United States Department of Labor
Employees' Compensation Appeals Board

RICHARD R. LEMAY, Appellant	)	
and	)	**Docket No. 04-1652**
	)	**Issued: February 16, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Manchester, NH, Employer	)	

Appearances:
James G. Noucas, Jr., Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On June 15, 2004 appellant filed a timely appeal from an Office of Workers' Compensation Programs' March 18, 2004 merit decision which denied modification of a previously issued schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award in this case.[1]

ISSUE

The issue is whether appellant has more than a 30 percent lower extremity impairment for which he received a schedule award. On appeal, appellant contends that the schedule award should have been based on the examination and findings of an impartial medical specialist, not that of the Office medical adviser.

[1] By decision dated August 20, 2003, the Office denied modification of its previous decision denying appellant's request to purchase a household massage lounger. On appeal, appellant's attorney does not contest this decision. Therefore, the Board will not review the August 20, 2003 decision of the Office.

FACTUAL HISTORY

This case is on appeal to the Board for the third time. On October 9, 1987 appellant, then a 40-year-old distribution clerk, filed a claim alleging that he was struck that day by a heavy cart. Appellant stopped work that day. He returned on December 4, 1987 for four hours a day with restrictions and stopped work again on December 16, 1987. Appellant later returned to a four-hour-a-day position on July 29, 1991 and left work in December 1993 due to a carpal tunnel release. Appellant has not returned to work. The Office accepted the claim for a lumbar strain and the subsequent conditions of sciatica and myofascial pain syndrome.

On the first appeal, the Board found that the Office did not abuse its discretion in denying authorization for the purchase of orthopedic work boots.[2] In the second appeal, the Board dismissed appellant's appeal for lack of jurisdiction.[3] The facts and the history surrounding the prior appeals are set forth in the initial decisions and are hereby incorporated by reference. To the extent the information is germane to the present appeal, it will be repeated.

Appellant filed a claim for a schedule award on January 24, 2001. In an April 17, 2001 report, Dr. Denrick L. Crespi, an attending osteopath, provided findings on examination and determined that appellant had a 65 percent impairment of the whole person based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Crespi indicated that, under Table 17-37, page 552, appellant was given a 30 percent whole person with a 75 percent impairment for the sciatic notch on his right leg, plus 2 for the sural nerve and, for the left leg, was given 20 plus 3 plus 1 for the sural nerve to total a 24 percent whole person. Using the Combined Values Chart on page 604, he took the two figures of 37 plus 24 and calculated a 52 percent whole person impairment for the legs and a 13 percent whole person impairment for the spinal injury.

The Office sent the case record to Dr. George L. Cohen, an Office medical adviser, for review. In a July 30, 2001 report, Dr. Cohen determined that the date of maximum medical improvement was March 1999. The Office medical adviser noted that Federal Employees' Compensation Act regulations did not permit impairment awards for the low back except for the lower extremities which may be involved and that section 16.8a, page 508 of the A.M.A., *Guides*, stated that decreased strength could not be rated in the presence of painful conditions. Using Table 15-18, page 424 of the A.M.A., *Guides*, he found that the maximum lower extremity impairment due to involvement of the nerve root L5 was five percent and the nerve root S1 was five percent. For the right lower extremity, the Office medical adviser found an eight percent impairment. This was based on a Grade 2 pain, Table 16-10, page 482 which equated to 80 percent impairment of each nerve root of 5 percent and which resulted in a 4 percent impairment for the L5 involvement and a 4 percent impairment for the S1 involvement. For the left lower extremity, Dr. Cohen found a six percent impairment. This was based on a Grade 3, Table 16-10, page 482 which equated to a 60 percent impairment for pain which interfered with activities. No additional impairment was provided for loss of motion or for weakness of either the right or the left lower extremity.

[2] Docket No. 93-205 (issued December 23, 1993).

[3] Docket No. 94-1140 (issued June 3, 1996).

