

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILLIAM T. BALL and DEPARTMENT OF THE TREASURY,
CUSTOMS SERVICE, Phoenix, AZ

*Docket No. 01-1248; Submitted on the Record;
Issued May 23, 2002*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issues are: (1) whether appellant has a greater than six percent impairment of the right lower extremity for which he had received a schedule award; and (2) whether the Office of Workers' Compensation Programs properly denied appellant's request for reconsideration under 5 U.S.C. § 8128.

On March 26, 1994 appellant, then a 47-year-old criminal investigator, filed a claim alleging that he injured his lower back while in the performance of duty.

On April 29, 1994 the Office accepted that appellant, then a 47-year-old criminal investigator, sustained an injury to his lower back, specifically a herniated disc at L5-S1, on March 26, 1994 and subsequently authorized a discectomy. Appellant was placed on the periodic rolls and received compensation benefits for total disability.¹

In a report dated December 5, 1994, Dr. Mark S. Ercius, appellant's treating physician Board-certified in neurological surgery, stated that appellant had a 7 percent permanent disability with a 25-pound weight lifting restriction.

In a report dated June 19, 1998, Dr. Ercius stated that appellant had intermittent bilateral lower extremity pain and bilateral foot pain when he works in the yard. He also noted that appellant's ambulation was normal with no weakness. Dr. Ercius rated appellant with a five percent permanent disability.

In a report of a telephone call dated April 4, 1998, the Office noted that appellant wished to file a claim for a schedule award.

In a report dated February 14, 1999, Dr. Leonard A. Simpson, an Office medical adviser and a Board-certified orthopedic surgeon, stated that he had reviewed appellant's records

¹ Appellant returned to restricted duty in October 17, 1994 and retired in April 1998.

including Dr. Ercius' June 19, 1998 report and determined that appellant's S1 nerve root disease rated a 5 percent impairment and rated appellant's pain at Grade III or 60 percent of the 5 percent rating or a 3 percent impairment rating for each lower extremity. Dr. Simpson noted that no atrophy or limitation of motion had been identified. Using the Combined Values Chart, three percent impairment for pain combined with zero percent for loss of motion and zero percent for atrophy resulted in a three percent impairment for each extremity. He noted that appellant's maximum medical improvement was December 5, 1994, which was approximately six months from the date of appellant's second (and last) surgery.

On February 16, 1999 the Office authorized appellant to see Dr. Debra Walter, his treating physician who is Board-certified in internal medicine and in physical medicine and rehabilitation, for an evaluation of his lower extremity impairment.

By decision dated March 9, 1999, the Office granted appellant a schedule award for a three percent impairment of his right lower extremity and three percent impairment of his left lower extremity. The period of the award ran for 17.28 weeks from December 5, 1994 to April 4, 1995. The Office awarded appellant 75 percent of his weekly pay rate of \$1,265.80 for the period of the award.

In a report dated April 7, 1999, Dr. Walter described appellant's lower extremity hip extension muscle function at Grade 4, as active movement against gravity with some resistance, resulted in a seven percent impairment rating. She then described his lower extremity knee extension as Grade 4, which resulted in a five percent impairment rating.² Dr. Walter stated that this was 12 percent whole person impairment rating. She also noted that appellant's extremity reflexes were "absent in the right ankle," and that his right calf circumference was one centimeter smaller than his left calf. Dr. Walter then determined that appellant's right lower extremity impairment rating was 10 percent based on "a loss of relevant reflex," noting the consistency of the rating with the DRE: lumbosacral Category III.³

Upon review of Dr. Walter's report, Dr. Simpson stated in a June 7, 1999 report that appellant had right lower extremity weakness based on the loss of one centimeter of appellant's calf muscle and rated this additional impairment at 3 percent based on Table 37 of the A.M.A., *Guides*.⁴ He recommended against using Table 39, "as the medical reports in the file noted that the weakness in the hip extensors and knees extensors were described as limited by cramping and is described as anywhere between a half to a whole grade." Dr. Simpson opined that the one centimeter of calf atrophy would be more objective. He then combined the three percent impairment for atrophy with the three percent for pain which resulted in a six percent impairment of the right lower extremity.

By decision dated June 30, 1999, the Office awarded appellant an additional three percent impairment rating for his right leg.

² American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993), 77, Table 39.

³ *Id.* at 102.

⁴ *Id.* at 77 Table 37.

By letter dated November 16, 1999, appellant, through counsel, requested reconsideration. Appellant requested that the Office either grant an additional schedule award of 21 percent for his right lower extremity or appoint an impartial medical examiner to resolve the conflict in medical opinion between Drs. Simpson and Walter.⁵

In a report dated July 16, 1999, submitted with appellant's petition, Dr. Walter stated that appellant had a 27 percent impairment rating of the right lower extremity based on Tables 37, 38 and 39 of the A.M.A., *Guides*.⁶ She noted that appellant demonstrated weakness in right hip extensors and knee flexors and thus according to Table 34, he had a Grade IV muscle function. According to Table 39, a Grade IV weakness in these muscle groups would be rated as a 17 and a 12 percent impairment respectively of the lower extremity. This translates into a 27 percent impairment of the right lower extremity. Dr. Walter added that according to Table 37, on the same page, the one centimeter of atrophy in the right calf could represent an additional three percent impairment of that limb. She also stated that the A.M.A., *Guides* recommend that doctors not use muscle strength testing as a guide, but since physicians are not allowed to use lumbar radiculopathy pages and since appellant had residual neurological changes in his right lower extremity, she opined that "this was the most fair section to base this on."

