U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PRISCILLA L. PADILLA and U.S. POSTAL SERVICE,
POST OFFICE, Belen, NM

Docket No. 99-21; Submitted on the Record;
Issued June 22, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant had greater than a 12 percent impairment to her left lower extremity and 31 percent impairment to her right lower extremity, for which she received a schedule award.

On July 19, 1995 appellant, then a 42-year-old rural letter carrier, filed a notice of traumatic injury and claim for compensation (Form CA-1), wherein she alleged that on July 8, 1995, when lifting a tray of mail, she injured her lower back and legs.

On January 16, 1996 the Office of Workers' Compensation Programs accepted appellant's claim for a lumbar strain. Later, the claim was also accepted for herniated nucleus pulposus, L5-S1.

On February 12, 1997 appellant filed a notice of recurrence of disability and claim for continuation of pay/compensation (Form CA-2a) commencing February 6, 1997.

On August 5, 1997 the Office accepted appellant's recurrence claim.

On October 23, 1997 Dr. Glen D. Kelley, a Board-certified physical medicine and rehabilitation specialist and appellant's treating physician, issued an impairment rating for appellant. He found that appellant's range of motion of the lower extremities, bilaterally, were as follows: hip flexion 110 degrees bilaterally, hip extension 0 degrees, hip internal rotation 15 degrees bilaterally, hip external rotation 20 degrees bilaterally, hip adduction 10 degrees bilaterally, hip abduction 15 degrees bilaterally, knee extension is full at 0 degrees bilaterally, knee flexion 120 degrees bilaterally, ankle plantar flexion 10 degrees bilaterally and hip plantar flexion 30 degrees. Dr. Kelley found that the strength in the lower extremities were on the right: hip flexion 4+/5, hip extension 4+/5, hip abduction 4+/5, knee extension 5-/5, knee flexion 5-/5, ankle dorsiflexion 5/5 and plantar flexion 5/5. He, using Table 40 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* determined that appellant's

range of motion to the hip show limitations of internal and external rotation 5 percent lower extremity impairment internal rotation and 5 percent lower extremity impairment to external rotation. He found appellant to also have five percent lower extremity impairment to abduction on the right and that on the left she had similar limitations. Utilizing Tables 41 and 42 of the A.M.A., *Guides*,[1] he determined that appellant had no lower extremity impairment for knee range of motion and no impairment for ankle range of motion. Dr. Kelley utilized Table 39, page 77 of the A.M.A., *Guides* to determine that appellant's right hip rates at a grade IV muscle group for hip flexion, extension and abduction causing 5 percent, 17 percent and 25 percent lower extremity impairment respectively. He further found that appellant had no impairment in her right knee or ankle or great toe from weakness, but that in the left lower extremity appellant had impairment from weakness to hip abduction causing 25 percent impairment in the left lower extremity. Dr. Kelley summarized:

> "In total, the patient for the right lower extremity has 5 percent for mild impairment internal rotation hip, 5 percent external rotation of hip, 5 percent abduction impairment of hip, 5 percent weakness hip flexion 17 percent weakness hip extension and 25 percent weakness hip abduction for a total of 62 percent impairment right leg. In the left lower extremity the patient has 5 percent lower extremity impairment for decreased internal rotation of the hip, 5 percent limitation external rotation of the hip and 5 percent limitation abduction of the hip, and 25 percent for weakness of hip abduction for a total of 40 percent lower extremity impairment on the left."

He noted that he took these measurements while appellant was on pain medication, and that without medication, her strength would be adversely affected. In completing the Office's Form CA-1303, Dr. Kelley indicated that appellant reached maximum medical improvement on October 20, 1997; that the nerve root affected was at the S1 on the right; that there was no impairment of the lower extremity due to loss of function from sensory deficit, pain or discomfort, that the degree of permanent impairment of the lower extremity due to loss of function from decreased strength equals 47 percent; and that the permanent impairment due to decreased range of motion equals 15 percent.

On November 21, 1997 the Office medical adviser reviewed Dr. Kelley's report and determined that the report did not meet the requirements of the Office regulations for a schedule award determination because the "magnitude of the lower extremity impairment appears greater than what one would expect from the job accepted condition of a herniated lumbar disc."

The Office referred appellant to Dr. Emmett Altman, a Board-certified orthopedic surgeon, for a second opinion. In a medical report dated January 9, 1998, Dr. Altman noted:

> "She has a full range of motion, full strength, no sensory disturbance, equal reflexes and no signs of motor impairment, sensory defect or any other defect in the lower extremities. Therefore, there is no impairment rating to the lower extremities."

[1] A.M.A., *Guides* (4th ed. 1993).

As a conflict existed between appellant's treating physician, Dr. Kelley and the physician chosen by the Office for the second opinion, Dr. Altman, the Office referred appellant to Dr. Thomas G. Grace, a Board-certified orthopedic surgeon, for an impartial medical examination. In a medical report dated February 27, 1998. Dr. Grace agreed with the opinion of Dr. Kelley that appellant reached maximum medical improvement on September 23, 1996 and further agreed with Dr. Kelley that appellant had a 62 percent impairment of the right leg and a 40 percent impairment of the left leg. However, the Board notes that the Office failed to send Dr. Kelley a statement of accepted facts and the questions to address.

