

In a November 26, 2001 report, Dr. Robert Dennis, a Board-certified orthopedic surgeon and an Office referral physician, advised that his examination of the lower extremities revealed normal straight leg raising at 90 degrees bilaterally and symmetric deep tendon reflexes. He found that appellant had normal dorsiflexion of both toes, which was symmetric and normal. Dr. Dennis was unable to detect any asymmetry between the strength of appellant's dorsiflexion power and noted that plantar flexion power was normal. He advised that appellant was "a little bit obese" and that she had no difficulty standing on her heels and toes. Dr. Dennis diagnosed herniated disc at L4-5 (resolved) post surgery, without evidence of recurrence, bilateral L5 radiculopathy of a questionable and variable severity, mild transient, subjective sciatica. He opined that there was no evidence of functional, neurological loss or permanency regarding the left lower extremity.

In a November 12, 2002 report, Dr. Michael Duch, a Board-certified orthopedic surgeon and treating physician, advised that appellant presented with complaints of low back pain. He examined appellant and found numbness in the web space of the first and second digit on the left side with no obvious weakness. Dr. Duch indicated that appellant had some sensation to light touch that was intact throughout the rest of her lower leg.

On May 20, 2003 appellant filed a claim for a schedule award. She submitted a February 20, 2003 report from Dr. Nicholas Diamond, an osteopath, and treating physician, who diagnosed L4-5 herniated nucleus pulposus, post L4-5 discectomy and L4 laminectomies with fibrosis and post-traumatic L4-5 spondylolisthesis. Dr. Diamond advised that appellant had motor strength deficit in the left lower extremity, and anterior quadriceps, and pain related impairment. He rated impairment as 15 percent to the left lower extremity.¹

In a June 27, 2003 report, an Office medical adviser noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (A.M.A., *Guides*). He noted that appellant had residual sensory involvement of her L5 nerve root which under Table 15-18 allowed a maximum loss of five percent.² The Office medical adviser utilized Table 15-15³ to grade the extent of sensory loss as Grade 2 or 80 percent to find that appellant had 4 percent impairment of her left lower extremity. He opined that appellant reached maximum medical improvement on November 26, 2001.

By decision dated July 22, 2003, the Office granted appellant a schedule award for four percent permanent impairment of the left leg.

¹ Dr. Diamond actually indicated right lower extremity; however, this appears to be a typographical error.

² A.M.A., *Guides* 424.

³ *Id.*

On July 29, 2003 appellant requested a hearing. On January 26, 2004 an Office hearing representative remanded the case for further development finding a conflict of medical opinion between Dr. Diamond and the Office medical adviser.⁴

By decision dated May 24, 2004, the Office denied appellant's request for an increased schedule award. Appellant requested a hearing, which was held on March 1, 2005. At the hearing, counsel contended that the Office did not follow its rotational system in referring appellant to the impartial medical examiner. In a May 31, 2005 decision, the Office hearing representative set aside the May 24, 2004 decision. The Office hearing representative determined that the Office failed to properly select the impartial medical examiner from its rotational list of physicians as it referred appellant to an associate of the physician that it had selected to resolve the conflict. The Office hearing representative directed the Office to refer appellant to a new impartial specialist to resolve the conflict in opinion.

On July 28, 2005 the Office referred appellant, together with a statement of accepted facts, and the medical record, to Dr. Howard Kapp, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Dr. Diamond and the Office medical adviser regarding the extent of any permanent impairment. In an August 18, 2005 report, Dr. Kapp reviewed appellant's history and findings on examination. He determined that appellant did not sustain any lower extremity impairment.

By decision dated August 31, 2005, the Office denied appellant's claim for an increased schedule award.

On September 7, 2005 appellant requested a hearing that was held on March 29, 2006. On April 25, 2006 the Office hearing representative found that Dr. Kapp was improperly selected as the Physicians' Directory System (PDS) was not used to select the physician as contemplated under Office procedures.⁵ The Office hearing representative remanded the case to the Office to select a new impartial medical examiner.

On November 21, 2006 the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Richard C. Gardner, a Board-certified orthopedic surgeon. In a December 4, 2006 report, Dr. Gardner listed appellant's history of injury and medical treatment. He conducted a physical examination and found a well-healed 14 centimeter lumbar incision at L3 in the sacrum, which was nontender and without any sciatic pain. Dr. Gardner stated that appellant reported that her left leg did not bother her at present. He indicated that appellant had lumbar lordosis which reversed normally. Regarding range of motion, Dr. Gardner advised that appellant had 60 degrees of flexion without pain, spasms, or pinpoint tenderness. Appellant had extension of 0 degrees for side bending, 20 degrees bilaterally and rotation of 25 degrees bilaterally. Dr. Gardner also indicated that her reflexes

⁴ To resolve the medical conflict, the Office initially referred appellant to Dr. George Glenn, a Board-certified orthopedic surgeon. On February 24, 2004 it referred her to Dr. Joseph Kozielski, a Board-certified orthopedic surgeon. In an April 12, 2004 report, he noted opined that appellant did not have any permanent impairment of the left leg.

