U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of THOMAS J. GREJDA and U.S. POSTAL SERVICE,
POST OFFICE, Pittsburg, PA

Docket No. 03-1097; Submitted on the Record;
Issued October 1, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, COLLEEN DUFFY KIKO,
DAVID S. GERSON

The issue is whether appellant is entitled to a schedule award for his accepted work-related conditions.

On August 7, 1989 appellant, then a 50-year-old postal carrier, filed a claim for traumatic injury alleging that, on August 5, 1989, he injured his back while in the performance of duty. The Office of Workers' Compensation Programs accepted appellant's claim for subluxation and lumbosacral sprain with lumbosacral radiculitis. Appellant retired on June 29, 2001.

On December 31, 2001 appellant, through counsel, filed a schedule award claim.

In support of his schedule award claim, appellant submitted a November 1, 2001 report from Dr. Rudolph Merick, Board-certified in internal medicine. In his report, Dr. Merick advised that appellant's sexual dysfunction condition was related by history to his back injury, and that, by using Table 7-6, criteria for scrotal disease, or Table 7-7, criteria for rating testicular, epididymal and spermatic cord disease,[1] he had a Class 1 disability which is a five percent disability. Using Table 13-21, criteria for rating neurological sexual impairment,[2] he determined that appellant had a five percent disability of the whole person. Regarding muscle weakness, Dr. Merick rated appellant with a Grade 4 disease based on Table 17-8, impairment due to lower extremity muscle weakness, which is a two percent disability of the hip and a five percent disability for loss of flexion and extension of each knee.[3] He then added 5 percent and 2 percent for a total of 7 percent and added that to the 5 percent nerve injury impairment to arrive at a 12 percent impairment for each lower extremity based on muscle weakness. Dr. Merick also noted that appellant's numbness and weakness could be attributable to sciatica, "although there is no

[1] A.M.A., *Guides*, 158, Table 7-6; 159, Table 7-7.

[2] *Id.* at 342, Table 13-21.

[3] *Id.* at 532, Table 17-8.

direct evidence of that." He then rated appellant with a 75 percent impairment of the lower extremities or 30 percent whole person impairment based on Table 17-37, impairments due to nerve deficits.[4] Dr. Merick then noted a Grade 3 injury based on Table 16-10, impairment of the upper extremity due to sensory deficits or pain,[5] and, as a result of the intermittent nature of his symptoms, he rated appellant with a 26 percent impairment based on sciatica. He then multiplied 26 percent by 30 percent, the sciatic whole person impairment, to arrive at an 8 percent impairment of both extremities for nerve deficit. Regarding his leg length discrepancy noted in a July 2000 report, Dr. Merick used 3 millimeters which is a 10 to 14 percent impairment of the lower extremity which is a 4 to 5 percent impairment of the whole person.[6] He then combined 8 percent sciatica and 4 percent whole person for a 12 percent whole person impairment based on the left lower extremity. By combining 8 percent for the right lower extremity and 12 percent for the left lower extremity, he rated appellant with a 19 percent impairment rating of the lower extremities. He then combined the 5 percent sexual dysfunction impairment to rate appellant with a 23 percent whole person impairment rating.

On January 7, 2002 an Office medical adviser recommended referral to a neurologist for a second opinion to determine any persistent evidence of radiculitis and, if so, what nerve roots were involved and to what extent.

On June 7, 2002 the Office referred appellant, along with the medical record, a statement of accepted facts and a set of questions to Dr. Edward Williamson, a Board-certified neurologist. In a report dated July 9, 2002, Dr. Williamson stated that he had examined appellant that day, but that he did not review any x-rays or magnetic resonance imaging (MRI) scans in his evaluation. He reported a normal physical examination and found no evidence of radiculopathy or nerve damage, and no need for additional treatment. Dr. Williamson stated that appellant had completely recovered and that his complaints "do not conform to any anatomic patterns or other patterns of disease."

By decision dated September 18, 2002, the Office denied appellant's claim. On September 22 and October 17, 2002, appellant requested review of the written record. In support of his request, he submitted an October 10, 2002 report from Dr. Robert Love Baker, II, who noted that appellant's September 30, 2002 MRI scan revealed a herniated disc at L4-5 and L5-S1. Dr. Baker, however, did not provide an opinion regarding impairment. In a report dated June 11, 2002, Dr. James D. Smith, appellant's chiropractor, noted range of motion findings of appellant's lower extremities. He also noted that appellant was not disabled as a result of his work-related injury. In a report dated August 29, 2002, Dr. Sean B. Labuda, also appellant's chiropractor, noted results similar to those of Dr. Smith, adding that appellant did not have a work-related disability. By decision dated March 3, 2003, an Office hearing representative affirmed the September 18, 2002 decision denying appellant's claim.

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

[4] *Id.* at 552, Table 17-37.

[5] *Id.* at 482, Table 16-10.

[6] *Id.* at 528, Table 17-4.

The schedule award provisions of the Federal Employees' Compensation Act[7] provide for compensation to employees sustaining impairment from loss, or loss of use of, specified members of the body. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice under the law, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[8]

The Board initially notes that, although the A.M.A., *Guides* include guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under the Act for injury to the spine.[9] In 1960, amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[10]

Section 15.12 of the fifth edition of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities as follows. The nerves involved are to be first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity. The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve.[11]

In this case, Dr. Merick advised that appellant had a two percent disability for muscle weakness of the hip and a five percent impairment for loss of flexion and extension of each knee for a total impairment of seven percent for each lower extremity. Regarding appellant's sciatica condition, he noted an eight percent impairment of the lower extremities. Dr. Merick also noted a 10 to 14 percent impairment for the lower extremities based on leg length discrepancy. On the other hand, Dr. Williamson, the second opinion physician, determined that appellant had no residuals from his work-related injury and thus had no ratable impairment. The Board finds that a conflict exists between Dr. Merick, appellant's treating physician, and Dr. Williamson, the second opinion physician, on the issue of whether appellant has an impairment based on his work-related injury. The case will be remanded for an impartial medical specialist to resolve the conflict in the medical opinions. On remand, the Office should refer the case record with all

[7] 5 U.S.C. §§ 8101-8193.

[8] *Jacqueline S. Harris*, 54 ECAB ___ (Docket No. 02-203, issued October 4, 2002).

[9] *James E. Mills*, 43 ECAB 215 (1991).

[10] *See George E. Williams*, 44 ECAB 530 (1993).

[11] A.M.A., *Guides* at 423.

relevant medical records and a statement of accepted facts to an appropriate physician to reevaluate the evidence pursuant to section 8123(a) of the Act. Following this and such further development as the Office deems necessary, it shall issue a *de novo* decision.

The decisions of the Office of Workers' Compensation Programs dated March 3, 2003 and September 18, 2002 are set aside and the case remanded to the Office for further action consistent with this decision.[12]

Dated, Washington, DC
October 1, 2003

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

[12] Appellant's June 11 and August 29, 2002 impairment evaluations by Drs. Smith and Labuda, appellant's chiropractors, noted that his injuries affected his usual activities of daily living and provided range of motion findings of his lower extremities. The Board has held that, even under the circumstances where a chiropractor is recognized as a physician under the Act, the chiropractor is still not considered a physician in diagnosing or evaluating disorders of the extremities, although those disorders may originate in the spine. As Drs. Smith and Labuda are not physicians for the purpose of calculating a schedule award, their opinions are of no probative medical value on this issue; *see George E. Williams, supra* note 10.