In a report dated March 2, 1998, Dr. Grace answered questions he received from the Office by reiterating his opinion that appellant reached maximum medical improvement on September 23, 1996 and had a 62 percent impairment of the right leg and a 40 percent impairment of the left leg that was supported by a positive magnetic resonance imaging (MRI) study showing a L5-S1 disc herniation, done on two occasions and substantiated by physical examination.

On March 13, 1998 the Office medical adviser stated that the report of Dr. Grace regarding impairment evaluation did not meet the Office's requirements for making a schedule award determination in that "it does not document any impairment of the lower extremities, nor does it correlate the impairment figures with the A.M.A., *Guides*."

On March 30, 1998 Dr. Altman responded to a March 24, 1998 letter from the Office by stating that appellant had "a full range of motion, full strength, no sensory disturbance, equal reflexes, no signs of motor defects in the lower extremities. Therefore, there is no impairment rating to the lower extremities."

Dr. Grace also issued a medical report dated March 30, 1998, wherein he noted that appellant had a 62 percent impairment of her right leg and a 40 percent impairment of the left leg with regard to the lower extremities based on Tables 40, 41 and 42 on page 78 of the A.M.A., *Guides* as well as Table 39 on page 77. He also characterized her as suffering from a 15 percent impairment of the whole person based on Table 72 of page 110 of the A.M.A., *Guides*.

On April 22, 1998 the Office medical adviser stated that he had no explanation for the tremendous difference between the opinion of Dr. Altman and the opinions of Drs. Grace and Kelley. He also agreed with the prior Office medical adviser that the impairments proposed by Drs. Kelley and Grace were out of proportion to the diagnosis. He recommended another examination of appellant.

A second Office medical adviser also reviewed appellant's case and stated that he agreed with the first office medical adviser that the impairments proposed by Drs. Kelley and Grace were out of proportion to the diagnosis. He continued:

> "Even though the report from Dr. Altman is the only one that meets all the OWCP requirements, his opinion is widely different from the two other physicians. In view of that, the only course that I believe to be suitable in this instance is to have another examination, this one by an orthopedic surgeon, a neurosurgeon, a specialist in physical medicine, who is Board-certified and of academic rank."

By letter dated April 29, 1998, the Office explained to Dr. Grace that his report did not meet the Office's requirement in that it did not document any impairment of the lower extremities, nor did it correlate the impairment figures with the A.M.A., *Guides*. The Office requested that Dr. Grace review the report and make any necessary corrections to bring the report in compliance with the A.M.A., *Guides*.

Dr. Grace reported on May 21, 1998:

> "Hip flexion 110 degrees bilaterally, hip extension 0 degrees bilaterally, hip internal rotation 15 degrees bilaterally, hip external rotation 20 degrees bilaterally, hip adduction 10 degrees bilaterally, hip abduction 15 degrees bilaterally. Knee extension is full, knee flexion is 120 degrees bilaterally and ankle plantar flexion 30 degrees bilaterally. Lumbosacral flexion 60 degrees, lumbosacral extension 25 degrees lumbosacral left and right lateral bend 20 degrees bilaterally, lumbosacral rotation 25 degrees bilaterally.
>
> "There is no decrease sensibility of the lower extremity which is constant and rateable.
>
> "The strength of the lower extremities is as follows: right hip flexion 4+/5, hip extension 4+/5, hip adduction 4+/5, knees extension 5/5, knee flexion 5-/5, ankle dorsiflexion 5/5, ankle plantar flexion 5/5. In the left lower extremity: hip flexion 5/5, hip extension 5-/5, hip adduction 4+/5, knee extension 5/5, knee flexion 5-/5, ankle dorsiflexion 5/5, ankle plantar flexion 5/5."

Dr. Grace opined that the impairment rating according to the A.M.A., *Guides* would "most appropriately be rated by the diagnosis-related estimates system for the whole body rather than according to the lower extremity." He opined that appellant "falls between diagnosis-related estimates category 3 and 4 on Table 72 page 110. That would give her an approximate whole person impairment of 15 percent." However, Dr. Grace also noted that appellant could have an impairment rating done by the lower extremity. He continued:

> "That lower extremity impairment would be rated as 62 percent of the right lower extremity and 40 percent of the left lower extremity. These are based as you will know on both weakness and decreased range of motion previously documented and according to Table 39 on page 77 and Tables 40, 41, 42 on pages 78. I have been asked to check pages 48 and 49 of the A.M.A., [*Guides*], which basically

> restates both impairment for sensory deficit on page 48 and for motor deficit on page 49. I [woul]d note that this section is dealing primarily with the upper extremity and if you refer to tables 39, 40, 41 and 42 are dealing pretty much with similar quantities for the lower extremity."