⁵ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.7 (May 2003).

were bilateral “2[+]” and she had muscle strength of “5/5” throughout bilaterally. Appellant’s sensation was intact and there was no evidence of any peripheral atrophy. Dr. Gardner also noted that the circumference of the lower extremities was equal and there was no evidence of causalgia or reflex sympathetic dystrophy. He opined that appellant had no impairment to the lower extremities.

By letter dated December 29, 2006, appellant’s representative contended that Dr. Gardner provided insufficient rationale for his medical opinion.

On April 3, 2007 an Office medical adviser reviewed Dr. Gardner’s report. He stated that the report revealed a normal examination and, therefore, no impairment calculations were performed. The Office medical adviser noted that Dr. Gardner found no abnormalities on examination of the left leg.” He concurred with Dr. Gardner’s opinion.

By decision dated April 6, 2007, the Office denied appellant’s claim for an increased schedule award.

On April 12, 2007 appellant’s representative requested a hearing, which was held on September 29, 2007. Counsel contended that Dr. Gardner was improperly provided with the previous reports from the disqualified impartial medical examiners. He also alleged that Dr. Gardner’s physical examination was insufficient and his opinion was not entitled to receive special weight.

By decision dated December 12, 2007, the Office hearing representative affirmed the April 6, 2007 decision, finding that the opinion of Dr. Gardner represented the weight of the medical evidence.

LEGAL PRECEDENT

The schedule award provisions of the Federal Employees’ Compensation Act⁶ and its implementing regulations⁷ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of specified members or functions of the body. However, the Act does not specify the manner in which the percentage loss shall be determined. For consistent results and to ensure equal justice under the law to all appellants, 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.⁸

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be itemized and stated in terms of percentage loss of use of the member in accordance with the

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ *Id.*

tables in the A.M.A., *Guides*.⁹ However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

Section 8123(a) of the Act provides, in pertinent part: “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.”¹⁰ 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.¹¹

ANALYSIS

The Office determined that a conflict arose between appellant’s physician, Dr. Diamond, who found 15 percent to the left lower extremity based on sensory and motor deficits. An Office medical adviser determined that appellant had four percent impairment of the left lower extremity based on sensory loss alone.

The Office referred appellant to Dr. Gardner for an impartial medical examination.¹² The Board finds that the report of Dr. Gardner, the impartial medical specialist selected to resolve the conflict in the medical opinion evidence, is sufficiently well rationalized and based on a proper factual and medical background. Therefore, it is entitled to special weight. In a December 4, 2006 report, Dr. Gardner conducted a physical examination and provided findings for range of motion which were normal. They included that appellant had 60 degrees of flexion with no pain, spasms, or pinpoint tenderness and extension of 0 degrees for side bending, 20 degrees bilaterally, and rotation of 25 degrees bilaterally. Dr. Gardner also determined that appellant’s reflexes were bilateral “2[+]” and she had normal muscle strength bilaterally. He determined that appellant’s sensation was intact and there was no evidence of any peripheral atrophy. He also noted that the circumference of the lower extremities was equal and there was no evidence of causalgia or RSD. He concluded that appellant had no accident-related impairment to her lower extremities. The Board notes that Dr. Gardner took measurements and explained his findings. He found no basis on which to attribute additional impairment to appellant’s left leg.

An Office medical adviser, in an April 3, 2007 report, reviewed Dr. Gardner’s findings, noting that it revealed a normal examination and no basis on which to rate additional impairment.

⁹ See *William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

¹⁰ 5 U.S.C. § 8123(a); see also *Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207, 210 (1993).

¹¹ See *Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

¹² As noted, the Office made earlier referrals to impartial examiners that were found to be procedurally deficient. Office decisions based on reports of these specialists, who were not properly selected, were set aside.

The Board finds that the Office properly relied upon Dr. Gardner's report in finding that appellant does not have additional impairment to the left lower extremity. There is no probative medical evidence of record establishing that appellant has more than a four percent impairment of the left lower extremity.

Appellant's attorney alleged that the impartial medical examiner's report was defective and should not be given special weight. A review of Dr. Gardner's report reveals that he conducted a thorough examination of appellant and found no basis on which to rate permanent impairment. Counsel also alleges that the report of Dr. Gardner was "contaminated" as he alluded to previous reports of disqualified physicians. The Board notes that Dr. Gardner merely listed the reports of the prior physicians of record without reference to any findings. However, he based his opinion on his examination of appellant, review of diagnostic studies and findings on examination. There is no indication that Dr. Gardner relied on any disqualified report in reaching his conclusions. As noted, his report is sufficient to represent the weight of the medical evidence.

CONCLUSION

The Board finds that appellant has not established that she sustained more than four percent permanent impairment of her left lower extremity for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs' hearing representative dated December 12, 2007 is affirmed.

Issued: July 14, 2009
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