United States Department of Labor
Employees' Compensation Appeals Board

L.F., Appellant	)	
and	)	**Docket No. 07-2035**
	)	**Issued: May 22, 2008**
DEPARTMENT OF DEFENSE, DEFENSE SUPPLY CENTER, Philadelphia, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 30, 2007 appellant filed a timely appeal from a July 17, 2007 merit decision of the Office of Workers' Compensation Programs that denied his request for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

ISSUES

The issues are: (1) whether appellant met his burden of proof in establishing that he developed erectile dysfunction causally related to his June 9, 1999 employment injury; and (2) whether appellant has more than 28 percent permanent impairment of the right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On June 9, 1999 appellant, then a 48-year-old logistics business specialist, injured his right back, thigh, groin and hip area while playing softball at an annual picnic. He stopped work on June 9, 1999 and returned to work on August 30, 1999. A June 14, 1999 magnetic resonance

imaging (MRI) scan of his right thigh revealed a hamstring muscle strain, possible partial tear of the semitendinosus, semimembranosus and biceps femoris strain with soft tissue contusion/edema. The Office accepted appellant's claim for right hamstring tear, right knee meniscus tear and L5-S1 herniated disc. On September 29, 2000 appellant underwent an approved partial medial meniscectomy and eventually returned to full duty.

On June 27, 2003 appellant claimed a schedule award. In an October 28, 2003 report, Dr. Edward J. Resnick, a Board-certified orthopedic surgeon, noted appellant's complaints of right leg weakness and atrophy with right hamstring and foot numbness. On examination, he found normal hip and knee range of motion but noted that appellant's right lateral hamstring tendons were almost completely atrophied. Dr. Resnick concluded that appellant's June 9, 1999 injury, which consisted of partial ruptures and nerve damage in the hamstring and calf muscles, caused his atrophy and weakness. He concluded that appellant's physical impairment had become "static and permanent."

On November 14, 2003 an Office medical adviser reviewed Dr. Resnick's report and applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) fifth edition.[1] The medical adviser applied Table 17-6[2] to find that, based on Dr. Resnick's measurements of appellant's calf and thigh, he had 13 percent impairment for right thigh atrophy and 13 percent impairment for right calf atrophy. Based on Table 17-37,[3] he rated sensory loss at four percent impairment of the common peroneal nerve based on a grade four (80 percent) deficit. Based on Table 17-33,[4] he noted two percent impairment for appellant's meniscectomy. Upon combining these values, the medical adviser concluded that appellant had a 28 percent total impairment of the right leg.[5] He determined that appellant reached maximum medical improvement as of October 28, 2003, the date of Dr. Resnick's report.

By decision dated November 18, 2003, the Office granted appellant a schedule award for 28 percent permanent impairment of the right leg. The period of the award covered 80.64 weeks of compensation and ran from October 28, 2003 to May 14, 2005.

In an August 1, 2005 report, Dr. George L. Rodriguez, a Board-certified physiatrist, noted appellant's complaints of low back pain radiating to the right leg, knee pain, right leg weakness and erectile dysfunction. He reviewed appellant's history and noted that his schedule award did not account for discogenic radiculopathy, right knee arthritis or erectile dysfunction. Dr. Rodriguez diagnosed semitendinosus muscle tear, semimembranosus and biceps femoris muscle sprain, right medial meniscus tear, knee arthritis, lumbar herniated nucleus pulposis, lumbosacral radiculopathy and erectile dysfunction. On examination he found that appellant's

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

[2] *Id.* at 530, Table 17-6.

[3] *Id.* at 552, Table 17-37, which provides a maximum of five percent impairment for sensory loss of the common peroneal nerve.

[4] *Id.* at 546, Table 17-33.

