United States Department of Labor
Employees' Compensation Appeals Board

D.L., Appellant	)	
and	)	**Docket No. 06-1577**
	)	**Issued: January 11, 2007**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Bellmawr, 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:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 26, 2006 appellant filed a timely appeal from a February 21, 2006 Office of Workers' Compensation Programs' decision, denying his claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has any permanent impairment causally related to his employment-related internal disc derangement at L5-S1.

FACTUAL HISTORY

On May 4, 2001 appellant, then a 42-year-old clerk, filed an occupational disease claim alleging that he developed a disc problem in his back on April 12, 2001 due to bending, twisting and turning motions in his job. The Office accepted his claim for internal disc derangement at L5-S1. On April 19, 2002 appellant filed a claim for a schedule award.

In a February 3, 2000 report, Dr. Philip M. Maurer, a Board-certified anesthesiologist, stated that appellant had severe tenderness in his lower back, restriction in spinal range of motion and weakness in his lower extremities. A magnetic resonance imaging (MRI) scan revealed a small subligamental right disc herniation. Dr. Maurer diagnosed chronic intractable low back pain and a degenerative disc at L5-S1.

In an April 30, 2001 report, Dr. Robert J. Ponzio, an orthopedic surgeon, stated that appellant had bilateral lower extremity pain and low back pain. An April 14, 2001 MRI scan of the lumbar spine revealed a marked loss of disc height, signal intensity and bulging discs. In an October 29, 2001 report, Dr. Ponzio indicated that appellant had L5 radiculopathy on the left and also had right-sided pain but an electromyogram (EMG) was reported as normal on that side.

In an October 11, 2001 report, Dr. Eric M. Lipnack, a Board-certified physiatrist, stated that appellant had lumbar pain radiating to both lower extremities. An EMG and nerve conduction study (NCS) performed on October 11, 2001 revealed L5 radiculopathy on the left. Neurologic examination revealed a weakness in both lower extremities.

In a January 30, 2002 report, Dr. David Weiss, an osteopath, provided findings on physical examination and diagnosed work-related cumulative and repetitive trauma disorder to appellant's low back, a bulging lumbar disc at L5-S1, discogenic disease of the lumbar spine at L5-S1, and lumbar radiculopathy as revealed by an EMG. Based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[1] he determined that appellant had a 45 percent permanent impairment of the right lower extremity, including 7 percent for a Grade 3 to 5 motor strength deficit of the right extensor hallucis longus muscle, 5 percent for a Grade 4 to 5 motor strength deficit of the right hip flexors and 25 percent for a Grade 3 to 5 motor strength deficit of the right gastrocnemius muscle, based on Table 17-8 at page 532. Dr. Weiss found a four percent impairment, each, of the right L4, L5 and S1 nerve roots due to sensory deficit, based on Tables 15-15 and 15-18 at page 424, and three percent for pain, based on Figure 18-1 at page 574. He found that appellant had a 43 percent impairment of the left lower extremity. The physical findings for the left lower extremity were the same as described above for the right lower extremity with the exception that there was no sensory deficit of the S1 nerve root.

In a December 13, 2002 report, Dr. Gregory S. Maslow, a Board-certified orthopedic surgeon and an Office referral physician, provided findings on physical examination and diagnosed a work-related lumbar strain with radiculitis by history. He stated:

> "[Appellant] does not have objective evidence of permanency or disability on today's clinical examination. He does not have evidence of radiculopathy or other neurologic deficit. There is zero impairment at the lower extremities…."

By decision dated April 15, 2003, the Office denied appellant's claim on the grounds that he failed to establish that he had any impairment causally related to his accepted internal derangement at L5-S1. By decision dated January 29, 2004, an Office hearing representative

[1] A.M.A., *Guides* (5th ed. 2001).

vacated the April 15, 2003 decision, finding a conflict in the medical evidence. The case was remanded for referral to an impartial medical specialist.

In a March 23, 2004 report, Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon, who was provided with a statement of accepted facts and medical reports, provided a history of appellant's condition and findings on physical examination. He diagnosed chronic axial back pain with degenerative disc disease at the L5-S1 level with an EMG diagnosis of chronic radiculopathy on the left at L5-S1. Dr. Glenn stated:

