United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 06-2005**
	)	**Issued: April 24, 2007**
DEPARTMENT OF THE ARMY, COMMUNICATIONS-ELECTRONICS COMMAND, Fort Monmouth, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 28, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' March 3, 2006 merit decision concerning her entitlement to schedule award compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant has more than a 17 percent permanent impairment of her right leg for which she received a schedule award and whether she has any permanent impairment of her left leg.

FACTUAL HISTORY

On August appellant, then a 33-year-old personnel staffing specialist, filed a traumatic injury claim alleging that she sustained a back injury at work on August 24, 1981 due to lifting heavy boxes. She stopped work on August 24, 1981. The Office accepted that appellant

sustained a herniated disc at L4-5 and paid compensation for periods of disability.[1] On November 30, 1981 appellant underwent a decompression hemilaminectomy and foraminectomy at L4-5. The procedure was authorized by the Office. The Office later accepted that appellant sustained scarring due to the surgery.

Appellant received treatment for her back problems over the years and complained of low back pain with limitations upon movement of her low back. The results of the December 21, 1989 magnetic resonance imaging (MRI) scan showed L4-5 and L5-S1 disc degeneration and mild osteophytic encroachment at L4-5 into the spinal canal with mild compression upon the thecal sac. The results of June 16, 1998 MRI scan testing showed a recurrent disc protrusion into the ventral epidural space at L5-S1 without effect on the thecal sac and a mild disc bulge at L4-5.

In June 1999 appellant returned to light-duty work for the employing establishment as a secretary. The results of an April 20, 2000 electromyogram (EMG) and nerve conduction testing revealed findings consistent with chronic L5-S1 root dysfunction as seen by an absent H-soleus reflex and decreased numbers of recruited motor units with polyphasic motor units in the right tibialis anterior.

On December 22, 2003 Dr. David Weiss, an attending osteopath Board-certified in orthopedic medicine, provided a history of appellant's findings on examination and diagnostic testing. He stated that examination revealed paravertebral muscle spasm and tenderness from L4 through S1 and bilateral posterior superior iliac spine tenderness. Range of motion testing showed forward flexion of 65 degrees, backward extension of 15 degrees, left lateral flexion of 10 degrees and right lateral flexion of 5 degrees with pain at the extremes. Dr. Weiss stated that straight leg raising was positive at 75 degrees above the horizontal line on the left producing midline low back pain and positive at 80 degrees above the horizontal line on the right producing midline low back pain. He indicated that manual muscle testing revealed that the hip flexors were Graded 4/5 on both sides and that the gastrocnemius muscles were Graded 4/5 on both sides and stated, "Sensory examination reveals a perceived sensory deficit over the L4, L5 and S1 dermatones involving the right lower extremity."

Dr. Weiss diagnosed chronic post-traumatic lumbosacral strain and sprain, herniated nuclei pulpous at L4-5 and L5-S1, status post decompressive hemilaminectomy at L4-5, discogenic disease at L4-5 and lumbar radiculopathy at L5-S1. He indicated that the August 24, 1981 injury was the competent producing factor for appellant's subjective and objective findings. For the right leg, Dr. Weiss stated that appellant had a 5 percent impairment for 4/5 motor strength loss of the hip flexors, a 17 percent impairment for 4/5 motor strength loss of the gastrocnemius (measured by ankle plantar flexion), a 4 percent impairment due to sensory loss associated with the L4 nerve root, a 4 percent impairment due to sensory loss associated with the L5 nerve root and a 4 percent impairment due to sensory loss associated with the S1 nerve root.[2] He combined these figures, using the Combined Values Chart of the A.M.A., *Guides* to equal a 30 percent impairment and then added a 3 percent impairment for "pain-related impairment" to

[1] The findings of September 24, 1981 myelogram testing showed some posterior bulging at L4-5 and L5-S1.

[2] Dr. Weiss applied Table 17-8 on page 532 and Table 15-5 on page 424 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed 2001).

conclude that appellant had a 33 permanent impairment of her right leg. For the left leg, Dr. Weiss added a five percent impairment for 4/5 motor strength of the hip flexors to a three percent impairment for "pain-related impairment" to conclude that appellant had an eight percent permanent impairment of her left leg.

