United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 07-817**
	)	**Issued: August 1, 2007**
U.S. POSTAL SERVICE, POST OFFICE, East Austin, TX, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 5, 2007 appellant, through his attorney, filed a timely appeal from a January 25, 2007 merit decision of the Office of Workers' Compensation Programs granting him a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a three percent permanent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

This case is before the Board for the second time. In the first appeal, the Board affirmed a February 15, 1995 decision denying appellant's request for reconsideration of the termination of his compensation on the grounds that it was untimely and did not establish clear evidence of

error.[1] The findings of fact and conclusions of law from the prior decision are hereby incorporated by reference.

On December 1, 2005 appellant filed a claim for a schedule award. By letter dated January 24, 2006, the Office requested that Dr. Richard D. Tallman, a Board-certified internist and neurologist, provide an impairment evaluation in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*). On January 30, 2006 Dr. Tallman notified the Office that he did not provide impairment ratings.

In a decision dated March 2, 2006, the Office denied appellant's schedule award claim on the grounds that the medical evidence was insufficient to show that he was at maximum medical improvement (MMI) and had a ratable permanent impairment. It noted that it had accepted appellant's claim for abdominal strain, a left inguinal hernia, an aggravation of other monomeuritis of the left lower limb and an aggravation of scrotal varices.

On August 9, 2006 appellant, through his attorney, requested reconsideration. He submitted an impairment evaluation dated February 17, 2006 from Dr. N.F. Tsourmas, a Board-certified orthopedic surgeon, who described appellant's history of a left inguinal hernia at work. He stated, "[Appellant] underwent a herniorrhaphy [that] was complicated postoperatively by pain and the appearance of a left varicocele which was operated on. Despite this operative intervention, subsequent to this operative intervention he became a chronic pain patient for what was described as ilioinguinal neuropathy." Dr. Tsourmas noted that appellant sustained increased pain in the left groin subsequent to a May 2005 motor vehicle accident. On examination he found an inguinal scar with no hernias. Dr. Tsourmas opined that appellant had reached MMI. He applied Chapter 6 of the A.M.A., *Guides* relevant to digestive system and determined that appellant had a Class II or 10 percent impairment of the whole person due to his hernia. Dr. Tsourmas opined that appellant had no impairment due to his mononeuritis as it was controlled by pain medication.

Appellant also submitted a report dated July 24, 2006 from Dr. Richard I. Zamarin, a Board-certified orthopedic surgeon, who reviewed Dr. Tsourmas' report and disagreed with his finding that appellant had no impairment due to mononeuritis. Dr. Zamarin opined that appellant had a 10 percent sensory impairment due to chronic groin pain and irritation of the genitoinguinal nerve according to Table 13-23 on page 846 of the A.M.A., *Guides*. He noted that Table 17-37 on page 552 of the A.M.A., *Guides* which provides impairments of the lower extremity due to nerve deficits, did not refer to the ilioinguinal nerve. Dr. Zamarin assigned the ilioinguinal nerve five percent which he determined was "in line with injuries to other sensory nerves in the lower extremities." Dr. Zamarin multiplied the 10 percent Class II sensory impairment by the 5 percent assigned to the ilioinguinal nerve to find a 0.5 percent lower extremity impairment due to mononeuritis.

By decision dated August 21, 2006, the Office denied appellant's request for merit review under 5 U.S.C. § 8128. It found that appellant had not submitted any evidence with his reconsideration request. On August 29, 2006 appellant again requested reconsideration and resubmitted the reports of Drs. Zamarin and Tsourmas. An Office medical adviser reviewed the

[1] *Dwight A. Benford*, Docket No. 95-2200 (issued November 4, 1997).

reports on October 26, 2006 and noted that Dr. Tsourmas found a 10 percent whole person impairment and Dr. Zamarin found a 0.5 percent lower extremity impairment. He stated, "I am unable to reconcile these two reports for a probative schedule award determination." The Office medical adviser recommended a second opinion evaluation.

