United States Department of Labor
Employees' Compensation Appeals Board

H.D., Appellant	)	
and	)	**Docket No. 07-1661**
	)	**Issued: March 11, 2008**
U.S. POSTAL SERVICE, LOYOLA STATION, New Orleans, LA, Employer	)	

Appearances:
Appellant, pro se
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 June 7, 2007 appellant filed a timely appeal from the May 21, 2007 decision of an Office of Workers' Compensation Programs' hearing representative affirming the August 31, 2006 denial of his claim for an increased 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 established that he has an employment-related permanent impairment of his lower extremities which would entitle him to a schedule award.

FACTUAL HISTORY

On January 4, 2000 appellant sustained lumbar strain, right carpal tunnel syndrome, right shoulder strain and right hand contusion when he grabbed a falling container with his right hand.

On July 25, 2002 appellant requested a schedule award. On July 22, 2002 Dr. Sofjan Lamid, a Board-certified physiatrist, found that appellant had a reduction of 75 percent in his right hand grip and a decreased pinprick sensation in the right median nerve distribution distal to

his right wrist. There were positive Phalen's and Tinel's signs in the right hand. Appellant had full range of motion in the thoracolumbar spine, but had pain in the paralumbar spine and pain radiating in the left leg. His right shoulder had a restricted range of motion with pain, tenderness and spasms in the deltoid muscles. Dr. Lamid diagnosed employment-related right carpal tunnel syndrome, facet spurring at L4-5 and L5-S1, disc bulging at L5-S1, bilateral sural neuropathy, left posterior tibial neuropathy and right shoulder strain. He found that appellant reached maximum medical improvement on April 2, 2002.

Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed., 2001), Dr. Lamid found reduced range of motion in appellant's right wrist and shoulder. He stated that Figure 16-26, page 466, and Table 16-3, page 439, indicated 14 percent right arm impairment for the 30 percent flexion and 30 percent extension of the right wrist. Based on Figure 16-42, page 477, and Table 16-3, page 439, Dr. Lamid assigned six percent right arm impairment for appellant's right shoulder abduction to 100 degrees and adduction to 0 degrees. Using Table 16-3, page 439, he found four percent right arm impairment for appellant's 40 degrees of right shoulder internal rotation and 50 degrees of external rotation. Dr. Lamid also assigned permanent impairment due to motor and sensory loss. He found 30 percent arm impairment for motor and sensory loss in the median nerve below the right wrist using Table 16-15, page 492, and Table 16-3, page 439. Dr. Lamid stated that, according to Table 17-37, page 552, appellant had four percent whole person impairment for the loss of sensation and dysesthesia of the sural nerve bilaterally and four percent whole person impairment for loss of motor and sensory functions of the left posterior tibial nerve. He found that appellant had a total whole person impairment of 35 percent based on the A.M.A., *Guides*, Combined Values Chart, page 604.

On April 27, 2004 an Office medical adviser, Dr. Ronald Blum, found that Dr. Lamid's report was an insufficient basis for a schedule award because it incorrectly applied the A.M.A., *Guides*, and did not provide adequate descriptions of objective findings.

On July 16, 2004 appellant underwent a second opinion examination by Dr. Stephen Kishner, a Board-certified physiatrist, who reported numbness and tingling on his thumb and wrist, and pain in his lower back, upper back, neck and right shoulder. Dr. Kishner found that appellant had normal strength in his lower extremities and a negative straight leg raising test bilaterally. He noted that appellant had no reflexes in his knees or ankles and that he had decreased sensation in a stocking distribution up to his mid-shin bilaterally. Dr. Kishner found that appellant had full range of motion in all of his upper extremity joints, though there was pain on resistive and active abduction of the right shoulder. Appellant had a severe laxity of the ulnar collateral ligament of the right thumb at the metacarpophalangeal joint and decreased sensation in the right superficial radial sensory nerve distribution. His upper extremity strength was normal in all areas other than the right thumb, but he had no reflexes in either arm.

