

intervertebral disc degeneration after moving furniture at work. It paid appellant compensation for periods of disability.

The findings of June 3, 1994 and October 3, 1995 x-ray testing of appellant's lumbar spine showed no significant abnormalities other than some degeneration at L4-5. The findings of July 24, 1997 magnetic resonance imaging (MRI) scan testing showed degenerative disc disease with diffuse disc bulges at L4-5 and L5-S1 without evidence of neural impingement. During the course of appellant's treatment over the years, she consistently reported experiencing low back pain that was aggravated by activity but denied having any leg symptoms.

On January 15, 2004 appellant underwent fusion surgery at L4-5 and L5-S1. On February 14, 2004 hardware from the January 15, 2004 surgery was removed. Both procedures were authorized by the Office. For several months after her surgeries, appellant reported experiencing lower extremity symptoms, including pain in the toes of both feet and a burning sensation on the tops of both feet.¹ She indicated that she continued to have low back pain, albeit of a lesser severity than she experienced prior to her surgery.

On May 18, 2005 Dr. Barry C. Gendron, an attending osteopath, stated that appellant reported that she experienced low back pain and paresthetic pain on the dorsum of both feet, greater on the left. Appellant's pain symptoms were increased by activity such as bending or twisting but she did not report specific weakness in the lower extremities. Dr. Gendron indicated that appellant's back had flexion of 40 degrees, extension of 5 degrees and lateral flexion of 15 to 20 degrees. Sensation in both legs was intact to light touch and pinprick and was no motor strength loss except for the extensor hallicus longus tendons. Dr. Gendron indicated that appellant had reached maximum medical improvement.

Dr. Gendron stated that under the standards of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) appellant's symptoms are most consistent with "DRE [diagnosis-based estimate] Lumbar Category 4" which was equivalent to a 23 percent whole person impairment based on complete loss of back motion segment integrity due to successful surgical arthrodesis at L4-5 and L5-S1 with ongoing radiculopathy. Using Table 17-3 on page 527, the 23 percent whole person impairment could be translated to a 57 percent lower extremity impairment for the right and left legs combined. Dr. Gendron stated:

"Alternate method of assessing permanent impairment in this individual, given the fact that she has no gait dysfunction, would be based on her sensory changes (she has none) as well as the weakness at the left ankle and foot, which is mild. This method, however, would not adequately quantitate permanent impairment and would not be representative of the percentage of impairment for an individual with 10 years of chronic pain and a [two]-level lumbar fusion."

On December 30, 2005 Dr. Thomas M. Frates, an attending Board-certified internist, indicated that appellant reported that she developed "new onset pain" in the anterior region of

¹ On April 13, 2004 appellant reported that her feet symptoms were slowly decreasing. A June 4, 2004 medical report indicates that appellant's "leg symptoms have essentially resolved."

her left hip on November 11, 2005, which tended to be present only while bearing weight. Appellant did not report any frank leg weakness or sensory changes. Dr. Frates stated that examination showed 5/5 strength and intact sensation upon light touch in both legs. He noted limited left hip motion and diagnosed left-sided iliopsoas tendinitis.

On March 13, 2006 Dr. Barry W. Levine, a Board-certified orthopedic surgeon, who served as an Office medical adviser, stated that prior to appellant's January 2004 surgery an MRI scan study revealed degenerative changes at L4-5 and L5-S without evidence of disc herniation or spondylolisthesis. According to the medical history, the May 9, 1995 employment injury aggravated preexisting spondylosis and led to chronic mechanical back pain. Dr. Levine indicated that appellant's most recent examination by Dr. Frates revealed no evidence of low back problems or residual of her lumbosacral disease. At the May 18, 2005 evaluation by Dr. Gendron, appellant complained of paresthesias on the top of her feet and bilateral foot pain, but her neurologic evaluation revealed no sensory or muscle strength loss or gait dysfunction. Dr. Levine stated, "Based on these findings there is no significant impairment of the lower extremities." He indicated that appellant reached maximum medical improvement on May 18, 2005.²

The Office determined that there was a conflict in the medical opinion between Dr. Gendron and Dr. Levine on the extent of the permanent impairment of appellant's legs and referred her, pursuant to section 8123(a) of the Federal Employees' Compensation Act, to Dr. David C. Morley, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.