On November 13, 2006 the Office referred appellant to Dr. Michael D. LeCompte, an osteopath, to determine the extent of any permanent impairment of the left lower extremity. On December 1, 2006 Dr. LeCompte found tenderness to palpation when testing for an inguinal hernia and over the left testes. He described appellant's complaints of "tingling in the medial aspect of the thigh and leg and some erectile dysfunction, occasional grabbing pain in the groin" and continuous groin pain "exacerbated by working." Dr. LeCompte opined:

> "Based on [appellant's] mechanism of injury, the medial thigh and medial leg pain/numbness is not compatible with the mechanism of injury [and], therefore, is not rated. The diffuse ilioinguinal discomfort is not ratable *per se,* as a sensory deficit using the [A.M.A., *Guides*] 5th ed. However, referencing Figure 18-1 from the [A.M.A., *Guides*], [appellant] does have a three [percent] impairment for pain[-]related impairment that increases the individuals condition slightly."

An Office medical adviser reviewed Dr. LeCompte's report and converted his three percent whole person impairment to a three percent permanent impairment of the left lower extremity.

By decision dated January 25, 2007, the Office issued appellant a schedule award for a three percent permanent impairment of the left lower extremity. The period of the award ran for 8.64 weeks, December 1, 2006 to January 30, 2007.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing federal regulation,[3] 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 for all claimants, the Office has adopted the A.M.A., *Guides* (5th ed. 2001) as the uniform standard applicable to all claimants.[4] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[5]

No schedule award is payable for a member, function or organ of the body that is not specified in the Act or in the implementing regulations. The Act identifies members such as the

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] 20 C.F.R. § 10.404(a).

[5] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

arm, leg, hand, foot, thumb and finger, functions as loss of hearing and loss of vision and organs to include the eye.[6] Section 8107(c)(22) provides for the payment of compensation for permanent loss of "any other important external or internal organ of the body as determined by the Secretary of Labor." The Secretary of Labor has made such a determination, and pursuant to the authority granted in section 8107(c)(22), added the breast, kidney, larynx, lung, penis, testicle, ovary, uterus and tongue to the schedule.[7] The Secretary made no provision in the implementing regulations for a hernia, repair of a hernia or residual abdominal symptomatology.[8]

Chapter 18 of the A.M.A., *Guides* provides methods for evaluating impairments due to pain. Section 18.3d on page 573 of the A.M.A., *Guides* provides as follows:

> "A detailed protocol for assessing pain-related impairments is described below and outlined in Figure 18-1.
>
> A. Evaluate the individual according to the body or organ rating system, and determine an impairment percentage. During the evaluation, the examiner should informally assess pain-related impairment.
>
> B. If the body system impairment rating appears to adequately encompass the pain experienced by the individual due to his or her medical condition, his or her impairment rating is as indicated by the body system impairment rating.
>
> C. If the individual appears to have pain-related impairment that has increased the burden of his or her condition *slightly*, the examiner may increase the percentage found in A by up to [three percent]." (Emphasis in the original.)

For impairments that either increases the individual's impairment more than the three percent provided above or that are not associated with a ratable impairment in other chapters of the A.M.A., *Guides*, a formal assessment of the pain-related impairment must be performed.[9] Examiners should not use Chapter 18 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[10]

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[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404; *Henry B. Ford, III*, 52 ECAB 220 (2001).

[8] *See J.D.*, 58 ECAB ___ (Docket No. 06-1924, issued January 5, 2007).

[9] A.M.A., *Guides* 573.

[10] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003); A.M.A., *Guides* at 18.3(b); *see also Philip Norulak*, 55 ECAB 690 (2004).

Proceedings under the Act are not adversarial in nature, nor is the Office a disinterested arbiter.[11] While the claimant has the responsibility to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[12] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[13]

ANALYSIS

The Office accepted that appellant sustained an inguinal hernia, other mononeuritis of the left leg and left scrotal varices due to an October 21, 2985 employment injury. Appellant filed a claim for a schedule award on December 1, 2005. In a report dated February 17, 2006, Dr. Tsourmas found that appellant had no impairment due to mononeuritis. He further determined that appellant had a 10 percent impairment pursuant to Chapter 6 of the A.M.A., *Guides* relevant to digestive disorders. Neither section 8107 of the Act, nor section 10.404 of the regulations, however, provide a schedule award for a hernia or residual abdominal symptoms.[14] Thus, Dr. Tsourmas' report does not establish that appellant sustained a permanent impairment to a scheduled member.

