be based on a direct physiological connection between the employment injury and the part of the body for which a schedule award is claimed.[23]

The Office's procedure manual notes that, while the A.M.A., *Guides* expresses the impairment of internal organs in terms of the whole person, schedule awards under the Act are based on the percentage of impairment of the particular organ.[24] The Office procedure manual provides a formula to measure the percentage of impairment of an organ when the whole person impairment is provided. The whole person impairment of the claimant, identified as A, is divided by B, the maximum allowable impairment of the organ, which equals X, the impairment rating, divided by 100.[25]

The Office procedure manual further provides:

> "For organs such as the penis, which have more than one physiologic function, the A.M.A., *Guides* provide whole person impairment levels for each function. When calculating the impairment of these organs, the [district medical adviser] must consider all functions as instructed in the A.M.A., *Guides*. In these cases, the maximum whole person impairment ascribed to the particular organ (B) is obtained by combining the maximum levels for all functions using the Combined Values [Chart] in the current edition of the A.M.A., *Guides*. The actual whole person impairment (A) is obtained by combining all functional impairments found using the Combined Values [Chart] in the [A.M.A.,] *Guides*.
>
> "For example: A claimant has a Class 2 sexual whole person impairment of the penis amounting to 15 percent, and there is no objective urethral impairment. A

[21] *See supra* note 11 and accompanying text.

[22] *See* 20 U.S.C. § 10.404(a); *Gordon G. McNeill*, 40 ECAB 790, 795 (1989); *William T. Trull*, 36 ECAB 659, 663-64 (1985).

[23] *Gregory C. Esparza*, 42 ECAB 911, 915 (1991).

[24] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(c)(2) (November 1998).

[25] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4(c)(2)(a) (August 2002).

> 15 percent whole person sexual impairment combined with a 0 percent whole person urethral impairment results in a whole person impairment of the penis of 15 percent. The maximum whole person impairment for the sexual and urethral functions of the penis is 28 percent."[26]

For the above-noted example, Office procedures provide that the Office medical adviser should divide 15 by 28 which equals X divided by 100, for a total impairment of the penis of 54 percent.[27]

ANALYSIS -- ISSUE 2

The Board finds that appellant did not meet his burden of proof to establish that he has more than a 36 percent permanent impairment of his penis, for which he received a schedule award. The Office based its determination regarding the impairment of appellant's penis on the December 1, 2004 opinion of Dr. Marx, a Board-certified urologist, who served as an Office referral physician. The Board notes that Dr. Marx properly determined that under Table 13-21 of the A.M.A., *Guides* appellant had a 10 percent permanent impairment of his whole person due to a Class 3 erectile dysfunction which was employment related.[28] Dr. Marx explained that appellant reported that he had a sudden loss of function after his July 6, 1998 injury and that frequency of sexual intercourse had diminished from twice per week to no more than once a month.

The Board further finds that Dr. Thompson, the Office medical adviser, properly utilized the above described formula to find that the 10 percent whole person impairment divided by the 28 percent maximum whole person impairment for the penis equaled X divided by 100 or a 35.7 percent permanent impairment of the penis. He then properly rounded this figure up to find a 36 percent penile impairment.[29]

In an October 16, 2003 report, Dr. Rodriguez determined that under Table 13-21 of the A.M.A., *Guides* appellant had a Class 3 or 20 percent permanent impairment of his whole person due to erectile dysfunction. The opinion of Dr. Rodriguez is of limited probative value in that Dr. Rodriguez failed to provide an explanation of how his assessment of permanent impairment was derived in accordance with the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses. He did not provide any explanation for determining that appellant had such a high level of impairment of his penis. Such rationale is particularly necessary because a Class 3 or 20 percent whole person impairment is intended for

[26] *Id.*

[27] *Id.*

[28] *See* A.M.A., *Guides* 342, Table 13-21.

[29] *See supra* note 25 through 27 and accompanying text.

persons experiencing no sexual function and the record reveals that appellant had at least some sexual function.[30]

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he has more than a 36 percent permanent impairment of his penis, for which he received a schedule award. The Board further finds that the case is not in posture for decision regarding whether he has more than a 10 percent permanent impairment of his left leg and a 0 percent permanent impairment of his right leg. The case is remanded to the Office for further development.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' October 3, 2006 decision is set aside and the case remanded to the Office for proceedings consistent with this decision of the Board. The Office's December 6, 2005 decision is affirmed.

Issued: October 25, 2007
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

[30] *See* A.M.A., *Guides* 342, Table 13-21. It should be noted that on March 9, 2006 Dr. Levin questioned whether appellant's erectile dysfunction was employment related but he did not provide a clear opinion on this matter. The Board further notes that appellant was not referred to Dr. Levin for the purpose of evaluating the impairment of his penis.