United States Department of Labor
Employees' Compensation Appeals Board

E.S., Appellant	)	
and	)	**Docket No. 08-2146**
	)	**Issued: June 9, 2009**
DEPARTMENT OF THE TREASURY, U.S. MINT, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 30, 2008 appellant filed a timely appeal from October 19, 2007 and May 12, 2008 decisions of the Office of Workers' Compensation Programs adjudicating his schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 12 percent permanent impairment of his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On September 19, 1991 appellant, a 36-year-old machinist, sustained a lumbar strain and a herniated disc at L5-S1 when he twisted his back while attempting to stop a motor that was suspended from a crane from swinging. On December 19, 1991 he underwent a microdiscectomy of his L5-S1 herniated disc performed by Dr. Ronald Wisneski, a Board-certified orthopedic surgeon.

On March 26, 2004 appellant filed a claim for a schedule award. In a January 19, 2004 report, Dr. David Weiss, an osteopathic physician specializing in orthopedic medicine, calculated 31 percent impairment of his right lower extremity due to hip and ankle muscle weakness, sensory loss and pain.

On June 7, 2004 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and an Office medical adviser, stated that the report from Dr. Weiss was not sufficient to determine appellant's right lower extremity impairment because his findings on physical examination and muscle testing were in conflict with the findings of other physicians and resulted in an inaccurate impairment rating.[1] He recommended a second opinion examination. In a July 16, 2004 report, Dr. Robert A. Smith, a Board-certified orthopedic surgeon, calculated seven percent right lower extremity impairment for sensory nerve deficit.

The Office found a conflict in the medical opinion evidence between Dr. Weiss and Dr. Smith. It referred appellant to Dr. William H. Simon, a Board-certified orthopedic surgeon, for an independent medical evaluation. In an April 14, 2005 report, Dr. Simon calculated seven percent impairment of appellant's right lower extremity for Grade 1 muscle weakness of the extensor hallucis longus muscle, based on Table 17-8 at page 532 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). On May 25, 2005 Dr. Berman reviewed the medical evidence and calculated 10.5 percent, rounded to 11 percent, right lower extremity impairment for sensory deficit. He found 1.25 percent impairment of the left lower extremity for sensory deficit.

By decision dated June 13, 2005, the Office granted appellant a schedule award based on 11 percent right lower extremity impairment for 31.68 weeks, from April 14 to November 21, 2005.[2] Appellant requested an oral hearing before an Office hearing representative that was held on March 3, 2006. By decision dated June 5, 2006, the hearing representative remanded the case for further development of the medical evidence.

On June 29, 2006 the Office asked Dr. Simon for a supplemental report. On July 18, 2006 Dr. Simon reiterated his right lower extremity impairment rating of seven percent.

On August 14, 2006 an Office medical adviser indicated that he would accept seven percent impairment unless Dr. Simon provided more data for the sensory loss. He indicated that perhaps the 11 percent already awarded was the correct percentage of impairment.

By decision dated August 21, 2006, the Office found that appellant had no more than 11 percent right upper extremity impairment. Appellant requested an oral hearing that was held on

[1] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (October 2005) (These procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[2] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 11 percent for the right lower extremity equals 31.68 weeks of compensation.

January 24, 2007. On March 21, 2007 an Office hearing representative found that Dr. Simon did not provide sufficient rationale for his seven percent impairment rating. Therefore, Dr. Simon's report was not sufficient to represent the weight of the medical evidence and resolve the conflict as to appellant's right lower extremity impairment. The Office hearing representative directed the Office to refer appellant for a new independent medical examination.

On April 24, 2007 the Office referred appellant, together with a statement of accepted facts and list of questions, to Dr. Robert Dennis, a Board-certified orthopedic surgeon.

In a May 15, 2007 report, Dr. Dennis reviewed the history of appellant's condition and provided findings on physical examination. He indicated that appellant had right hip and leg pain but opined that he had no identifiable ratable pain. There was no atrophy or gait derangement. There was some weakness of dorsiflexion (extension) of the hallux on the right foot. Dr. Dennis calculated 12 percent right lower extremity impairment, including 2 percent for Grade 4 sensory deficit of the L5 and S1 nerves, based on Table 15-15 at page 424 of the A.M.A., *Guides*, 3 percent for muscle weakness of the great toe, based on Table 17-8 at page 532 and 7 percent for sensory deficit of the sciatic nerve, based on Table 17-37 at page 552. He found no impairment of appellant's left lower extremity.

In a report dated July 23, 2007, Dr. Morley Slutsky, a Board-certified specialist in preventive medicine and an Office medical adviser, stated that he agreed with Dr. Dennis' calculation of two percent impairment for sensory loss in the L5 and S1 nerve roots but disagreed with his impairment rating of three percent for great toe muscle weakness and seven percent for sensory deficit of the sciatic nerve. He calculated four percent right lower extremity impairment, including two percent for sensory deficit of the L5 and S1 nerve roots, based on Table 15-15 at page 424 of the A.M.A., *Guides* and two percent muscle weakness of the extensor hallucis longus muscle of the great toe, based on Grade 4 muscle weakness from Table 17-7 at page 531 and Table 17-8 at page 532.