Due to conflict in the medical opinion evidence regarding the extent of appellant's permanent impairment, the Office referred appellant, together with the case file, to Dr. Frank A. Graf, a Board-certified orthopedic surgeon selected as the impartial medical specialist. In a March 7, 2002 report, Dr. Graf provided a history of appellant's condition, detailed findings on examination and indicated that he had reviewed the case file. He stated that his examination did not confirm a complete motor deficit in the right lower extremity or the presence of any sensory deficit in the lower extremities. Dr. Graf stated:

> "In rating [appellant's] permanency, reference is made to Table 15-18, Unilateral Spinal Nerve Root Impairments affecting the lower extremities with loss of function due to alteration in strength in the anterior tibial tendon and posterior tibial tendon with further reference to Table 13-15, Criteria for Rating Impairments Due to Station and Gait Disorders. This patient has an abnormality in station and gait. Examination confirms his ability to rise to a standing position but walking some distance is performed with difficulty and is limited to essentially level surfaces. At times the patient requires the aid of a cane and at times rises and maintains standing positions with difficulty. The patient is judged to meet the criteria between Class II and Class III of Table 13-15 with a 25 percent whole person impairment. A 25 percent whole person impairment is converted to a 62 percent lower extremity impairment by referencing page 527, Table 17-3, which includes whole person impairment values calculated from lower extremity impairment. Reference to Table 15-18 further serves as a cross-check with the impairment rating obtained through the suggested maximum percent loss of function in extremities due to strength changes from spinal nerve root dysfunction. The permanencies assigned through consideration of the gait pattern changes through station and gait disorder caused by the patient's spinal condition and motor deficits documented in this examination are not intended to be combined since they are both manifestations of the same condition."

In a November 11, 2002 report, Dr. Cohen, the medical adviser, reviewed Dr. Graf's report and stated:

> "It is possible to revise the original recommendations based on an independent evaluation by Frank Graf, M.D., orthopedic surgeon. His examination did not confirm the presence of a sensory deficit in the lower extremities, but we may allow the previously determined impairment due to pain.
>
> "The A.M.A., *Guides* does not ordinarily allow loss of strength to be combined with pain unless the weakness is based on a different etiology (section 16.8a, page 482). In this instance, the problems described with walking and the occasional need of a cane are not related to pain and can be used separately to determine impairment based on weakness in addition to pain.
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> "Using Table 15-18, page 424, the maximum lower extremity impairment due to weakness when the L5 nerve root is impaired is 37 percent. Table 15-16, Grade 4, page 424 allows 25 percent for mild to moderate weakness. Twenty-five

percent of 37 percent results in a 9 percent impairment of the right lower extremity and 9 percent of the left lower extremity.

"Using the Combined Values Chart, page 604, 8 percent impairment of the right lower extremity due to pain is combined with 9 percent for weakness resulting in a 16 percent impairment of the right lower extremity. Six percent impairment of the left lower extremity due to pain combined with 9 percent due to weakness results in a 14 percent impairment of the left lower extremity.

"Table 17-2, page 526 does not allow pain or loss of strength to be combined with gait derangement. FECA regulations do not generally allow for whole body impairment and, as noted, impairment for the spine is not allowed. In addition, whole person impairment may not be converted back to lower extremity impairments except in unusual circumstances. It is also rarely necessary to do so based on other available information."

By decision dated November 26, 2002, the Office issued a schedule award for a 16 percent impairment to the right lower extremity and a 14 percent impairment to the left lower extremity which ran for a period of 86.4 weeks of compensation from March 1, 1999 to October 25, 2002.

In a November 19, 2003 letter, appellant requested reconsideration. He argued that the Office acted inappropriately in issuing the schedule award based on the report of the Office medical adviser after it had referred the matter out for evaluation by an impartial medical specialist. Appellant contended that the report and findings of the impartial medical specialist must be given special weight and that the award of compensation should be modified consistent with and based on Dr. Graf's findings.

By decision dated March 18, 2004, the Office denied modification of its November 26, 2002 decision.

LEGAL PRECEDENT

Section 8107 of the Act[4] provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[5] The schedule award provisions of the Act[6] and its implementing federal regulation[7] 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

[4] 5 U.S.C. § 8107(a).

