United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 07-1523**
	)	**Issued: February 13, 2008**
U.S. POSTAL SERVICE, POST OFFICE, Dagsboro, DE, 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
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 14, 2007 appellant, through her attorney, filed a timely appeal from the merit decisions of the Office of Workers' Compensation Programs dated June 2 and December 5, 2006 denying her claim for greater than six percent impairment of the left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant is entitled to a schedule award greater than six percent for her left lower extremity.

On February 22, 2000 appellant, then a 25-year-old rural carrier, filed a traumatic injury claim alleging that, on February 8, 2000, she was picking up a "tub of flats" when she felt a pain in her back, which gradually increased. Although her claim was initially denied, it was subsequently approved by decision dated February 22, 2002 for herniated disc L5-S1 and lumbar surgery. On August 20, 2002 appellant began employment for the State of Delaware Sussex County Correctional Institute as a full-time drug and alcohol counselor.

On April 24, 2003 appellant filed a claim for a schedule award. In support thereof, she submitted a medical report by Dr. Nicholas P. Diamond, an osteopath, wherein he opined that she had reached maximum medical improvement on January 2, 2003. Dr. Diamond diagnosed appellant with L5-S1 herniated nucleus pulposus with free fragment; status post hemilaminectomy and discectomy L5-S1 and chronic residual left S1 radiculopathy. He evaluated her pursuant to the American Medical Association, *Guides to Evaluation of Permanent Impairment* (fifth edition) by noting that, pursuant to Table 17-8, page 532, appellant was entitled to a rating of two percent for 4/5 motor strength deficit left extensor hallucis longus. For the sensory deficit to her left S1 nerve root, she was entitled to four percent impairment pursuant to Table 15-15 and 15-18 of the A.M.A., *Guides*. Dr. Diamond then combined these figures and found that appellant was entitled to six percent impairment for combined left lower extremity. He then added four percent for pain-related impairment pursuant to Figure 18-1 on page 574 of the A.M.A., *Guides*. Combining these figures, Dr. Diamond determined that appellant was entitled to nine percent impairment of her left lower extremity.

On September 3, 2003 the Office forwarded the report of Dr. Diamond to the Office medical adviser and asked if he agreed with the rating. He responded by indicating that he did not completely agree with Dr. Diamond's assessment. The medical adviser noted that the A.M.A., *Guides* at Table 15-18 on page 424 includes pain and loss in the sensation rating, and that therefore, Dr. Diamond duplicated the pain rating by listing it separately. Therefore, using Dr. Diamond's figures for sensory and motor impairment, he found that appellant was entitled to a schedule award based on a six percent impairment of the left lower extremity. The medical adviser also listed the date of maximum medical improvement as January 2, 2003 as per the report of Dr. Diamond.

By decision dated October 6, 2003, the Office issued a schedule award for six percent loss of use of the left leg. It found that appellant reached maximum medical improvement on January 2, 2003.

By letter dated October 7, 2003, appellant requested a hearing.

In a medical report dated June 24, 2004, Dr. David Weiss, an osteopath, argued that although the four percent impairment due to sensory deficit in the left S1 nerve roots does encompass pain, pursuant to the A.M.A., *Guides*, page 574, Figure 18-1, if pain-related impairment appears to increase the burning of the individuals condition slightly, the examiner can increase the percentage found by up to three percent. He noted after reviewing appellant's chart that she was unable to perform gainful employment as a postal employee and noted other difficulties including difficulties with household chores, sleep difficulties and prolonged sitting, standing and walking. Dr. Weiss noted that she has difficulties with repetitive bending, lifting and twisting and difficulty with prior hobbies. He opined that appellant should be entitled to an additional three percent impairment for pain.

In a decision dated August 20, 2004, the hearing representative found that a conflict existed between appellant's physician and the Office medical adviser over the level of appellant's impairment and remanded the case for the Office to refer appellant to an impartial medical examiner.