On March 15, 2007 Dr. Morley discussed appellant's medical history and stated, "She has noted marked improvement in her back pain after the two-level spinal fusion, however, she does have intermittent paresthesias and numbness into the dorsum of both feet." He indicated that appellant had straight leg raising of 90 degrees (both sitting and standing) and that her back had flexion of 40 degrees and lateral flexion of 15 degrees. Deep tendon reflexes of the knees were 2+ and sensation was intact to light touch throughout the lower extremities. Dr. Morley indicated that there was no lower extremity atrophy or loss of muscle strength. He stated that appellant's ongoing back problem was causally related to her May 9, 1994 employment injury and asserted that she had reached maximum medical improvement. Dr. Morley noted that appellant had been left with ongoing lower extremity symptoms consistent with a low-grade radiculopathy. He indicated that under Table 15-3 on page 384 of the A.M.A., *Guides* appellant fell under "DRE Lumbar Category 4" and had a 20 percent impairment of the whole person.

In a supplemental report dated June 29, 2007, Dr. Morley noted that appellant had reached maximum medical improvement and had a physical impairment causally related to her May 9, 1994 employment injury. He indicated that the A.M.A., *Guides* provided two possible methods for calculating appellant's impairment, the DRE method and the range of motion method. Dr. Morley determined that the DRE method was more applicable for appellant's case and posited that under Table 15-3 her situation was best categorized as a "DRE Lumbar Category 4" which constituted a 20 percent whole person impairment. Utilizing Table 17-3, this

² On May 30, 2006 Dr. Frates stated that appellant reported that she had leg pain "with certain moves" that rated 3 out of 10 on a pain scale but that she did not have any gait instability.

translated to a 40 percent lower extremity impairment. Dr. Morley stated, “This impairment reflects the history and physical examination, which is consistent with both a chronic S1 radiculopathy on the right, as well as persistent radicular pain into both extremities causally related to the injuries of May 9, 1994.”

On October 8, 2007 Dr. George L. Cohen, a Board-certified orthopedic surgeon, who served as an Office medical adviser, concluded that appellant had a six percent permanent impairment of her left leg and a six percent permanent impairment of her right leg under the standards of the A.M.A., *Guides*. He indicated that the Act did not allow for evaluation of permanent impairment based on back impairment. Dr. Cohen stated that appellant had a 60 percent pain grade (Grade 3) for sensory loss associated with the L5 nerve in each leg (derived from Table 15-15) and noted that multiplying this value times the 5 percent maximum for sensory loss associated with that nerve (derived from Table 15-18) yielded a 3 percent impairment in each leg. Appellant’s 60 percent pain grade for sensory loss associated with the S1 nerve in each leg (derived from Table 15-15) multiplied times the 5 percent maximum for sensory loss associated with that nerve (derived from Table 15-18) also yielded a 3 percent impairment in each leg. The Office medical adviser then used the Combined Values Chart on page 604 to combine these impairment ratings in each leg.

In an October 29, 2007 decision, the Office granted appellant a schedule award for a six percent permanent impairment of her left leg and a six percent permanent impairment of her right leg. The award ran for 34.56 weeks from May 18, 2005 to January 14, 2006.

LEGAL PRECEDENT

The schedule award provision of the Act³ and its implementing regulation⁴ 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.⁵

A schedule award is not payable for the loss, or loss of use, of a part of the body that is not specifically enumerated under the Act. Neither the Act nor its implementing regulations provides for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is

³ 5 U.S.C. § 8107.

⁴ 20 C.F.R. § 10.404 (1999).

⁵ *Id.*

specifically excluded from the definition of organ under the Act.⁶ A schedule award is not payable under section 8107 of the Act for an impairment of the whole person.⁷

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.”⁸ 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 such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.⁹

ANALYSIS

The Office accepted that on May 9, 1994 appellant sustained a lumbosacral joint sprain, sacroiliac region sprain/strain and lumbosacral intervertebral disc degeneration and granted her a schedule award for a six percent permanent impairment of her left leg and a six percent permanent impairment of her right leg.¹⁰

The Office had determined that there was a conflict in the medical opinion between Dr. Gendron, an attending osteopath, and Dr. Levine, a Board-certified orthopedic surgeon, who served as an Office medical adviser, on the extent of the permanent impairment of appellant’s legs. It referred appellant, pursuant to section 8123(a) of the Act, to Dr. Morley, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion on the matter.¹¹ The Office based its schedule award on the October 8, 2007 report of Dr. Cohen, a Board-certified orthopedic surgeon, who served as an Office medical adviser. Dr. Cohen made his schedule award calculation after reviewing the medical evidence of record, including the March 15 and June 29, 2007 reports of Dr. Morley.

The Board notes, however, that Dr. Morley actually served as an Office referral physician rather than as an impartial medical specialist because, at the time of the referral to Dr. Morley, there was no conflict in the medical evidence regarding the extent of the permanent impairment of appellant’s legs. Neither Dr. Gendron nor Dr. Levine provided a probative opinion on appellant’s leg impairment under the relevant standards of the A.M.A., *Guides*.