Dr. Kishner diagnosed rotator cuff disease in the right shoulder, though appellant had normal strength and range of motion at that joint. He also diagnosed an ulnar collateral ligament injury and a right radial sensory nerve injury. Dr. Kishner stated that appellant's lower extremity peripheral neuropathy was likely secondary to his diabetes. Using Table 16-15, page 492, of the A.M.A., *Guides*, he found that appellant's radial sensory nerve injury, with pain, rated a five percent upper extremity impairment. The 35 degree excess radial deviation of the right thumb

metacarpophalangeal joint, due to the ulnar collateral ligament injury, yielded three percent upper extremity impairment. This result was arrived at by multiplying 9 percent, from Table 16-18, page 499, by 30 percent, from Table 16-20, page 500. Dr. Kishner rated appellant's lower extremity impairments using Table 17-37, page 552. He found that the loss of sensation rated five percent permanent impairment in the superficial peroneal nerve, two percent for the sural nerve, five percent for the medial plantar, and five percent for the lateral plantar in each leg. Using the Combined Values Chart, page 604, Dr. Kishner rated the right upper extremity impairment as 8 percent and the lower extremity impairments as 17 percent for each leg.

On August 5, 2004 Dr. H. Mobley, an Office medical adviser, reviewed the medical record and found that appellant had reached maximum medical improvement on July 16, 2004. He concurred with Dr. Kishner's findings, but found that appellant had 80 percent, rather than 100 percent, impairment related with the pain and sensory deficit of the right radial nerve below the elbow at the wrist. Therefore, the total right upper extremity rating was seven percent, rather than eight percent. As diabetes was not accepted by the Office, Dr. Mobley found that appellant's lower extremity impairment ratings were not employment related.

By decision dated September 2, 2004, the Office granted appellant a schedule award for the seven percent impairment of his right upper extremity for 21.84 weeks for the period September 5, 2004 to February 4, 2005.

On September 7, 2004 appellant requested a review of the written record by an Office hearing representative. He stated that he should have been awarded a schedule award for his lower extremities, contending that his lower extremity neuropathy was related to his lumbar condition.

On September 29, 2004 Dr. Bryant George, a Board-certified neurological surgeon, evaluated appellant for complaints of lumbar pain with radiation into his left hip and leg. He noted that appellant's lumbar range of motion was decreased in all planes and that he had palpable paravertebral lumbar muscle spasms. Dr. George stated that the straight leg raising (SLR) maneuver was negative, and that sensory examination was normal. He found normal strength and tone in all lower extremity muscle groups, normal gait, and no evidence of atrophy or fasciculation. Appellant had symmetrical reflexes of 1+ in his legs. Dr. George noted that a 2000 magnetic resonance imaging (MRI) scan showed mild multilevel spondylosis. He diagnosed lumbar spondylosis with radiculopathy. Dr. George recommended that appellant undergo another MRI scan and that he be placed on total disability until more diagnostic testing was done.

On October 19, 2004 an MRI scan of appellant's spine revealed no evidence of spondylolysis or spondylolisthesis. The lumbar vertebral bodies were of normal alignment, height and signal intensity. There was mild dehydration at L3-4 and mild to moderate degenerative facet joint arthropathy at L5-S1.

By decision dated February 14, 2005, the Office hearing representative modified appellant's schedule award to eight percent, in accordance with the opinion of Dr. Kishner. Noting that the Office had issued no formal opinion on appellant's claimed lower extremity impairment she remanded the case for appropriate action on this issue.

On February 21, 2005 after reviewing appellant's updated MRI scan results, Dr. George stated that appellant was not a candidate for neurosurgery treatment and referred appellant for pain management with Dr. Rand Metoyer, a Board-certified anesthesiologist. On March 15, 2005 Dr. Metoyer noted mild limitations to lumber extension and lateral flexion and tenderness to light palpitation throughout the lumbar paraspinous musculature. He diagnosed chronic lower back pain, degenerative disc disease, myofascial pain, mild facet athropathy at L5-S1 and psychological factors affecting his physical condition.