In a medical report dated October 14, 1999, Dr. Walter stated that appellant had a disc herniation at S1, that he has ongoing symptoms in the right lower extremity with increased activity, that he has a one centimeter atrophy of the gastrocnemius (calf muscle) as well as four by five weakness in the right hip extenders and knee flexors. She stated that appellant had a 27 percent impairment rating of the right lower extremity based on weaknesses of these muscle groups. Dr. Walter also noted that appellant's left leg had a "lack of any neurologic abnormality and ongoing symptoms."

In a report dated February 11, 2000, Dr. Boris Stojic, a second opinion physician and a Board-certified orthopedic surgeon, stated that he had examined appellant on that day and reported findings. Dr. Stojic noted a familiarity with appellant's history of injury and treatment and stated that appellant demonstrated subjective complaints of low back pain with tingling sensations on the right on exertion and tightness of the right hamstrings with straight leg raising. He made no objective findings of either radiculitis or radiculopathy and opined that appellant could return to full-time work without restrictions.

In a report dated April 25, 2000, the Office medical adviser determined that a conflict in medical opinion existed in this case. Specifically, he noted a conflict in the opinions of Dr. Stojic who found no weakness and Dr. Walter who found that a weakness did exist.

On May 8, 2000 the Office referred appellant, a statement of accepted facts and his medical record to Dr. Dennis G. Crandall, a Board-certified orthopedic surgeon and an impartial medical specialist. The Office asked Dr. Crandall to indicate appellant's permanent functional loss of the use of his right leg and the date of maximum medical improvement.

⁵ Appellant did not dispute the Office's award of three percent for his left lower extremity.

⁶ *Id.* at 77.

In a report dated June 14, 2000, Dr. Crandall stated that he had examined appellant that day and noted a familiarity with his history of injury and treatment. He related appellant's subjective complaints of right-sided posterolateral radiating pain which descended the buttock posterior through the hamstring and knee and occasionally to the right foot. The pain was noted as worse when standing and when engaged in activities such as yard work. The right leg felt heavy and noted a "subtle weakness in the right foot." Regarding his lower extremity examination, he noted "full and pain free motion of the hips, knees and ankles. Straight leg raise is negative. Contralateral straight leg raise test is negative."

Dr. Crandall made additional findings as follows:

"Reflexes: Deep tendon reflex in the knees and ankles are normal bilaterally.

"Motor Exam[ination]: Resisted strength testing is five plus and normal bilaterally for the iliopsoas, quads, tibialis anterior, EHL and cl[a]onus. Babinski's [reflex] is negative. Five minus strength in the right gastroc[nemius]....

"Sensory exam[ination]: sensation is intact bilaterally for all dermatomes.

"Imaging Studies: Standing AP and lateral both oblique views and lateral flexion views of the lumbar spine shows degenerative settling at the L5-S1 disc with very subtle osteophyte formation anteriorly at L4-5. The primary degenerative focus is at L5-S1."

* * *

"[A] June 10, 1994 CT [computerized tomography] scan of the lumbar spine is compared to the MRI [magnetic resonance imaging] scan showing interval right laminectomy and an abnormal soft tissue density around the right S1 nerve root. Disc bulge is noted at L4-5."

* * *

"Diagnosis Related to the Industrial History of March 22, 1994.... Right L5-S1 disc herniation. Right L5-S1 discectomy May 16, 1994.... Right L5-S1 discectomy and scar excision and nerve root exploration June 16, 1994... Degenerative disc disease L5-S-1. Subtle residual right calf weakness....

"Additonal diagnosis: Mild degenerative disc disease L3-4. Mild degenerative disc disease L4-5.

"Discussion/Causation: [Appellant] continues six years later to have some subtle weakness in the right calf and a sence of heavy feeling particularly with moderate levels of activity....

"[Appellant] does have a very subtle weakness in the gastrocnemius on the right side. He does not have any stretch signs and no other suggestive evidence of

ongoing sciatic nerve irritability. He does not have ongoing back pain now, even though he does have quite significant degenerative disc disease at L5-S1 and mild degenerative disc disease at L3-4 and L4-5 according to prior imaging studies....

“[Appellant] did achieve maximum medical improvement in December 1994, in my opinion. According to the A.M.A., *Guides* (4th ed. 1993), a having had a lumbar discectomy and a second surgery for lumbar discectomy, he has a 10 percent impairment of the whole person. This comes from Table 75 on page 3, 113. This refers specifically to surgically treated disc herniation with a second operation. Since his leg pain and symptoms are related to the disc herniation, I think that it is most correct to relate his impairment to the spine and therefore 10 percent is appropriate.”