Due to the discrepancies between the impairment calculations of Dr. Dennis and Dr. Slutsky, the Office asked Dr. Dennis for a supplemental report.

On August 17, 2007 Dr. Dennis reiterated his opinion that appellant had 12 percent right lower extremity impairment based on the criteria in his May 12, 2007 report. He explained that the three percent impairment for loss of extension of the great toe was selected because appellant was between a Grade 4 and 3 and he determined that three percent was more appropriate. Dr. Dennis stated that an April electromyogram (EMG) revealed three level radiculopathy in the right leg. The right foot had some decreased sensation from the ankle down along the L5-S1 nerve root. Dr. Dennis determined that this constituted a mixed distribution of the sciatic nerve from at least two and possibly three nerve root impingements in the lumbar spine producing neurological deficit. He stated that seven percent impairment for sensory deficit of the sciatic nerve was appropriate and consistent with mixed findings of involvement of more than one nerve root.

On September 28, 2007 Dr. Berman stated that Dr. Dennis' rating for the sciatic nerve was not appropriate because only nerve root calculations were permitted in schedule awards. He calculated 12 percent right lower extremity impairment, including 9 percent for Grade 4 muscle

weakness of the extensor hallucis longus muscle of the great toe, based on Figure 16-11 at page 484 of the A.M.A., *Guides*[3] and Table 15-18 at page 424 (25 percent for Grade 4 weakness multiplied by 37 percent maximum for L5 loss of strength equals 9.25 percent, rounded to 9 percent) and 3 percent for Grade 4 sensory loss for the L5 and S1 nerves, based on Tables 15-15 and 15-18 at page 424 (25 percent maximum for Grade 4 in Table 15-15 multiplied by 5 percent maximum, each, for the L5 and S1 nerves equals 1.25 percent for each nerve or 2.50 percent for both nerves, rounded to 3 percent).

On October 19, 2007 the Office granted appellant a schedule award based on an additional one percent right lower extremity impairment for 21 days (2.88 weeks) from May 16 to June 5, 2007. Appellant requested an oral hearing that was held on February 20, 2008.

By decision dated May 12, 2008, the Office hearing representative affirmed the October 19, 2007 decision.[4]

LEGAL PRECEDENT

The schedule award provision of the Act[5] and its implementing regulations[6] 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.[7]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[8] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[9] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements

[3] Dr. Berman referenced Figure 16-16 but it is clear from the context that he meant Figure 16-11 at page 484 which is used for determining motor deficits due to peripheral nerve disorders for both lower and upper extremities. *See* A.M.A., *Guides* 484, Figure 16-11; text at 550, section 17.2l.

[4] Subsequent to the July 31, 2008 Office decision, appellant submitted additional evidence. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*.

[8] A.M.A., *Guides* 525.

[9] *Id.*

and meniscectomies.[10] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[11] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[12] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[13] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[14]

Section 8123(a) of the Act provides that "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[15] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.

Board case precedent provides that, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the deficiency in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should the Office refer the claimant to a second impartial specialist.[16]

ANALYSIS

The Board finds that this case is not in posture for a decision. The report of Dr. Dennis is not sufficient to resolve the conflict in the medical opinion evidence. Further development of the medical evidence is necessary to determine appellant's right lower extremity impairment.

In his May 15 and August 17, 2007 reports, Dr. Dennis reviewed the history of appellant's condition and provided findings on physical examination. He indicated that appellant had right hip and leg pain but opined that he had no identifiable ratable pain. Dr. Dennis calculated 12 percent right lower extremity impairment. This included two percent for Grade 4

[10] *Id.*

[11] *Id*. at 525, Table 17-1.

[12] *Id*. at 548, 555.

[13] *Id*. at 526.

[14] *Id*. at 527, 555.

[15] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[16] *See Nancy Keenan*, 56 ECAB 687 (2005).