> "[I]n … 2000 while [appellant] was working for the [employing establishment] … he allegedly sustained an injury to his low back…."
>
> * * *
>
> "There is a report … from Dr. Maurer … which describes … chronic intractable back pain…. I suggested to [appellant] that the wording of [Dr. Maurer's] report would suggest that he had had problems for some period of time…. Dr. Maurer did describe radiographs taken of the lumbar spine on February 1, 2000 as demonstrating narrowing of the L5 disc space with degenerative end plate changes…. These are long-standing changes and clearly antedate the date of the initial injury which [appellant] admitted was probably sometime in January of 2000. On the same date an MRI scan [was] interpreted … as showing … [a] small … right disc herniation [which] could have been present in the past or might have been of recent origin."
>
> * * *
>
> "At the present time, [appellant] states that he has constant pain involving his low back … more on the right than the left with pain radiating into the legs … to his feet.
>
> "In the upright position, I could not detect any lumbar spasm, nor did [appellant] have any local tenderness. He could heel and toe walk without difficulty and did so for some distance. He squatted rather gingerly, but nonetheless accomplished it, however, assumed the upright [position] with a cogwheel-type motion commenting that this caused severe pain in his back…."
>
> * * *
>
> "In the upright position, [appellant] did demonstrate all of the Waddell signs of symptom magnification…. On request [appellant] sat on the examining table and did so with the hips flexed and his knees bent over the edge. One could obtain a straight leg raising test to a full 90 [degrees]…. [He] comment[ed] that this caused pain in his back. I questioned him specifically if he had any leg or sciatic pain and he denied that he did. He similarly could hip flex from the sitting position about 20 [degrees] and did maintain this against resistance which was

painless. However, in the supine position he would allow no more than about 45 [degrees] of straight leg raising on the right and left commenting that this caused pain not only in his back, but pain shooting down his leg. He had similar complaints with hip flexion describing excruciating pain in the low back with the same reported pain with any hip rotational movements. The Patrick's test which stretches the sacroiliatic joints was said to produce excruciating pain in his low back; however, any motion of the hips through any degree of rotation was said to produce pain in the low back. This of course would suggest a level of inconsistency in that the sitting and supine responses should be identical.

"In the prone position, [appellant] denied tenderness along any of the spinal elements down to and including the lumbosacral joint and sacrum. He, however, complained bitterly of tenderness when any portion of the flank was palpated from the rib cage distally to the iliac crest, tenderness reportedly extending out to the lateral and onto the anterior abdominal wall.

"It is generally agreed that such diffuse tenderness over such an extensive area cannot be explained on the basis of an organic injury pattern. Again, in spite of the complaint of severe pain there was no evidence of spasm or muscle guarding. He had no tenderness of the sacrosciatic notches. He had no tenderness along the course of either sciatic nerve. The femoral stretch test was normal."

* * *

"[Appellant had] equally active and symmetrical patellar and Achilles' reflexes in the lower extremities. There were no pathological reflexes, no areas of muscle fasciculation, and no areas of muscle atrophy…. Calf circumferences measured 33 [centimeters] on the right and 32 [centimeters] on the left…. Motor power was perfectly normal in both upper and lower extremities down to the dorsiflexors and plantar flexors of both feet where [appellant] demonstrated a complete and total give away weakness.

"There was a symmetrical response involving all motor function of the leg from the ankle distally both on the right and left. Such a motor deficit could not be explained on an organic basis and is a response generally seen in functional situations. [Appellant] similarly reported less ability to feel the pinprick involving the entire left leg when compared to the right [and] blunting of sensation … involving the plantar aspect of both feet. None of this follows a dermatomal distribution and cannot be explained on an organic nerve injury basis.

"[Appellant] … reported diminished vibratory sensibility involving the lateral malleolus of the right ankle when compared to the left, commenting that he could not feel the vibrating tuning fork over the left anterior superior spine, but could on the right. Position sense was maintained throughout [the] lower extremities. This, again, is an inconsistent finding in that [the] two functions are closely

connected…. The gait, although slow and protective, was normal, heel/toe reciprocal.

"Although the internal derangement of the disc at L5-S1 has been listed as an accepted fact, I am nonetheless obliged to report that the initial history would suggest some element of long-standing chronicity and possibly prior treatment. The second diagnosis … is chronic L5-S1 radiculopathy on the left. Dr. Maurer … clearly describes the subligamentous disc herniation as being on the right. Throughout the reports there appears to be emphasis on the presence of right leg pain greater than left. [Appellant's] current complaints are solely related to the right lower extremity, however, in the distribution described does not follow a dermatomal pattern that one would expect with an L5-S1 nerve root involvement. [Appellant's] current physical findings are interspersed with a multitude of inconsistencies. There is nothing in my opinion to suggest any evidence of an organic motor involvement (weakness).