[5] The Board notes that the medical adviser did not address Table 17-2 on page 526 of the A.M.A., *Guides*, which precludes combining impairment ratings for atrophy with ratings for sensory loss and diagnosis based estimates.

right thigh measured two centimeters smaller than his left thigh and his right calf measured six centimeters smaller than his left calf. Dr. Rodriguez also noted that sensation was absent from the right L5 and S1 nerve distribution in appellant's ankle and foot. He concluded that appellant had 20 percent impairment of the right leg for arthritis under Table 17-31[6] and his measurement of a two millimeter cartilage interval and 40 percent impairment of the right leg for sciatic nerve motor deficit, under Tables 16-11[7] and 17-37.[8] Dr. Rodriguez found a total of 52 percent impairment of the right leg and asserted that, taking into account the 28 percent schedule award previously granted, stated that appellant was entitled to an additional schedule award for 37 percent impairment of the right leg. He also determined that appellant had 35 percent impairment of the penis for erectile dysfunction based on Table 7-5[9] of the A.M.A., *Guides* and on the Office's procedures.[10] Dr. Rodriguez advised that appellant reached maximum medical improvement on December 31, 1999.

On August 10, 2005 appellant requested an additional schedule award.

In an undated report, an Office medical adviser reviewed Dr. Rodriguez' August 12, 2005 impairment rating and concluded that appellant did not have more than 28 percent impairment, as previously rated. He noted that Dr. Rodriguez calculated weakness based on the entire sciatic nerve but that the entire nerve was not implicated. The medical adviser also explained that the record did not support 20 percent impairment rating based on right knee arthritis and that the Office had not accepted erectile dysfunction as work related.

On March 2, 2006 the Office referred appellant to Dr. Steven Valentino, an osteopath, for a second opinion concerning the degree of permanent impairment. In a March 21, 2006 report, Dr. Valentino noted appellant's complaints of right foot numbness and weakness and occasional low back pain but indicated that he denied any other weakness, paresthesias, bowel or bladder dysfunction. He found that appellant had full and normal range of motion of the hips, knees, ankles and feet as well as a normal hamstring examination. Dr. Valentino stated that appellant's thighs were equivalent in circumference and that his right calf measured one and a half inches smaller than his left calf. He diagnosed right sciatica, status post internal derangement of the right knee and resolved right hamstring injury. Dr. Valentino concluded that appellant had 17 percent permanent impairment of the right lower extremity based on Table 17-8[11] of the A.M.A., *Guides*. Appellant had some "weakness of the ankle plantar flexors graded as four out of five." In a work capacity evaluation prepared the same day, Dr. Valentino advised that appellant was capable of performing full-duty work without restrictions.

[6] *Id.* at 544, Table 17-31.

[7] *Id.* at 484, Table 16-11.

[8] *Id.* at 552, Table 17-37.

[9] *Id.* at 156, Table 7-5.

[10] Federal (FECA) Procedure Manual, Part 3 -- *Medical*, *Schedule Award*, Chapter 3.0700.4(c)(2) (March 2005).

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

On April 4, 2006 the Office scheduled appellant for an evaluation by Dr. Marc I. Schwarzman, a urologist. In an April 21, 2006 report, Dr. Schwarzman noted appellant's complaints of five and a half years of progressive erectile dysfunction. He indicated that appellant denied depression or anxiety but stated that he was upset at being limited physically by his right leg weakness. Dr. Schwarzman advised that appellant's erectile dysfunction may have been caused by a number of factors, particularly his history of hyperlipidemia and cigarette smoking, which likely caused atherosclerotic vascular disease. He stated that "traumatic arterial injury causing erectile dysfunction is unlikely in the absence of a severe pelvic fracture," which appellant did not sustain. Dr. Schwarzman also noted that appellant's injury was sustained at the L5-S1 nerve root, whereas the pudendal nerve stimulating erections was located at the S2-4 levels. He explained, moreover, that erectile dysfunction with neurologic roots generally responded well to oral or injection medication, while appellant's erectile dysfunction had not. Moreover, the commencement of his erectile dysfunction occurred a year and a half after his injury, rather than concurrently with his nerve root injury. Therefore, Dr. Schwarzman opined that appellant's erectile dysfunction was not related to the June 9, 1999 work injury.