On March 31, 2005 Dr. Blum, an Office medical adviser, reviewed appellant's medical record and found that appellant was not entitled to a schedule award for his lower extremity condition. He noted that Dr. Kishner attributed appellant's neuropathy to diabetes, which was not an accepted condition.

By decision dated April 22, 2005, the Office denied appellant's claim for a schedule award for his lower extremities. The Office noted that Dr. Kishner and Dr. Blum found that appellant's lower extremity condition was unrelated to his accepted conditions.

On April 26, 2005 appellant requested a review of the written record.

By decision dated January 19, 2006, the Office hearing representative set aside the April 22, 2005 decision and remanded the case for further development. A conflict of medical opinion was found between Drs. George and Lamid and Dr. Kishner on the issue of whether there was an employment-related impairment to appellant's lower extremities. In accordance with the hearing representative's decision, on February 1, 2006 the Office updated the statement of accepted facts. On February 8, 2006 it combined the file from the instant claim, File No. 162010130, with File No. 160346776, which was based on the same accepted employment injury.

On July 11, 2006 Dr. John Andrew, a Board-certified orthopedic surgeon selected as the impartial medical specialist, examined appellant and conducted a review of the medical evidence. He diagnosed Type II diabetes mellitus with peripheral neuritis of both upper and lower extremities. At the examination, appellant reported that he had back pain radiating down both lower extremities in a stocking-type distribution. He described intermittent shocking sensations, generally after rising from sitting, which radiated into both sides of the buttocks and the ankles. The radiating pain in appellant's legs was aggravated by prolonged walking or climbing stairs and relieved by sitting down. He reported weakness and numbness in his right hand and right shoulder. On physical examination, Dr. Andrew found that appellant's back was straight and that he had inconsistent findings in all range of motion studies. From standing, appellant was limited by pain from bending his back more than 50 degrees or flexing his hips more than 30 degrees. From lying down, he could not perform an active straight leg raising test because he could not flex his hips beyond 0 degrees without pain. Appellant stated that there was extreme back pain on the recumbent passive straight leg raising test when his leg was lifted beyond 30 degrees. When sitting on the table, however, he complained of no pain when his hips were flexed to 90 degrees and his knees were at both 90 and 180 degrees. Dr. Andrew found a full passive range of motion in all the joints in the upper extremities. Because appellant had a negative Phalen's test on the right, he found no clinical evidence of right carpal tunnel syndrome. Dr. Andrew found no significant atrophy in any extremities. He noted inconsistent sensory

findings in both the upper and lower extremities, but found that, when findings did occur, they appeared in a circumferential distribution. Dr. Andrew stated that this was an indication that the neuropathy was related to diabetes and not radiculitis. He found that all the deep tendon reflexes were markedly diminished in upper and lower extremities.

Dr. Andrew found that there was no evidence of a significant back injury in the medical record. He noted that appellant appeared to exaggerate most of his symptoms, making it difficult to describe objective findings. Dr. Andrew noted no measurable muscle atrophy or joint ankylosis. He stated that the sensory changes noted were in a glove or stocking-type distribution, which is characteristic of peripheral neuritis related to diabetes. Dr. Andrew made no sensory findings that were suggestive of radiculopathy. He found that appellant's subjective complaints "did not fit the picture of any significant injury" and were not due to any anatomical problem. Because Dr. Andrew found no evidence of impairment related to the accepted injury, he provided an impairment rating of zero for appellant's lower extremities.

On August 22, 2006 Dr. Mobley, an Office medical adviser, stated that appellant's date of maximum medical improvement was July 11, 2006. He concurred with Dr. Andrew's opinion that appellant had no lower extremity impairment related to his accepted employment injuries.

By decision dated August 31, 2006, the Office denied appellant's claim for a schedule award for his lower extremities. The Office found that Dr. Andrew's opinion carried the weight of the medical evidence and established that appellant had no employment-related impairment to his lower extremities.

On September 11, 2006 appellant requested an oral hearing, which was held on April 3, 2007. He stated that he retired from the employing establishment in September 2006 and provided a description of his previous employment activities and injuries. Appellant stated that his lower extremity pain was intermittent, but worsening.