sensory deficit of the L5 and S1 nerves, based on Table 15-15 at page 424 of the A.M.A., *Guides*. However, Chapter 15 of the A.M.A., *Guides* addresses impairment of the spine. Under the Act, a schedule award is not payable for the loss or loss of use of any member of the body or function that is not specifically enumerated in section 8107 of the Act or its implementing regulations.[17] The back is specifically excluded from coverage of the schedule award provisions of the Act.[18] Although a schedule award may not be issued for an impairment to the back under the Act, such an award may be payable for permanent impairment of the lower extremities that is due to an employment-related back condition.[19] Additionally, Chapter 15 provides for determination of impairment based on the "whole person." However, the Act does not provide for a schedule award based on permanent impairment of the whole person.[20] For these reasons, it was inappropriate for Dr. Dennis to evaluate the permanent impairment of appellant's right lower extremity by using a section of the A.M.A., *Guides* pertaining to the back.[21] Dr. Dennis should have used Chapter 17 (The Lower Extremities) in determining appellant's right lower extremity impairment due to sensory deficit,[22] specifically, section 17.2l for Peripheral Nerve Injuries beginning at page 550. The 12 percent right lower extremity impairment rating also included 7 percent for sensory deficit of the sciatic nerve, based on Table 17-37 at page 552. However, in Table 17-37 the only seven percent figure for the sciatic nerve is seven percent of the whole person. Table 17-37 provides 17 percent lower extremity impairment for sensory deficit of the sciatic nerve. The third component of the 12 percent right lower extremity rating from Dr. Dennis was 3 percent for muscle weakness of the great toe, based on Table 17-8 at page 532. He explained that he based his calculation of three percent on his finding that appellant was between a Grade 3 and 4 and he determined that three percent was appropriate. Table 17-8 provides for seven percent impairment for Grade 3 great toe muscle weakness in extension and three percent impairment for Grade 4 great toe weakness. The midrange between seven percent for Grade 3 and three percent for Grade 4 would be four or five percent, not three percent. Dr. Dennis indicated that appellant had right hip and leg pain but opined that he had no identifiable ratable pain. However, he provided insufficient explanation for his opinion. The applicable sections of the A.M.A., *Guides* for determining lower extremity impairment due to pain or sensory deficit are section 17.2l beginning at page 550 and Table 16-10 at page 482. As noted, Dr. Dennis found that appellant had right lower extremity impairment due to sensory deficit but he should have applied Chapter 17, the chapter on the lower extremity, rather than Chapter 15, the chapter on the spine. For these reasons, his impairment rating for appellant's right lower extremity is not sufficient to resolve the conflict in the medical opinion evidence.

[17] *See Leroy M. Terska,* 53 ECAB 247 (2001).

[18] 5 U.S.C. § 8101(19); *see also Vanessa Young,* 55 ECAB 575 (2004).

[19] *Vanessa Young, supra* note 18; *Gordon G. McNeill,* 42 ECAB 140 (1990).

[20] *Tania R. Keka,* 55 ECAB 354 (2004); *Guiseppe Aversa,* 55 ECAB 164 (2003).

[21] *Guiseppe Aversa, supra* note 20 (the Board found that the impartial medical specialist improperly used Chapter 15 in evaluating right leg impairment caused by a spinal injury).

[22] The introduction to Chapter 17 at page 523 states that this chapter provides criteria for evaluating permanent impairment of the lower extremities. A.M.A., *Guides* 523, 525; *see also* 555, 17.3, lower extremity impairment evaluation procedure summary and examples.

On remand, the Office should refer appellant to a new impartial medical specialist for a determination of his right lower extremity impairment based on correct application of the fifth edition of the A.M.A., *Guides* and reference to specific sections, tables and pages. The physician should provide medical rationale explaining why a particular rating method was selected. If more than one impairment rating method can be used in evaluating appellant's impairment, the method that provides the higher rating should be adopted.[23]

On appeal, appellant asserts that he has impairment to his left lower extremity causally related to his September 19, 1991 employment injury. On May 25, 2005 report Dr. Berman referenced an April 28, 2003 EMG which revealed bilateral radiculopathy affecting the L5 and S1 nerve roots. He indicated that appellant had 1.25 percent left lower extremity impairment but he did not explain how the left lower extremity impairment was causally related to appellant's employment injury or show how he calculated the 1.25 percent impairment. The evidence is not sufficient to establish that appellant has left lower extremity impairment causally related to his September 19, 1991 employment-related back injury. Appellant also asserts on appeal that the Office did not properly select Dr. Dennis from the Physicians Directory Service (PDS). A physician selected by the Office to serve as an impartial medical specialist should be wholly free to make a completely independent evaluation and judgment. To achieve this, the Office has developed specific procedures for the selection of impartial medical specialists designed to provide safeguards against any possible appearance that the selected physician's opinion is biased or prejudiced. The procedures contemplate that impartial medical specialists will be selected from a Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.[24] The Federal (FECA) Procedure Manual (the Procedure Manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The Procedure Manual provides that the PDS should be used for this purpose wherever possible.[25] The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.[26] The PDS database of physicians is obtained from the American Board of Medical Specialties Directory of Board-certified Medical Specialists, which contains the names of physicians who are Board-certified in certain specialties. In this case, the Office's April 24, 2007 referral form indicates that the referral source for the selection of Dr. Dennis was the PDS. There is no evidence that the Office did not select Dr. Dennis from the PDS. Therefore, appellant's assertion is without merit.

CONCLUSION

The Board finds that this case is not in posture for a decision. The conflict in the medical opinion evidence as to appellant's right lower extremity impairment has not been resolved. On

[23] A.M.A., *Guides* 527.

[24] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003). *See also Willie M. Miller*, 53 ECAB 697 (2002).

[25] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

[26] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7 (May 2003).

remand, the Office should refer appellant to a new impartial medical specialist for a right lower extremity impairment evaluation based on correct application of the fifth edition of the A.M.A., *Guides*. After such further development as the Office deems necessary, it should issue a *de novo* decision on appellant's schedule award claim.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 12, 2008 and October 19, 2007 are set side and the case is remanded for further action consistent with this decision.

Issued: June 9, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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