In an August 4, 2006 report, Dr. Guy T. Bernstein, a treating Board-certified urologist, noted appellant's progressive sensory motor deficit in the right lower extremity. He stated that his progressive symptoms of sexual dysfunction may be explained from this nerve impairment.

On September 27, 2006 the Office found a conflict in the medical evidence between Dr. Rodriguez and Dr. Valentino concerning the extent of appellant's work-related right leg impairment. The Office also found a conflict in medical opinion between Dr. Rodriguez and Dr. Schwarzman concerning whether appellant had any employment-related erectile dysfunction. On October 20, 2006 the Office referred appellant to Dr. Barry J. Snyder, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict concerning his right leg impairment. On October 31, 2006 the Office referred appellant to Dr. Frank L. D'Elia, a Board-certified urologist, for an impartial medical examination to resolve the medical conflict concerning any work-related erectile dysfunction.

In a December 4, 2006 report, Dr. D'Elia noted appellant's history, beginning in 2001, of gradual difficulty attaining and sustaining erections. He explained that he had reviewed the reports of Dr. Schwarzman and Dr. Rodriguez. On physical examination, Dr. D'Elia noted marked atrophy of the right thigh and testicle, with decreased sensation of the anterior right thigh. However, he found that the penis, left thigh and scrotum were normal. Dr. D'Elia explained that his physical examination and review of the diagnostic reports did not reveal evidence of any nerve injury at the S2-4 levels, which were the relevant nerve levels. He noted that appellant had a history of low serum testosterone, elevated cholesterol and lipids, smoking and grossly abnormal atrophic testicles, all of which contributed to his erectile dysfunction, if indeed he had the condition. Dr. D'Elia also explained that neurologic impotence secondary to disc disease is generally a sudden phenomenon. He concluded that the evidence did not support that appellant's erectile dysfunction was caused by his work injury.

In a March 2, 2007 report, Dr. Snyder noted examining appellant on November 21, 2006. On physical examination, he noted that appellant's right thigh measured three and a half centimeters smaller than his left thigh and his right calf measured five and a half centimeters smaller than his left calf. Dr. Snyder diagnosed multilevel degenerative disc disease with L5-S1

disc displacement and possible radiculopathy, possible sciatic neuropathy and resolved right hamstring strain. He noted that appellant's abnormal physical examination, which revealed absence of sensation in the right Achilles' reflex and marked atrophy in the right lower extremity, seemed likely related to his 1999 work injury and resulting S1 radiculopathy. Dr. Snyder advised that appellant had reached maximum medical improvement and had a combined total of 38 percent whole person impairment. He arrived at this percentage by finding that, under the A.M.A., *Guides*, appellant had 7 percent whole person impairment for weakness and loss of range of motion of the right knee, 4 percent impairment of the whole person for sensory deficit and weakness of the S1 nerve root and 5 percent impairment of the whole person for loss of plantar flexion of the right ankle and toes, that combined to equal 15 percent whole person impairment. Dr. Snyder combined this with seven percent impairment of the whole person for degenerative changes to an intervertebral disc and one percent impairment for the severity of herniation. He also combined 10 percent whole person impairment for leg atrophy, 5 percent for the right thigh and 5 percent for the right lower leg. Dr. Snyder then combined 11 percent whole person impairment for loss of lumbar spine ranges of motion, to total 38 percent whole person impairment. He stated that appellant's right knee arthroscopic surgery resulted in no residual impairment.