The Office referred appellant to Dr. Robert Dennis, a Board-certified orthopedic surgeon, for further evaluation of the extent of her lower extremity impairment. On April 12, 2005 Dr. Dennis indicated that he had reviewed the medical evidence of record, including the December 22, 2003 evaluation of Dr. Weiss and provided a history of appellant's findings on examination and diagnostic testing. Dr. Dennis stated that on examination appellant exhibited decreased sensation in the superficial femoral nerve distribution in the right thigh, that there was slight weakness of plantar flexion and dorsiflexion of the right foot, that the right Achilles reflex was absent and that there was weakness in the right gastrocnemius muscle which was associated with the S1 nerve root. He indicated that there was no deficit in the L4 nerve root, that the L5 nerve root was intact and that there was no weakness in the hip flexors or hip rotators bilaterally. Dr. Dennis stated:

> "The nerve that was most significantly involved was the sciatic nerve. It made up the L5 and S1 nerve roots, which were the two most involved nerve roots. This affects the gastric muscle and it certainly affects the Achilles reflex. The nerve roots involved are isolated to the L5 and S1 nerve roots in the right side, in my opinion. They have been left with some permanent deficits, which are reflected in the weakness and sensory deficits described in this document. In referring to Figure 17-8, one can further identify the specific muscles involved. It should be noted that I found no hip flexor weakness. Therefore, the femoral nerve is not involved in my opinion, but did explain the loss of sensation along the right thigh is a meralgia paresthetica, which is truly sensory peripheral nerve issue without a functional loss.
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> "I refer you to [p]age 532, Table 17.8 where muscle strength is identified. It is my opinion [that appellant] has a Grade [3] to [4] deficit of flexion indicating a 10 percent deficit and knee flexion representing a 7 percent deficit as it relates to the lower extremity.
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> "There are no other deficits in regard to muscle strength identified whatsoever. There is no sensory deficit associated with sciatic nerve in my opinion, since the meralgia paresthetica is what is causing the sensory loss and this is not register[ed] as a functional impairment. I have referred to [p]age 529 and find no evidence of gait deficit. I refer to [p]age 537 and find no joint motion loss. Zero percent permanency has to be attributed to sensory loss, in my opinion and to joint contracture.
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> "Taking the muscle loss identifiable to the sciatic nerve and the peripheral extensions of the nerve, it is my opinion [that appellant] has suffered a total 17 percent functional impairment of the right lower extremity as defined and consistent with the A.M.A., *Guides.* This represents a permanent impairment. I

have looked at Dr. Weiss' report and I am quite aware that my determination is in contradiction to some of the methodologies that he has used to defining large sensory deficits, which I do not confirm. He has also defined extensive weakness of hip flexors, which I did not identify."

On April 21, 2005 Dr. Dennis provided clarification of his April 12, 2005 evaluation. He emphasized that he felt he performed a complete examination of both of appellant's legs and indicated that confusion may have been created by the fact that he placed his findings for testing of appellant's legs in the section for findings of back testing. Dr. Dennis repeated his conclusion that appellant had a 17 percent permanent impairment of her right leg but no impairment of her left leg.

On April 12, 2005 an Office medical adviser stated that he agreed with the impairment rating provided by Dr. Dennis. In a July 22, 2005 award of compensation, the Office granted appellant a schedule award for a 17 percent permanent impairment of her right leg and a 0 percent permanent impairment of her left leg.

Appellant requested a hearing before an Office hearing representative. At the December 19, 2005 hearing appellant argued that the opinion of Dr. Weiss showed that she was entitled to additional schedule award compensation.

By decision dated and finalized March 3, 2006, the Office hearing representative affirmed the Office's July 22, 2005 decision.

LEGAL PRECEDENT

The schedule award provision of the Act[3] and its implementing regulation[4] 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 justice under the law to 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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[5]

It is well established that proceedings under the Act are not adversarial in nature, and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[6]

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

[6] *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

ANALYSIS

The Office accepted that appellant sustained a herniated disc at L4-5 on August 24, 1981. On November 30, 1981 she underwent a decompression hemilaminectomy and foraminectomy at L4-5. The Office later accepted that appellant sustained scarring due to the surgery. In a July 22, 2005 award of compensation, the Office granted appellant a schedule award for a 17 percent permanent impairment of her right leg and a 0 percent permanent impairment of her left leg. The award was based on the opinion of Dr. Dennis, a Board-certified orthopedic surgeon, who served as an Office referral physician.