Dr. Zamarin reviewed Dr. Tsourmas' report on July 24, 2006 and disagreed with his finding that appellant had no impairment due to mononeuritis. He applied Chapter 13 of the A.M.A., *Guides* relevant to impairments of the central and peripheral nervous system and determined that he had a 10 percent sensory deficit due to a peripheral nerve disorder according to Table 13-23 on page 346. Dr. Zamarin then assigned a five percent impairment percentage for the ilioinguinal nerve which he found in accord with the percentages assigned for other sensory nerves affecting the lower extremity under Table 17-37 on page 552. He multiplied the 10 percent peripheral nerve deficit by the 5 percent impairment that he assigned to the ilioinguinal nerve to find a 0.5 percent impairment of the left lower extremity. As noted by Dr. Zamarin, Table 17-37 of the A.M.A., *Guides* does not provide an impairment percentage for an ilioinguinal nerve deficit. Consequently, Dr. Zamarin's opinion is not in conformance with the A.M.A., *Guides* and thus, is of diminished probative value.[15]

The Office medical adviser was unable to provide an impairment rating under the A.M.A., *Guides* based on a review of the opinions of Dr. Tsourmas and Dr. Zamarin. The Office referred appellant to Dr. LeCompte for a second opinion evaluation. Dr. LeCompte found tenderness when palpating the inguinal area without evidence of a hernia. Appellant described tingling in the thigh and leg, some erectile problems and sporadic sharp groin pain which worsened with work activities. Dr. LeCompte determined that he had no impairment due to his medial thigh and leg numbness and pain because it was "not compatible with the mechanism of

[11] *Vanessa Young*, 55 ECAB 575 (2004).

[12] *Richard E. Simpson*, 55 ECAB 490 (2004).

[13] *Melvin James*, 55 ECAB 406 (2004).

[14] *See J.D., supra* note 8.

[15] *Mary L. Henninger*, 52 ECAB 408 (2001).

injury." He did not, however, explain his finding that appellant's leg pain and numbness was not employment related given that the Office accepted an aggravation of mononeuritis of the left lower limb. Dr. LeCompte concluded that he had a three percent whole person impairment pursuant to Figure 18-1 on page 574 of the A.M.A., *Guides*. An Office medical adviser reviewed Dr. LeCompte's report and found that appellant had a three percent left lower extremity impairment due to pain pursuant to section 18.3d of the A.M.A., *Guides*. It is unclear, however, whether Dr. LeCompte based his determination that appellant had an impairment due to pain on abdominal pain which would not be covered as a scheduled member under the Act and implementing regulations or on pain of the left lower extremity. Further, Chapter 18 provides that an impairment percentage determined according to the body or organ rating system in other chapters may be increased by up to three percent based on an informal pain assessment.[16] Dr. LeCompte, however, did not find that appellant had any impairment based on other chapters of the A.M.A., *Guides*. In order to provide an impairment due to pain not associated with a ratable impairment from other chapters, a formal assessment of the pain-related impairment must be performed under Chapter 18.[17] Dr. LeCompte did not provide a formal assessment of appellant's pain; consequently, his opinion is not in conformance with the A.M.A., *Guides*. His opinion is thus, of little probative value and insufficient to resolve the issue of the extent of any permanent impairment of appellant's left lower extremity.

It is well established that proceedings under the Act are not adversarial in nature, nor is the Office a disinterested arbiter.[18] While appellant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[19] The Office undertook development of the medical evidence by referring him to Dr. LeCompte for a second opinion examination. It thus, has an obligation to secure a report adequately addressing the relevant issue of the extent of appellant's left lower extremity impairment. The case will be remanded for the Office to obtain an opinion on the extent of appellant's permanent impairment in accordance with the A.M.A., *Guides*.

CONCLUSION

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

[16] *Supra* note 9.

[17] *Id*.

[18] *See Vanessa Young*, *supra* note 11.

[19] *Richard E. Simpson*, *supra* note 12.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 25, 2007 is set aside and the case is remanded for further proceedings consistent with this decision by the Board.

Issued: August 1, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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