By letter dated April 18, 2005, the Office referred appellant to Dr. Charles A. Mauriello for an impartial medical examination. In a medical report dated June 23, 2005, he indicated that appellant was not at maximum medical improvement. Dr. Mauriello noted that, if one were to adhere strictly to the A.M.A., *Guides*, a permanency rating should not be issued at this time. He recommended further diagnostic studies. However, Dr. Mauriello noted:

> "If one were to require an impairment rating at this time, and at times that would be required by jurisdiction, there would be a nine percent permanent partial impairment to the left lower extremity secondary to her work activities. I understand that the impairment rating to the spine would not be rendered but rather to the left lower extremity. It should be noted, through, she does have objective findings on physical examination to support the subjective complaints. Consider:
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> > (a) Five percent permanent partial impairment to the left lower extremity secondary to the mild, left thigh atrophy (Table 17-6, [p]age 530). The range would be three to eight percent impairment to the lower extremity. Given this clinical picture, I would pick just shy of the mid line at the lower edge which would equate to the five percent impairment.
> >
> > (b) Four percent permanent partial impairment to the left lower extremity secondary to sensory loss (Table 15-15, [p]age 424). Consider:
> >
> > - She would fall within the Grade 2 because of her decreased sensation and abnormal sensations with hypersensitivity that may interfere with some activities. This would be in the range of 61 [to] 80 percent deficit. Given her clinical picture, I would place her at the higher level.
> >
> > - The S1 root would be the culprit causing this problem secondary to the herniated lumbosacral disc to the left. The maximum loss for the S1 root because of a sensory deficit pain would be five percent (Table 15-18, [p]age 424).
> >
> > - Eighty percent of the maximum five percent equates to four percent impairment because of the sensory aberration.
> >
> > - The five percent secondary to the mild atrophy would be combined with the four percent due to sensory loss and that equates to nine percent impairment.

By memoranda dated July 15, 2005, the Office asked its medical adviser if he concurred with Dr. Mauriello's impairment rating of June 23, 2005. The Office medical adviser responded:

> "Dr. Mauriello noted atrophy of the left lower extremity and on the basis of that, he recommended a scheduled award for left lower extremity atrophy. He then

went on to make recommendations for left lower extremity sensory loss based on peripheral nerve injury.

"Accordingly to the [A.M.A., *Guides*] page 526, [T]able 17-2, it is not permitted to make a scheduled award for atrophy in the presence of an award for peripheral nerve injury. Therefore, the scheduled award for atrophy is negated.

"In regards to the scheduled award for sensory loss of the left lower extremity, page 424, [T]able 15-15 for S1 reduction in sensation, Dr. Mauriello concluded that this should fall within a [G]rade 2 award. This could be debated in regards to the [G]rade 2 determination, and it could be argued there is at least some evidence that it would be deserving of a [G]rade 3 or 4, *i.e.*, reduced award.

"However, we will suggest agreeing with his judgment with regards to [G]rade 2 award and an 80 percent deficit. Based upon the S1 deficit, [T]able 15-18, page 424, the maximum sensory loss for S1 is five percent. Therefore, 80 percent of 5 percent equals 4 percent.

"It would, therefore, be my recommendation that [appellant] receive a scheduled award of four percent impairment of the left lower extremity."

By letter dated May 11, 2006, the Office asked Dr. Mauriello for a clarification of his report. Specifically, the Office noted that the A.M.A., *Guides*, indicate that it is not appropriate to make a schedule award for atrophy in the presence of an award for peripheral nerve injury, and that therefore, it appeared that appellant would only be entitled to a four percent award due to sensory aberration.

By letter dated May 15, 2006, Dr. Mauriello noted that he gave no impairment rating for a sensory deficit because of a peripheral nerve injury. He noted that appellant had symptoms in the left lower extremity secondary to a nerve root symptom and that this was not a peripheral nerve injury. Dr. Mauriello noted that the impairment rating he rendered was for the S1 nerve root and was according to the spine protocol in Chapter 15. He then stated:

"The atrophy which I noted in the extremity was not secondary to a peripheral nerve injury but rather to a root injury. The nerve root injury has affected her left lower extremity and my impairment rating as outlined in my [June 23, 2005] report would stand at a nine percent impairment rating to the left lower extremity. There would be no overlap of ratings because of the findings in the left lower extremity. Clinically, there are findings in the left lower extremity to account for this symptomatology to include the objective finding of atrophy and the objective finding of an absent Achilles reflex."

By letter dated May 23, 2006, the Office referred appellant's file to the Office medical adviser. In a report dated May 23, 2006, the Office medical adviser indicated that it was very

clear that muscle atrophy cannot be combined with peripheral nerve injury and therefore Dr. Mauriello was incorrect. He noted:

