U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GEORGE VIERA and DEPARTMENT OF THE ARMY, CORPUS CHRISTI ARMY DEPOT, Corpus Christi, TX

Docket No. 98-239; Submitted on the Record;
Issued November 24, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON, MICHAEL E. GROOM

The issue is whether appellant has more than a 12 percent permanent impairment of the left lower extremity for which he received schedule awards.

This case is before the Board for the second time. By decision dated June 12, 1997,[1] the Board affirmed the Office of Workers' Compensation Programs modification of appellant's wage-earning capacity based on his actual earnings as a timekeeper/trouble call dispatcher. The Board, however, remanded the case for a determination of whether appellant had more than a six percent impairment of his left lower extremity for which he received a schedule award. The Board instructed the Office to determine whether appellant had permanent impairment of his right lower extremity. The law and facts of the case as set forth in the Board's June 12, 1997 decision are hereby incorporated by reference.

By letter dated July 10, 1997, the Office referred appellant to Dr. Frank Luckay, a Board-certified orthopedic surgeon, for an opinion regarding whether appellant had a permanent impairment of either upper or lower extremity in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993).

In a report dated July 29, 1997, Dr. Luckay opined that, according to the A.M.A., *Guides*, appellant had a five percent impairment. An Office medical adviser reviewed Dr. Luckay's

[1] Docket No. 95-995.

report and noted that the physician provided findings relevant to appellant's lumbosacral impairment.[2] The Office medical adviser recommended that the Office obtain another evaluation.

By letter dated August 19, 1997, the Office referred appellant to Dr. Hyman Roosth, a Board-certified orthopedic surgeon, for a determination of whether appellant had a permanent impairment of his lower extremities causally related to his employment injury. The Office informed Dr. Roosth of the applicability of the fourth edition of the A.M.A., *Guides*.

By decision dated September 30, 1997, the Office granted appellant a schedule award for an additional six percent impairment of the left lower extremity.[3]

The Board finds that the case is not in posture for decision.

Under section 8107 of the Federal Employees' Compensation Act,[4] and section 10.304 of the implementing federal regulations,[5] schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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* have been adopted by the Office, and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[6]

In a report dated September 18, 1997, Dr. Roosth, a Board-certified orthopedic surgeon and Office referral physician, diagnosed "[p]ostoperative laminectomy with removal of ruptured disc L4-5, recovered [and] [l]eft gluteal strain and sacroiliac fat-pad bursitis with secondary back and left leg pain." He opined that the date of maximum medical improvement was May 3, 1993 and stated:

> "For the [appellant] there is no impairment percentage rating for the lower extremities based on a lumbar spine nerve root origin of pain. His leg impairment is based on the residual complaints of pain in the back and left leg as a result of the untreated gluteal strain and sacrioliac fat-pad bursitis. The impairment would

[2] The Act provides for the payment of schedule awards only for permanent loss of, or loss of use of, specified anatomical members or functions of the body; *see* 5 U.S.C. § 8107(a). The Act does not provide payment for an impairment of the back but rather is payable for an impairment to a member of the body provided for in the schedule regardless of whether the impairment originated in a scheduled or nonscheduled member. *Rozelle L. Skinner*, 37 ECAB 398 (1986).

[3] The Office's decision states that the additional award was for the left upper extremity. The Board determines that the Office was in fact referring to the left lower extremity.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.304.

[6] *James J. Hjort*, 45 ECAB 595 (1994).

be for lower extremity pain attributed to the job[-]related back and leg pain, not job[-]related 'back condition.'"

On physical examination Dr. Roosth noted that appellant's "left hip was weak for abduction and extension against resistance."

He determined that, according to Table 68 and Figure 59 on pages 89 and 93 of the A.M.A., *Guides*, appellant had a 1 percent impairment due to pain in the lateral femoral cutaneous, the posterior femoral cutaneous, anterior femoral cutaneous and cluneal nerves, which he added together to reach a total impairment of 4 percent. He stated:

> "Muscle weakness, and possibly secondary lower back pain, results from tendonitis of the origin-insertion of the gluteal-pyriformal muscles. For weakness of the hip muscles, using Tables 38 [and] 39, page 77, the impairment is five percent for abduction weakness and three percent for extension weakness, a total of eight percent. Four percent plus 5 percent plus 3 percent equals [a] 12 percent impairment for the left lower extremity."

In a report dated September 25, 1997, an Office medical adviser reviewed Dr. Roosth's report and applied the appropriate tables and figures of the A.M.A., *Guides*. The Office medical adviser noted:

> "Dr. Roosth reports status/post laminectomy with L4-5 disc removal, left gluteal strain and sacroiliac fat-pad bursitis with secondary back and left leg pain, no evidence of nerve root irritation, hip weakness of abduction and extension, an 8 [percent] whole body impairment for the lumbar spinal pathology, and a 12 [percent] left lower extremity impairment consisting of 4 [percent] for pain and 8 [percent] for weakness."

Applying the A.M.A., *Guides*, the Office medical adviser determined that appellant had a five percent sensory impairment of the lateral femoral cutaneous, the posterior femoral cutaneous, the anterior femoral cutaneous and the cluneal nerves.[7] He graded appellant's pain according to Table 11 on page 48 as 20 percent, multiplied the 20 percent by the 5 percent impairment of the listed sensory nerves to find a 1 percent permanent impairment of each nerve, and combined the 1 percent impairments of the nerves to reach a total sensory impairment of 4 percent of the left lower extremity.[8] For muscle weakness of the hip, he found that a five percent impairment in abduction and a three percent impairment of extension constituted an eight percent impairment of the left lower extremity.[9] He combined the 8 percent for weakness

[7] A.M.A., *Guides*, 89, 93, Table 68, Figure 59.

[8] *Id.*

[9] *Id.* 77, Tables 38-39.

and the 4 percent for pain and concluded that appellant had a 12 percent permanent impairment of the left lower extremity.[10]

However, the Board notes that Tables 38 and 39 on page 77 of the A.M.A., *Guides*, provide impairment ratings for muscle weakness of the hip in abduction and extension which appear to differ substantially from the findings of both Dr. Roosth and the Office medical adviser. Further, Dr. Roosth and the Office medical adviser combined appellant's four percent impairment due to peripheral nerve deficits found in Table 68 page 89 of the A.M.A., *Guides*, with the impairment found for muscle weakness in the hip in reaching their estimation of impairment. However, the A.M.A., *Guides*, states: "Estimates for peripheral nerve impairments may be combined with those for other types of lower extremity impairments, except those for muscle weakness and atrophy."[11] Thus, it appears that an impairment due to muscle weakness of the hip is not combined with an impairment due to a sensory deficit for a peripheral nerve. As it appears neither Dr. Roosth nor the Office medical adviser supported their recommendation of appellant's impairment rating in accordance with the A.M.A., *Guides*, the Board finds that the case must be remanded for further development. After such further development as necessary, the Office shall issue a *de novo* decision.[12]

The decision of the Office of Workers' Compensation Programs dated September 30, 1997 is set aside and the case is remanded for further proceedings in accordance with this decision.

Dated, Washington, D.C.
November 24, 1999

George E. Rivers
Member

David S. Gerson
Member

Michael E. Groom
Alternate Member

[10] *Id*. 322.

[11] *Id*. at 88.

[12] In accordance with the Board's June 12, 1997 remand order, the Office should also issue a final decision with regard to appellant's right leg.