In the form report for the lower extremity, Dr. Crandall stated that the S1 nerve root was affected, that appellant’s pain and discomfort was varied, not consistent, that appellant’s weakness or atrophy was “subtle-gastrocnemius (five minus),” and that appellant graded at five for active movement against gravity with full resistance.

In a report dated July 16, 2000, Dr. Ellen Pichey, the Office medical adviser, stated that she had reviewed appellant’s medical file including Dr. Crandall’s report. Dr. Pichey also noted that appellant had been previously awarded a schedule award for a six percent impairment of the right leg and a two percent impairment of the left lower extremity.⁷ She then stated:

“According to the A.M.A., *Guides*, 4th ed., the right lower extremity impairment can be determined as follows: Impairment due to sensory deficit pain: level of symptoms as Grade 2, 25 percent (Table 11, p[age] 480.) Maximum impairment based on S1 nerve is 24 percent (Table 83, 130); 25 percent times 24 percent equals 6 percent. The total impairment for the right lower extremity equals six percent. There is no additional impairment indicated. The date of maximum medical improvement is June 14, 2000.”

By decision dated July 19, 2000, the Office denied modification of appellant’s petition for reconsideration.

By letter dated October 11, 2000, appellant, through counsel, requested reconsideration. In support of his request for reconsideration, appellant submitted a medical report dated August 30, 2000 from Dr. Walter who stated that she had examined appellant on that day and determined that he continued to have loss of right ankle reflex, atrophy of the right calf and one grade of weakness in the right gluteus and hamstring muscle groups. Dr. Walter then calculated these finding with the A.M.A., *Guides* and opined that appellant had a seven percent impairment of the right lower extremity. She repeated her earlier finding that appellant had a Grade 4 weakness based on hip extension and knee flexion muscle groups and thus “has an impairment of the lower extremity of 27 percent.”

⁷ The Office awarded three percent impairment for the left lower extremity vice two percent.

In a letter dated December 27, 2000, the Office requested Dr. Crandall to clarify his June 14, 2000 report by determining appellant's schedule award for lower extremity. The Office noted that his earlier report provided only an award for whole person which the Federal Employees' Compensation Act does not provide.

In a report dated January 5, 2001, Dr. Crandall stated that appellant's lower extremity condition is a sequela of appellant's disc herniation and that based on Tables 71 and 72 of the A.M.A., *Guides*, "decreased circumference atrophy" is allowed a 10 percent impairment for the whole person. He added that it would be inappropriate to rate hip, ankle or knee impairments based on herniated disc sequela and atrophy for nerve root compression.

In a January 24, 2001 decision, the Office denied appellant's request for reconsideration without reviewing the merits of the claim on the grounds that the evidence submitted was repetitious and not relevant to the issue for which the Office denied appellant's claim.

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

In this case, the Office properly determined that there was a conflict in the medical opinion between Drs. Stojic and Walter, and referred appellant, pursuant to section 8123(a) of the Act, to Dr. Crandall for an impartial medical examination and an opinion on appellant's impairment rating.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

However, the Office requested Dr. Crandall to provide a supplemental report to his initial June 14, 2000 report on the grounds that his initial report determined only a whole person impairment award. Dr. Crandall in his January 5, 2001 report again determined a whole person impairment rating and failed to provide an impairment rating for appellant's lower extremity.

The Board has held that in a situation where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict of medical opinion and this specialist's opinion requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report.¹⁰ If the impartial medical specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second

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." 5 U.S.C. § 8123(a).

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

¹⁰ *Elmer K. Kroggel*, 47 ECAB 557-58 (1996); *April Ann Erickson*, 28 ECAB 336, 341-42 (1997).

impartial medical specialist for the purpose of obtaining his rationalized medical opinion on the issue.¹¹

As Dr. Crandall's report requires further clarification on appellant's impairment rating, it cannot constitute the weight of the medical opinion evidence and the conflict in medical opinion now remains unresolved. The case must therefore be remanded for another impartial medical specialist to render an opinion on the extent of appellant's work-related impairment. On remand the Office should refer appellant with a statement of the accepted facts and the case record to another impartial medical specialist to resolve the conflict in the evidence.

Based on this determination, the issue of whether the Office abused its discretion by denying appellant's request for a further review of her case on its merits under 5 U.S.C. § 8128(a) is moot.

The decisions of the Office dated July 19, 2000 and January 24, 2001 are hereby set aside and the case is remanded for further development in accordance with this decision.¹²

Dated, Washington, DC
May 23, 2002

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

¹¹ *Talmadge Miller*, 47 ECAB 673, 682 (1996).

¹² The Board notes that the July 16, 2000 report of Dr. Ellen Pichey, the Office medical adviser who reviewed Dr. Crandall's findings, did not resolve the conflict in medical opinion. The FECA Manual prohibits an Office medical adviser from resolving a conflict in medical opinion. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(g) (April 1993).