[5] *Id.*

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[8]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[9] As neither the Act nor its regulations provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole, no claimant is entitled to such a schedule award.[10] The Board notes that section 8109(19) specifically excludes the back from the definition of "organ."[11] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[12]

Section 8123(a) of the Act provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict.[13] When there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a), to resolve the conflict in the medical evidence.[14]

ANALYSIS

The record reflects a conflict in the medical opinion evidence between Dr. Crespi, an attending osteopath, and Dr. Cohen, an Office medical adviser, as to the degree of appellant's work-related permanent impairment to his lower extremities.[15] The Office properly referred appellant to Dr. Graf, a Board-certified orthopedic surgeon, for an impartial medical examination and to render an opinion on the percentage of permanent impairment.

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.[16] The Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the

[8] *Id*.

[9] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[10] 5 U.S.C. § 8107; *see also Phyllis F. Cundiff*, 52 ECAB 439 (2001); *Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[11] 5 U.S.C. § 8109(c).

[12] *Thomas J. Engelhart, supra* note 9.

[13] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB ___ (Docket No. 01-1599, issued June 26, 2002).

[14] *William C. Bush*, 40 ECAB 1064 (1989).

[15] In an April 17, 2001 report, Dr. Crespi determined that appellant had a 65 percent whole person permanent impairment based on the fifth edition of the A.M.A., *Guides*. In a report dated July 30, 2001, the Office medical adviser determined that appellant had an eight percent permanent impairment to his right lower extremity and a six percent permanent impairment to his left lower extremity based on pain.

[16] *See Roger Dingess*, 47 ECAB 123 (1995).

impairment from the attending physician is obtained.[17] The Office procedures note that, after all necessary medical evidence is obtained, the case file must be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.[18] However, cases returned from a referee medical examiner or an impartial medical specialist should not be routinely sent to an Office medical adviser unless a schedule award is at issue. Where a referee examination is arranged to resolve a conflict created between a claimant's physician and an Office medical adviser with respect to a schedule award issue, the same Office medical adviser should not review the referee specialist's report. Rather, another Office medical adviser or consultant should review the file.[19]

The Board notes that as a referee examination was arranged to resolve a conflict created between Dr. Crespi and Dr. Cohen, the medical adviser, with respect to appellant's impairment. It was improper for Dr. Cohen, whose report had created the conflict in the medical opinion, to review Dr. Graf's March 7, 2002 report. Rather, another Office medical adviser should have reviewed the impartial specialist's report.[20] In reviewing Dr. Graf's report, Dr. Cohen noted that, although Dr. Graf's examination did not confirm the presence of a sensory deficit in the lower extremities, "we may allow the previously determined impairment due to pain." In order to properly resolve the conflict created, however, it is the impartial medical specialist, Dr. Graf, who should provide a reasoned opinion as to the extent of permanent impairment in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[21] As Dr. Graf was the impartial medical specialist assigned to resolve the conflict in this case, Dr. Cohen inappropriately looked outside of Dr. Graf's March 7, 2002 report to allow previously reviewed medical evidence to factor into the schedule award determination. The case will be remanded to the Office to have another Office medical adviser review Dr. Graf's March 7, 2002 report. If it is determined that Dr. Graf's opinion as to appellant's permanent impairment is in accordance with the A.M.A., *Guides,* then his March 7, 2002 report should be given the weight of medical opinion. Should Dr. Graf's opinion require clarification, the Office should request a supplemental opinion consistent with Board precedent.[22] Following such further development as is necessary, the Office shall issue an appropriate merit decision on the schedule award issue.

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

[18] *Id.* at Chapter 2.810.11(d); *see John W. Slonaker*, 35 ECAB 997 (1984).

[19] *Id.*

[20] *See John W. Slonaker*, *supra* note 18. *See also Carol J. Jackson*, 37 ECAB 641 (1986).

[21] *See, e.g., Willie C. Howard*, 55 ECAB ___ (Docket Nos. 04-342 & 04-464, issued May 27, 2004) (where the Office medical adviser concurred that the impartial medical specialist's impairment rating was appropriate under the fifth edition of the A.M.A., *Guides*).

[22] *See Harry T. Mosier*, 49 ECAB 688, 693 (1998).

CONCLUSION

The Board finds that the case is not in posture for decision with respect to the schedule award determination as further development of the medical evidence is required.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 18, 2004 be set aside and the case remanded for action consistent with this decision of the Board.

Issued: February 16, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member