> "Upon reviewing Dr. Mauriello's [May 15, 2006] letter, my comments are as follows:
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> > On page 1, item 1, he states that this individual did not have a peripheral nerve injury, however, the nerve roots are treated as peripheral nerves as determined by the rules of the [A.M.A., *Guides*]. Therefore, nerve roots and peripheral nerves are one and the same as it relates to calculation of this schedule award.
> >
> > Item number 2 of the [May 15, 2006] letter, it is true that this nerve root injury is not a peripheral nerve injury, however, this individual does have an impairment of the S1 nerve root. By definition [the Office] requires that the nerve roots be calculated in the same context as peripheral nerves utilizing the [A.M.A., *Guides*]. This indicates that there is compression of the nerve root. This is further documented by the absence of the left Achilles reflex.
> >
> > Therefore, we are in agreement that there is damage to the S1 nerve root on the left, and I am therefore, in basic agreement with item 2, page 1 of Dr. Mauriello's report.
> >
> > Item number 3 of Dr. Mauriello's report, we are in agreement with the four percent impairment of the S1 nerve root in Dr. Mauriello's original report of [June 23, 2005]. However, I stated in my previous letter of [July 15, 2005] that the decision to use [G]rade 2 is debatable and represents what could be interpreted to be a generous schedule award for this claimant.
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> > Item number 4 on page 2 of Dr. Mauriello's report, [May 15, 2006], again tries to differentiate peripheral nerve root injury from a nerve root injury. These are treated the same and are required to follow the same rules whether there be peripheral nerve or nerve root. Therefore, Dr. Mauriello was incorrect in utilizing the atrophy to total 9 percent. Instead, the award should be a total of 4 percent left lower extremity impairment."

In a decision dated June 2, 2006, the Office found that appellant was only entitled to a schedule award of 4 percent of the lower extremity.

By letter dated June 6, 2006, the Office requested a hearing. At the hearing held on October 25, 2006, appellant's attorney argued that the weight should go to the opinion of the impartial medical examiner, not the Office medical adviser.

In a decision dated December 5, 2006, the hearing representative affirmed the Office's decision, finding that the weight of the evidence rested with the Office medical adviser as he properly applied the A.M.A., *Guides.*

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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.[3]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[4] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[5] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[6] The functional method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[7] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[8] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[9] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[10]

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

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[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] *Id.*

[4] A.M.A., *Guides* 525.

[5] *Id.*

[6] *Id.*

[7] *Id.* at 525, Table 17-1.

[8] *Id*. at 548, 555.

[9] *Id*. at 526.

[10] *Id.* at 527, 555.

Labor shall appoint a third physician who shall make an examination.[11] 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.[12]

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.[13] 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.[14] 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.[15]

ANALYSIS

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

In the instant case, a conflict arose between the opinion of appellant's physician Dr. Diamond and the Office medical adviser with regard to the amount of the schedule award. In order to resolve the conflict, the Office referred appellant to Dr. Mauriello for an impartial medical examination. Dr. Mauriello recommended nine percent impairment to appellant's left lower extremity. He calculated four percent for sensory loss and five percent for mild trophy. When the Office referred the case to the Office medical adviser, he noted that, according to the A.M.A., *Guides*, it is not permitted to make a schedule award for atrophy in the presence of a peripheral nerve injury, and that therefore the schedule award for atrophy was negated. Due to the Office medical adviser's comments, the Office asked Dr. Mauriello for clarification. Dr. Mauriello indicated that he gave no impairment rating for a sensory deficit because of a peripheral nerve injury but that his award was based on the S1 nerve root, and that therefore there would be no overlap of ratings. The Office medical adviser disagreed. He noted that nerve roots and peripheral nerves are one and the same in calculating schedule awards. Therefore, the Office medical adviser noted that Dr. Mauriello was incorrect in utilizing atrophy to yield a total schedule award of nine percent. The Office medical adviser correctly noted that, pursuant to the A.M.A., *Guides*, one may not allow a percentage for atrophy in the presence of an award for

[11] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusingnan (Henry Lusingnan)*, 45 ECAB 207 (1993).

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

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

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

[15] *Roger W. Griffith*, *supra* note 14; *Harold Travis*, 30 ECAB 1071 (1979).

peripheral nerve injury.[16] He also persuasively explained that the A.M.A., *Guides* prevent distinguishing nerve roots from peripheral roots and that they are to be considered one and the same when evaluating entitlement to a schedule award. Therefore, Dr. Mauriello's opinion is deficient and the conflict in the medical evidence has not been resolved.

CONCLUSION

The Board finds that this case is not in posture for decision. On remand, the Office should refer appellant, together with the case record and statement of accepted facts, to another Board-certified specialist for an impartial medical evaluation of appellant's permanent impairment. After such further development as the Office deems necessary, it should issue an appropriate decision on the merits of the schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated December 5 and June 2, 2006 are set aside and the case remanded for further action consistent with this decision.

Issued: February 13, 2008
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

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