On May 18, 2005 Dr. Gendron stated that under Table 15-3 of the A.M.A., *Guides* appellant’s symptoms were most consistent with “DRE Lumbar Category 4.” This was

⁶ *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

⁷ *See Gordon G. McNeill*, 42 ECAB 140, 145 (1990).

⁸ 5 U.S.C. 8123(a).

⁹ *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

¹⁰ On January 15, 2004 appellant underwent fusion surgery at L4-5 and L5-S1. On February 14, 2004 hardware from the January 15, 2004 surgery was removed. Both procedures were authorized by the Office.

¹¹ *See supra* notes 8 and 9 and accompanying text.

equivalent to a 23 percent whole person impairment based on complete loss of back motion segment integrity.¹² Dr. Gendron indicated that under Table 17-3 the 23 percent whole person impairment could be translated to a 57 percent lower extremity impairment for the right and left legs combined.¹³ The Board notes, however, that neither the Act nor its implementing regulations provides for a schedule award for impairment to the back or to the body as a whole.¹⁴ On March 13, 2006 Dr. Levine acknowledged that the medical evidence had shown some evidence that appellant had sensory loss in her legs. He stated that “there is no significant impairment of the lower extremities” but he did not provide a detailed evaluation of the permanent impairment of appellant’s legs under the relevant standards of the A.M.A., *Guides*.

In his March 15 and June 29, 2007 reports, Dr. Morley concluded that under Table 15-3 of the A.M.A., *Guides* appellant fell under “DRE Lumbar Category 4” and had a 20 percent impairment of the whole person. In his June 29, 2007 report, he used Table 17-3 to convert this back-derived 20 percent impairment of the whole person to a 40 percent lower extremity impairment. This impairment rating is of limited probative value regarding appellant’s leg impairment because it was impermissibly based on back impairment.

The Board finds that the only impairment evaluation of record that conforms to the standards of the A.M.A., *Guides* and Board precedent is the October 8, 2007 evaluation of Dr. Cohen. His report shows that appellant has a six percent permanent impairment of her left leg and a six percent permanent impairment of her right leg.

The Board notes that appellant first complained of pain radiating from her back to the tops of her feet in the several months after her January and February 2004 low back surgeries. Between 2005 and 2007 she reported moderate symptoms of pain or numbness radiating into her feet. For example, in May 2006 appellant reported having leg pain “with certain moves” that rated 3 out of 10 on a pain scale and in March 2007 she reported experiencing intermittent paresthesias and numbness that extended into the dorsum of both feet. Under these circumstances, Dr. Cohen properly determined that appellant had a 60 percent pain grade (Grade 3) for sensory loss associated with the L5 nerve in each leg and noted that multiplying this value times the 5 percent maximum for sensory loss associated with that nerve yielded a 3 percent impairment in each leg.¹⁵ He also correctly found that appellant had a 60 percent pain grade for sensory loss associated with the S1 nerve in each leg and noted that multiplying the 5 percent maximum for sensory loss associated with that nerve also yielded a 3 percent

¹² A.M.A., *Guides* 384, Table 15-15.

¹³ *Id.* at 527, Table 17-3.

¹⁴ *See supra* note 6 and accompanying text. The fact that Dr. Gendron used Table 17-3 to convert the back-derived whole person impairment to a lower extremity impairment would not change the fact that his impairment rating was impermissibly based on back impairment. Moreover, a schedule award is not payable under section 8107 of the Act for an impairment of the whole person. *See supra* note 7 and accompanying text.

¹⁵ A.M.A., *Guides* 424, Tables 15-15 and 15-18. Table 15-15 indicates that a Grade 3 is appropriate when sensory loss interferes with some activities.

impairment in each leg.¹⁶ Dr. Cohen then properly used the Combined Values Chart to combine these impairment ratings in each leg.¹⁷

Appellant did not submit any evidence showing that she has more than a six percent permanent impairment of her left leg or a six percent permanent impairment of her right leg. For these reasons, the Office properly granted appellant schedule award compensation to reflect this level of leg impairment.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establishment she has more than a six percent permanent impairment of her left leg or a six percent permanent impairment of her right leg.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 29, 2007 is affirmed.

Issued: November 5, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

¹⁶ A.M.A., *Guides* 424, Tables 15-15 and 15-18. Figure 17-8 shows that the L5 and S1 nerves distributions enervate the tops of the both feet. A.M.A., *Guides* 551, Figure 17-8.

¹⁷ *Id.* at 604, Combined Values Chart.