"In rating a lumbar spine injury which includes disc herniation and radiculopathy one is obliged to use the [d]iagnosis-[r]elated [e]stimate model. [The] categories are listed in Box 15-1, page 382: (1) Muscle Spasm -- not present in [appellant]. (2) Muscle Guarding -- not present in [appellant]. (3) Asymmetry of Spinal Motion -- not present…. (4) Nonverifiable Radicular Root Pain -- the distribution of pain described by [appellant] … is not consistent with the level of disc involvement, L5-S1. (5) Reflexes -- [appellant's] reflexes are normal. (6) Weakness and Loss of Sensation -- as stated, to be valid the sensory findings must be in a strict anatomic distribution and the motor finding consistent with the [a]ffected nerve structure. (7) Atrophy is also sought -- [appellant] has no atrophy as demonstrated by measurement. (8) Radiculopathy -- again, this requires a dermatomal distribution of pain, numbness, and/or paresthesia with a comment about the diagnosis of a herniated disc [and] must be substantiated by appropriate findings on the imaging study…. [Appellant] does not fit into this category. (9) Electrodiagnostic Verification of Radiculopathy. [Appellant] does have a positive electromyogram as interpreted by Dr. Lipnack, however, again the radiculopathy is on the left and the reported disc herniation is on the right. [Appellant] in my opinion does not fulfill any of these criteria.

"It is my opinion based upon reasonable medical certainty that [appellant,] because of the positive [EMG] and [NCS,] does not qualify for a [d]iagnosis-[r]elated [e]stimate [lumbar category I], however, [appellant] does appear within reasonable medical probability to fall within a [d]iagnosis-[r]elated [e]stimate [lumbar category II] which equates to 5 to 8 [percent] impairment of the whole person (Table 15-3, page 384) this based on the conflicting, but nonetheless reported presence of a disc herniation at the L5-S1 level on the right with a chronic L5-S1 radiculopathy on the left."

By decision dated May 14, 2004, the Office denied appellant's claim on the grounds that the weight of the medical evidence established that he had no impairment causally related to his

accepted internal disc derangement at L5-S1. By decision dated January 10, 2005, an Office hearing representative vacated the May 14, 2004 decision, stating that Dr. Glenn determined that appellant had an impairment of the whole person which is not provided for under the Federal Employees' Compensation Act. He remanded the case for a supplemental report from Dr. Glenn addressing the issue of whether appellant had any impairment of his lower extremities due to his accepted back condition.

On May 4, 2005 the Office advised Dr. Glenn that the Act did not provide for a schedule award for impairment of the whole person. It asked him to provide a supplemental report addressing the issue of whether appellant had any impairment of the lower extremities causally related to his accepted back condition.

In a June 9, 2005 supplemental report, Dr. Glenn stated that his opinion that appellant had a category II diagnosis-related estimate impairment of five to eight percent of the whole person was based on Table 15-3 at page 384 of the A.M.A., *Guides* and appellant's positive EMG and NCS. He stated:

> "There certainly was an inconsistency in the [EMG/NCS] report of the subligamentous disc herniation as being on the right and the chronic L5-S1 radiculopathy as being on the left. Even if one were to utilize the [d]iagnosis-[r]elated [e]stimate category, the [A.M.A.,] *Guides* are really not clear where specific inconsistencies exist.
>
> "I did not find any objective evidence of a lower extremity radiculopathy or[,] for that matter[,] any lower extremity residual impairment.
>
> "Within the confines of that guideline, then [appellant,] by definition[,] does not have any residual permanency of impairment involving either lower extremity."

By decision dated June 29, 2005, the Office denied appellant's claim on the grounds that the weight of the medical evidence established that he had no impairment of his lower extremity causally related to his April 12, 2001 internal disc derangement at L5-S1.

Appellant requested a hearing that was held on December 7, 2005. Counsel argued that Dr. Glenn's reports were not sufficiently rationalized to be accorded special weight. Dr. Glenn did not provide for any pain-related impairment although appellant had complaints of pain. He merely dismissed the pain as due to symptom magnification. Dr. Glenn did not perform tests for lateral flexion tests, hip flexor, tendon reflexes or motor strength. He did not perform tests to assess leg weakness or motor function or measurements for dorsal and plantar flexors. Dr. Glenn provided no impairment for atrophy despite a difference in calf circumference between the right and left legs. He noted that appellant had less ability to feel pinprick involving the left leg and, on the right, a blunting sensation, but provided no impairment rating for sensory deficit.

By letter dated January 10, 2006, appellant, through his attorney, indicated that he was submitting a December 30, 2005 report from Dr. Weiss.[2]

[2] There is no December 30, 2005 report from Dr. Weiss of record.

By decision dated February 21, 2006, an Office hearing representative affirmed the June 29, 2005 decision.

LEGAL PRECEDENT

The schedule award provision of the Act[3] and its implementing regulation[4] sets 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]

Section 8123(a) of the Act provides that "if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [of Labor] shall appoint a third physician who shall make an examination."[6] 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.[7]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[8] However, when the impartial 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 impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[9] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[10]

---

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.*

[6] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[7] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

[8] *Nancy Lackner (Jack D. Lackner)*, 40 ECAB 232 (1988); *Ramon K. Ferrin, Jr.*, 39 ECAB 736 (1988).