The Board finds that the impairment evaluation of Dr. Dennis has several deficiencies that require the Office to further develop the medical evidence. In his April 2005 evaluation, Dr. Dennis concluded that appellant had a 17 percent permanent impairment of her right leg based on Table 17-8 on page 532 of the A.M.A., *Guides* which pertains to muscle weakness.[7] He indicated that appellant had a Grade 3 to 4 deficit of flexion on the right which would warrant a 10 percent impairment rating. However, Dr. Dennis did not indicate what type of flexion to which he was referring and the Board is unable to make such a determination.[8] Dr. Dennis added this 10 percent rating to a 7 percent impairment rating which was derived from the fact that appellant had a Grade 3 to 4 deficit of right knee flexion. However, an examination of Table 17-8 shows that a Grade 3 to 4 deficit of right knee flexion would equal a 12 to 17 percent impairment of the right leg.[9]

Dr. Dennis concluded that appellant had no other sensory or strength deficits in her legs, but he did not provide sufficient rationale for this conclusion. On one hand, he stated that the most significantly involved nerve was the right sciatic nerve that "made up the L5 and S1 nerve roots" and noted that the right L5 and S1 nerve roots had "been left with some permanent deficits, which are reflected in the weakness and sensory deficits described in this document." But he also indicated in the same report that there was no deficit in the L4 nerve root and that the L5 nerve root was intact and he provided no impairment rating for a deficit associated with these nerve roots. Dr. Dennis noted that appellant exhibited weakness of dorsiflexion of the right foot, but he did not adequately explain why this finding would not warrant an impairment rating for weakness in the right ankle muscle group associated with the L4 or L5 nerve root.[10] In addition, Dr. Dennis indicated that appellant did not have any deficit upon motion of her lower extremities. However, he did not provide findings of range of motion testing under the relevant standards.[11]

[7] *See* A.M.A., *Guides* 532, Table 17-8.

[8] Table 17-8 provides ratings for deficits upon hip, knee, ankle or great toe flexion, among other movements. *Id.*

[9] *Id.*

[10] *See* A.M.A., *Guides* 551, Figures 17-8 and 17-9. These figures show the distribution of the L4 and L5 nerves into the foot.

[11] *See* A.M.A., *Guides* 537, Tables 17-9 through 17-14.

In a December 22, 2003 evaluation, Dr. Weiss, an attending osteopath Board-certified in orthopedic medicine, concluded that appellant had a 33 percent permanent impairment of her right leg and an 8 percent permanent impairment of her left leg. However, this impairment rating also exhibits a number of deficiencies. Dr. Weiss determined that, for the right leg, appellant had a 5 percent impairment for 4/5 motor strength loss of the hip flexors and a 17 percent impairment for 4/5 motor strength loss of the gastrocnemius (measured by ankle plantar flexion) and that, for the left leg, she had a 5 percent impairment for 4/5 motor strength of the hip flexors.[12] However, Dr. Weiss did not explain how these findings were related to the employment-related injury to appellant's L4 or L5 nerve distributions.

Dr. Weiss indicated that sensory examination revealed "a perceived sensory deficit over the L4, L5 and S1 dermatones involving the right lower extremity" and concluded that appellant had a four percent impairment due to sensory loss associated with the L4 nerve root, a four percent impairment due to sensory loss associated with the L5 nerve root and a four percent impairment due to sensory loss associated with the S1 nerve root.[13] However, he did not clearly explain the basis for this "perceived sensory deficit." Moreover, Dr. Weiss's addition of impairment ratings for loss of muscle strength and peripheral nerve deficits would not generally be allowed under the relevant standards[14] and he did not adequately explain why he assigned a three percent impairment rating to each leg for "pain-related impairment."[15]

For these reasons, the medical evidence requires further development. The Office should refer appellant and the case record to an appropriate specialist for examination and evaluation of the permanent impairment of her lower extremities. After such further development as the Office deems necessary, the Office should issue an appropriate decision regarding appellant's claim.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than a 17 percent permanent impairment of her right leg, for which she received a schedule award and whether she has any permanent impairment of her left leg. The case is remanded to the Office for further development.

[12] Dr. Weiss applied Table 17-8 on page 532 of the A.M.A., *Guides.*

[13] Dr. Weiss applied Tables 15-5 and 15-18 on page 424 of the A.M.A., *Guides.*

[14] *See* A.M.A., *Guides* 526, Table 17-2.

[15] *See* A.M.A., *Guides* 573-81, sections 18.3d through 18.3f.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' March 3, 2006 decision is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: April 24, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board