On March 23, 2007 the Office medical adviser reviewed the record, including Dr. Snyder's impairment rating. He noted that the accepted conditions included unspecified right knee and leg sprains and displacement of lumbar intervertebral disc without myelopathy. The medical adviser explained that valid impairment deficits included atrophy of the right thigh and calf, right ankle flexion weakness, right S1 sensory deficit and right knee partial medial meniscectomy. He found that the largest available impairment rating was 24 percent impairment of the right lower extremity based on atrophy of the right thigh and calf, for which he applied the measurements obtained by Dr. Snyder and Dr. Rodriguez. Because the atrophy impairment could not be combined with other impairment ratings pursuant to Table 17-2 on page 526 of the A.M.A., *Guides*,[12] the medical adviser concluded that the atrophy impairment, being the largest value, was the most appropriate impairment rating. He concluded that appellant did not have more than the 28 percent impairment, for which he previously received a schedule award. With regard to erectile dysfunction, the medical adviser concurred with Dr. Delia and Dr. Schwartzman that his erectile dysfunction was not causally related to appellant's accepted conditions and therefore did not warrant a schedule award for impairment of the penis. He advised that appellant reached maximum medical improvement on or about December 31, 1999.

By decision dated July 17, 2007, the Office denied appellant's claim for an increased schedule award and for erectile dysfunction.

LEGAL PRECEDENT -- ISSUE 1

The Board notes that, before applying the A.M.A, *Guides*, the Office must determine whether the claimed impairment of a scheduled member is causally related to the accepted work injury.[13] Where an employee claims that, a condition not accepted or approved by the Office

[12] *Id.* at 526, Table 17-2.

[13] *Michael S. Mina*, 57 ECAB 379 (2006).

was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[14]

Section 8123(a) of the Federal Employees' Compensation 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 shall appoint a third physician who shall make an examination.[15] When the case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical evidence, the opinion of such specialist will be given special weight when based on a proper factual and medical background and sufficiently well rationalized on the issue presented.[16]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof in establishing that he developed erectile dysfunction related to his June 9, 1999 injury. The Office accepted appellant's claim for right hamstring tear, right medial meniscus tear and L5-S1 herniated disc. However, appellant did not initially claim erectile dysfunction as related to his employment injury. As noted, to establish a claim for injury in the performance of duty, an appellant must submit rationalized medical evidence explaining the causal relationship between the diagnosed condition and the claimed employment injury.

The Office found a conflict in the medical evidence concerning whether appellant had an employment-related erectile dysfunction. The conflict was found between Dr. Rodriguez, for appellant, who opined that his erectile dysfunction was work related and caused permanent impairment of the penis. Dr. Schwarzman, for the Office, concluded that appellant's erectile dysfunction was not work related. To resolve the conflict, the Office referred appellant to Dr. D'Elia for an impartial medical examination.

Dr. D'Elia examined appellant and prepared a well-rationalized report on December 4, 2006. After conducting a thorough physical examination, he found no evidence that appellant's erectile dysfunction was caused by nerve damage from appellant's June 9, 1999 injury. Dr. D'Elia explained that the medical evidence provided no support for nerve damage at the S2-4 levels of appellant's spine, where the implicated nerves for achieving and sustaining an erection are located. He advised that neurologic impotence due to disc disease usually came about rather suddenly but noted that appellant asserted that his impotence occurred gradually. Dr. D'Elia also noted a number of nonwork-related causes for appellant's condition, specifically his history of smoking, elevated cholesterol and lipids, low serum testosterone and atrophic testicles. He concluded that appellant's erectile dysfunction was not caused by any nerve damage from his June 9, 1999 employment injury. Dr. D'Elia's report is reasoned and explains his conclusion clearly; specifically, appellant's erectile dysfunction was not caused by nerve damage resulting from his June 9, 1999 injury because the implicated nerves were undamaged.

[14] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[15] 5 U.S.C. § 8123(a); *see Elsie L. Price*, 54 ECAB 734 (2003); *Raymond J. Brown*, 52 ECAB 192 (2001).

[16] *See Bernadine P. Taylor*, 54 ECAB 342 (2003); *Anna M. Delaney*, 53 ECAB 384 (2002).

Because he is an impartial medical examiner who presented a rationalized medical opinion and resolved a conflict in the evidence, his report is entitled to special weight and establishes that appellant does not have erectile dysfunction caused by his employment injury.