By decision dated May 21, 2007, the Office hearing representative affirmed the August 31, 2006 decision. He found that the Office properly relied on Dr. Andrew's medical opinion that appellant had no lower extremity impairment associated with his employment.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] 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 should 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* as the uniform standards applicable to all claimants.[3]

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404.

[3] 20 C.F.R. § 10.404(a).

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.[4]

The standards for evaluation of the permanent impairment of an extremity under the A.M.A., *Guides* are based on loss of range of motion, together with all factors that prevent a limb from functioning normally, such as pain, sensory deficit and loss of strength. All of the factors should be considered together in evaluating the degree of permanent impairment.[5]

The Act provides that, if there is a disagreement between a physician making an examination for the United States and the physician of the employee, the Secretary must appoint a third physician to make an examination.[6] Likewise, the implementing regulation states that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office must appoint a third physician to make an examination. This is called a referee examination and the Office is required to select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[7] It is well established that, when 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 proper factual and medical background, must be given special weight.[8]

ANALYSIS

The Office accepted appellant's claim for lumbar strain, right carpal tunnel syndrome, right shoulder strain and right hand contusion. The Office issued a schedule award for eight percent impairment of appellant's upper right extremity, but denied his claim for a lower extremity schedule award. The issue is whether appellant has established that he has permanent impairment in his lower extremities causally related to his accepted injuries.

The Office properly found that there was a conflict of medical opinion between Dr. Lamid and Dr. Kishner, both Board-certified physiatrists, as to whether appellant's lower extremity condition was causally related to his accepted injuries. To resolve this conflict, the Office referred appellant to an impartial medical examiner, Dr. John Andrew, a Board-certified orthopedic surgeon.

On July 11, 2006 Dr. Andrew reviewed the medical evidence and examined appellant, who reported back pain radiating down both legs and intermittent shocking sensations that radiated into both sides of the buttocks and the ankles. The radiating pain was aggravated by prolonged walking or climbing stairs and the shocking sensation was related to rising to a

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

[5] *Paul A. Toms*, 28 ECAB 403 (1987).

[6] 5 U.S.C. §§ 8101-8193, 8123(a).

[7] 20 C.F.R. § 10.321.

[8] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

standing position. On physical examination, Dr. Andrew found that appellant had inconsistent findings in the back range of motion studies. He found no significant atrophy, but noted that all the deep tendon reflexes were markedly diminished in upper and lower extremities. Dr. Andrew stated that there were inconsistent sensory findings in the extremities, but that, when they did occur, they appeared in a circumferential distribution, an indication that the neuropathy was related to diabetes rather than radiculitis. He diagnosed Type II diabetes mellitus with peripheral neuritis in the lower extremities. Dr. Andrew found that there was no evidence of a significant back injury in the medical record and that appellant appeared to exaggerate most of his symptoms, which made it difficult to describe objective findings. He noted no measurable muscle atrophy or joint ankylosis. Dr. Andrew found that appellant's sensory changes occurred in a glove or stocking-type distribution, which is characteristic of peripheral neuritis related to diabetes. He made no sensory findings that were suggestive of radiculopathy. Dr. Andrew concluded that appellant's subjective complaints "did not fit the picture of any significant injury," that they were not due to any anatomical problem and that there was no impairment related to the accepted employment injury. He found no evidence of any impairment of the lower extremity related to the accepted injury. Dr. Andrew provided an impairment rating of zero percent for appellant's lower extremities. The Board finds that his medical opinion is sufficient to carry the special weight of the medical opinion evidence because it is well rationalized and based on proper factual and medical background. The Office properly relied on this medical opinion in denying appellant's claim of a schedule award for his lower extremities.

The Board finds that because appellant did not submit any medical evidence sufficient to overcome the special weight of Dr. Andrew's opinion. He has not established that he is entitled to a schedule award for his lower extremities.

CONCLUSION

The Board finds that appellant has not established that he has any employment-related impairment of his lower extremities which would entitle him to a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated May 21, 2007 and August 31, 2006 are affirmed.

Issued: March 11, 2008
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