[9] *Roger W. Griffith*, 51 ECAB 491 (2000); *Talmadge Miller*, 47 ECAB 673 (1996).

[10] *Roger W. Griffith*, *supra* note 9; *Harold Travis*, 30 ECAB 1071 (1979).

ANALYSIS

The Office accepted that appellant sustained an internal disc derangement in his back at the L5-S1 level. Due to the conflict in the medical opinion between Dr. Weiss and Dr. Maslow as to whether he had any impairment of his lower extremities due to his accepted back condition, the Office referred appellant to Dr. Glenn.

The Board finds that the reports of Dr. Glenn are not sufficient to resolve the conflict in the medical opinion evidence as to whether appellant has any lower extremity impairment causally related to his accepted back condition.

Dr. Glenn stated that appellant "allegedly" sustained an injury to his low back. However, his back injury was accepted by the Office. He stated that appellant had experienced back problems for some period of time. Radiographs taken of the lumbar spine on February 1, 2000 demonstrated narrowing of the L5 disc space with degenerative end plate changes which were long-standing changes and predated the April 12, 2001 employment injury. Dr. Glenn stated that an MRI scan revealed a small right disc herniation which could have been present in the past. It is well established that, in determining entitlement to a schedule award, preexisting impairments are to be included.[11] It appears that Dr. Glenn did not understand that preexisting conditions are to be considered in an impairment rating. Therefore his opinion regarding appellant's impairment is of diminished probative value.

Dr. Glenn based his impairment rating on Chapter 15 of the A.M.A., *Guides* which addresses impairment of the spine, rather than using Chapter 17 which addresses lower extremity impairment. Under the Act, a schedule award is not payable for the loss or loss of use of any member of the body or function that is not specifically enumerated in section 8107 of the Act or its implementing regulations.[12] The back is specifically excluded from coverage of the schedule award provisions of the Act.[13] Although a schedule award may not be issued for an impairment to the back under the Act, such an award may be payable for permanent impairment of the lower extremities that is due to an employment-related back condition.[14] Additionally, Chapter 15 provides for determination of impairment based on the "whole person." The Act does not provide for a schedule award based on permanent impairment of the whole person.[15] Therefore, it was inappropriate for Dr. Glenn to evaluate the permanent impairment of appellant's lower extremities by using a section of the A.M.A., *Guides* pertaining to the back alone and by making

[11] *See Lela M. Shaw,* 51 ECAB 372 (2000).

[12] *See Leroy M. Terska,* 53 ECAB 247 (2001).

[13] 5 U.S.C. § 8101(19); *see also Vanessa Young,* 55 ECAB 575 (2004).

[14] *Vanessa Young, supra* note 13; *Gordon G. McNeill,* 42 ECAB 140 (1990).

[15] *Tania R. Keka,* 55 ECAB 354 (2004); *Guiseppe Aversa,* 55 ECAB 164 (2003).

references to whole person impairment.[16] Dr. Glenn should have used Chapter 17 in determining whether appellant had any lower extremity impairment.[17]

In a June 9, 2005 supplemental report, Dr. Glenn stated that appellant no impairment of his lower extremities. However, he did not explain why he did not use Chapter 17 of the A.M.A., *Guides* to determine whether appellant had any lower extremity impairment. As noted, the Office had advised him that the Act did not provide for impairment of the whole person as described in Chapter 15. At this point, the Office should have referred appellant to a second impartial medical specialist.

CONCLUSION

The Board finds that Dr. Glenn's reports are not sufficient to resolve the conflict in the medical opinion evidence. This case must be remanded for further development. On remand, the Office should refer appellant to an appropriate Board-certified specialist for a thorough examination and a well-rationalized determination, based on the fifth edition of the A.M.A., *Guides*, as to whether appellant has any permanent impairment of the lower extremities causally related to his accepted back condition. After such further development as it deems necessary, the Office shall issue a *de novo* decision.

[16] *Guiseppe Aversa, supra* note 15 (the Board found that the impartial medical specialist improperly used Chapter 15 in evaluating right leg impairment caused by a spinal injury).

[17] The introduction to Chapter 17 at page 523 states that this chapter provides criteria for evaluating permanent impairment of the lower extremities. Impairment of the lower extremities is based on anatomic changes, diagnostic categories, and functional changes. A.M.A., *Guides*, 523, 525; *see also* 555, 17.3, Lower Extremity Impairment Evaluation Procedure Summary and Examples.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 21, 2006 is set aside and the case remanded for further development consistent with this decision.

Issued: January 11, 2007
Washington, DC

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

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

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