On June 11, 1998 the second Office medical adviser found that Dr. Altman's report found no medical evidence to warrant a permanent partial impairment of either extremity and that the remaining two doctors' medical reports were deficient in determining appellant's impairment rating under the A.M.A., *Guides* as Dr. Kelley did not provide the measurements of hip motion and did not combine the components and Dr. Grace did not furnish any hip motion measurements as was required by the Office and therefore his permanent partial impairment estimate was not probative for the Office adjudication. Using the information provided by Dr. Grace, the Office medical adviser determined that for appellant's left lower extremity, she had a five percent impairment of the motion of her hip pursuant to Table 40, page 78 of the A.M.A., *Guides*, 0 percent impairment to her right knee pursuant to Table 41, page 78, a 7 percent impairment of her range of motion in her ankle pursuant to Table 42, page 78 and that by combining the figures, she had a 12 percent permanent impairment of the left lower extremity. With regard to her right lower extremity and utilizing the same tables, he determined that appellant had a five percent impairment due to her range of hip motion, zero percent impairment due to range of motion of knee and seven percent impairment of her ankle. In addition, he found that appellant had motor deficit in hip flexion, grade 4 which amounted to a 5 percent impairment and a motor deficit on hip extension of grade 4, which amounted to a 17 percent impairment. Combining these figures, he determined that appellant suffered from a 31 percent permanent impairment of her right lower extremity.

By decision dated June 26, 1998, the Office granted appellant a schedule award based on a 12 percent impairment to her left lower extremity and a 31 percent impairment to her right lower extremity for the period June 21, 1998 to November 3, 2000.

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

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.304 of the implementing regulations,[3] 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.[4]

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.304.

[4] *Richard F. Kastan*, 47 ECAB 651, 652 (1997).

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.[5] In the case at hand, a conflict existed between the opinion of Dr. Kelley, who found a 62 percent impairment of the right leg and a 40 percent impairment of the left and that of Dr. Altman, who opined that appellant had no impairment to either extremity. The impartial medical specialist, Dr. Grace utilized the A.M.A., *Guides* and noted which tables and pages upon which he relied in reaching his conclusion that appellant sustained a 62 percent impairment to his right leg and a 40 percent impairment to his left leg. However, none of Dr. Grace's opinions sufficiently explain how the measurements were applied to the A.M.A., *Guides,* and after reviewing the A.M.A., *Guides,* the Board is unable to understand Dr. Grace's methodology. Accordingly, Dr. Grace's opinion cannot resolve the conflict between the opinions of Drs. Kelley and Altman.[6]

The Board further finds that the Office medical adviser's opinion is also insufficient to determine the amount of impairment, as the Office medical adviser failed to properly apply the A.M.A., *Guides*. For example, the Office medical adviser, utilizing Table 40 on page 78 of the A.M.A., *Guides*, determined that appellant suffered from a five percent impairment to the left lower extremity. In making this calculation, he utilized Dr. Grace's findings that appellant had hip internal rotation of 15 degree bilaterally, hip external rotation 20 degrees bilaterally, hip adduction 10 degrees bilaterally and hip abduction 15 degrees bilaterally. The Office medical adviser applied these findings to Table 40 and concluded that appellant had a mild impairment of five percent, as all of the listed limitations were described individually as causing a five percent impairment. However, pursuant to the A.M.A., *Guides*, "Impairment estimates for extension, abduction, and adduction are combined" utilizing the Combined Values Chart on page 322.[7] When the five percent estimate for each measurement, *i.e.*, extension, abduction and adduction, are combined, the figure is considerably higher. Furthermore, the Office medical adviser found that appellant had a 7 percent impairment motion of the ankle based on Dr. Grace's findings of 10 degrees ankle dorsiflexion and 30 degrees plantar flexion. When applying the measurements to Table 42 of the A.M.A., *Guides*, as the Office medical adviser stated he did, appellant would have 0 percent impairment due to plantar flexion capability, but 21 percent impairment due to dorsiflexion. Accordingly, the Office medical adviser did not properly apply the A.M.A., *Guides.*

As there remains an unresolved conflict in the medical evidence, and neither the independent medical examiner nor the Office medical adviser have issued a well-rationalized rating utilizing the A.M.A., *Guides,* and as the independent medical examiner has already issued four reports attempting to find a proper rating, the Board finds that this case should be referred to a new impartial medical examiner to resolve the conflict between Drs. Kelley and Altman.

[5] *Rosie E. Garner*, 48 ECAB 220, 225 (1996).

[6] *See generally Bobby L. Jackson*, 40 ECAB 593, 600-01 (1989); *David E. Fishback*, 38 ECAB 654 (1987).

[7] A.M.A., *Guides* at 79.

Accordingly, the decision of the Office of Workers' Compensation Programs dated June 26, 1998 is set aside and the case is remanded for further proceedings in accordance with this decision.

Dated, Washington, D.C.
June 22, 2000

Michael J. Walsh
Chairman

David S. Gerson
Member

Michael E. Groom
Alternate Member