Accordingly, the Board finds that the medical evidence, as represented by Dr. D'Elia's December 4, 2006 report, does not support that appellant's erectile dysfunction was causally related to his June 9, 1999 employment injury.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of the Act[17] and its implementing regulations[18] 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 regulations as the appropriate standard for evaluating schedule losses.[19]

ANALYSIS -- ISSUE 2

The Office found a conflict in the medical evidence between Dr. Rodriguez and Drs. Valentino concerning the degree of appellant's work-related right leg impairment. Dr. Rodriguez concluded that appellant had 52 percent permanent impairment of the right leg. Dr. Valentino determined that appellant had 17 percent impairment of the right leg. However, the Board finds that the impairment rating of Dr. Rodriguez is of diminished probative value as he did not properly apply the A.M.A., *Guides*. Therefore, no conflict in medical opinion arose in this case. Contrary to Table 17-2 of the A.M.A., *Guides,*[20] Dr. Rodriguez combined impairments for arthritis strength loss and diagnosed based impairment estimates. The impact of this was to artificially inflate the impairment rating provided. Because Dr. Rodriguez's report did not properly follow the A.M.A., *Guides* his rating is of diminished probative value and insufficient to create a medical conflict.[21]

Dr. Valentino, however, properly applied the A.M.A., *Guides* in concluding that appellant had 17 percent impairment of the right lower extremity. He explained that appellant had full and normal range of motion of the leg and a normal hamstring examination. Dr. Valentino found that appellant had weakness of the ankle plantar flexors graded as four out

[17] 5 U.S.C. § 8107.

[18] 20 C.F.R. § 10.404 (1999).

[19] *See id.*

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

[21] Although Dr. Snyder is not an impartial medical examiner, his report may be considered for its own intrinsic value. *See Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996).

of five. Under Table 17-8, Grade 4 impairment for muscle weakness of the ankle for plantar flexion represents 17 percent impairment of the leg.[22] He found no other basis on which to attribute permanent impairment. This impairment rating conforms to the A.M.A., *Guides* and Table 17.2.

Moreover, the Board notes that Dr. Snyder's report does not establish any greater impairment as he improperly characterized appellant's impairment in terms of whole person rather than lower extremity impairment.[23] The Board notes that this is inconsistent with the Act and Board precedent which do not provide for whole person impairments.[24] Dr. Snyder rated atrophy in terms of whole person impairment instead of the right leg. He also included an 11 percent whole person impairment based on loss of lumbar range of motion. No schedule award is payable for permanent loss of, or loss of use of, anatomical members or functions or organ of the body not specified in the Act or in the implementing regulations.[25] As neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back, no claimant is entitled to such an award.[26] The Board therefore finds that Dr. Snyder provided no basis on which to establish any greater impairment than that found by Dr. Valentino.

Accordingly, as Dr. Valentino is the only physician whose opinion on permanent impairment properly applies A.M.A., *Guides,* his report constitutes the weight of the medical evidence and establishes that appellant has 17 percent permanent impairment of the right leg. Accordingly, the Board finds that appellant has not established that he has more than 28 percent impairment of the right lower extremity, for which he received a schedule award.

CONCLUSION

The Board finds that appellant has not established that his erectile dysfunction was causally related to his June 9, 1999 employment injury or that he had more than 28 percent impairment of the right lower extremity, for which he received a schedule award.

[22] A.M.A., *Guides* 532, Table 17-8; *see* Table 17-7 at 531 (sets forth criteria for grades).

[23] Furthermore, Dr. Snyder's report did not address why impairment for atrophy would be combined with other impairments, such as loss of strength and lost range of motion, in view of Table 17-2 of the A.M.A., *Guides* which provides that such impairments should not be combined. *See* A.M.A., *Guides* 526.

[24] *Marilyn S. Freeland*, 57 ECAB 607 (2006).

[25] *Anna V. Burke*, 57 ECAB 521 (2006).

[26] *George E. Williams*, 44 ECAB 530 (1993).

ORDER

IT IS HEREBY ORDERED THAT the July 17, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 22, 2008
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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