United States Department of Labor
Employees' Compensation Appeals Board

T.M., Appellant	)	
and	)	**Docket No. 08-2055**
	)	**Issued: September 23, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Tulsa, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 21, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' May 27, 2008 merit decision concerning entitlement to schedule award compensation. 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 met his burden of proof to establish that he has more than 2 percent permanent impairment of his right leg and 10 percent permanent impairment of his left leg, for which he received schedule awards.

FACTUAL HISTORY

This is the second appeal in this case. The Board issued a decision on May 15, 2006, which set aside the January 20, 2005 decision of the Office and remanded the case to the Office for further development.[1] The Board found that, due to an unresolved conflict in the medical

[1] Docket No. 06-98 (issued May 15, 2006).

evidence, the case was not in posture for decision regarding whether appellant had more than five percent permanent impairment of his left leg.[2] The Board found that the Office properly determined that there was a conflict in the medical evidence regarding appellant's entitlement to schedule award compensation between Dr. Mayoza and Dr. Robert Shackelford, a Board-certified orthopedic surgeon, who served as an Office referral physician.[3] The Board further found that the Office properly referred appellant and the case record to Dr. Framjee for an impartial medical evaluation and opinion on this matter.

The Board noted that, in a November 29, 2004 report, Dr. Framjee concluded that appellant had a five percent impairment of the left leg due to sensory loss associated with the S1 nerve root but had no impairment of the right leg. The Board found that there were various deficiencies in Dr. Framjee's evaluation. Although Dr. Framjee did not indicate so, it appears that he applied Tables 15-15 and 15-18 of the A.M.A., *Guides* to determine that appellant had five percent impairment of the left leg due to sensory loss associated with the S1 nerve root. The Board noted, however, that he did not fully explain how he applied these standards to find that appellant had no sensory loss impairment of the right leg. The Board found that additional development of the medical evidence was needed to resolve the existing conflict in the medical evidence regarding appellant's permanent impairment. The facts and the circumstances of the case up to that point are set forth in the Board's prior decision and are incorporated herein by reference.

On remand, the Office was unable to obtain an adequate supplemental report from Dr. Framjee and, by decision dated September 1, 2006, it remanded the case for referral to another impartial medical specialist. In a December 5, 2006 report, Dr. C.L. Soo, a Board-certified orthopedic surgeon, who served as an impartial medical specialist, determined that appellant had a 1 percent permanent impairment of his right leg and 10 percent permanent impairment of his left leg. In a January 4, 2007 decision, the Office granted appellant additional schedule award compensation to reflect this level of permanent impairment.

In a June 20, 2007 report, Dr. Richard A. Hastings, II, an attending osteopath and Board-certified internist, discussed appellant's medical history and reported findings on examination. He noted that appellant complained of numbness and pain radiating into his lower extremities with the deficits on the left being more predominate than on the right. Appellant also

[2] The Office accepted that appellant sustained an employment-related herniated disc at L5-S1 due to his job duties in 1997 and he claimed entitlement to a schedule award due to this employment-related condition. Based on the opinion of Dr. Sami Framjee, a Board-certified orthopedic surgeon, who served as an impartial medical specialist, the Office determined that appellant had five percent permanent impairment of his left leg. Appellant received schedule award compensation for this degree of permanent impairment. On March 23, 1998 Dr. Mark A. Capehart, an attending Board-certified orthopedic surgeon, performed a left L5-S1 hemilaminectomy with excision of the herniated nucleus pulposus. On December 11, 2000 Dr. James C. Mayoza, another attending Board-certified orthopedic surgeon, performed a repeat L5-Sl laminectomy and disc excision. Both procedures were authorized by the Office.

[3] In reports dated May 15, 2003 and June 24, 2004, Dr. Mayoza concluded that, under Tables 15-15, 15-16 and 15-18 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001), appellant had a 40 percent permanent impairment of his left leg and a 35 percent permanent impairment of his right leg. In contrast, Dr. Shackelford determined in an October 16, 2003 report that appellant did not have any permanent impairment of his lower extremities. He concluded that appellant's medical condition was located in his back and did not extend into his legs.

complained of weakness of the lower extremities with the deficits on the left being more predominate than on the right. Dr. Hastings found that on examination he exhibited weakness of his right quadriceps muscle (Grade 4 under Table 17-8 of the A.M.A., *Guides*) to strength testing analysis and weakness in dorsiflexion and plantar flexion on the right (Grade 4). Neurosensory assessment of appellant's right leg revealed neurosensory loss over his right foot extending up to the level of his right calf. Examination of appellant's left leg revealed weakness of the left quadriceps and hamstring (Grade 4) to strength testing analysis. Dr. Hasting indicated that he had weakness in dorsiflexion and plantar flexion on the left and weakness of the extensor hallucis longus on the left (Grade 4). Appellant had neurosensory loss over the left foot involving the medial plantar surface and the anterior foot extending up bilaterally in the foot to the level of the midcalf as shown by neurosensory testing.

Dr. Hastings found that because appellant had deficits in his legs stemming from his work-related back injury and subsequent surgeries it was appropriate to evaluate his impairment under Chapter 17 of the A.M.A., *Guides*, including application of Tables 17-8 and 17-37. He concluded that appellant had a five percent whole person impairment due to right quadriceps weakness; a five percent whole person impairment due to right ankle dorsiflexion weakness; a seven percent whole person impairment due to right ankle planter flexion weakness; and a seven percent whole person impairment on the right due to neurosensory loss over the right foot and ankle as a result of sciatic neuropathy related to his back injury and subsequent surgeries.[4] Dr. Hastings also determined that appellant had a five percent whole person impairment due to left quadriceps weakness; a five percent whole person impairment due to left hamstring weakness; a five percent whole person impairment due to left dorsiflexion weakness; a seven percent whole person impairment due to left planter flexion weakness; a one percent whole person impairment due to left extensor hallucis longus weakness and a seven percent whole person impairment on the left due to neurosensory loss as a result of sciatic neuropathy related to his back injury and subsequent surgeries.[5]

In an August 10, 2007 decision, an Office hearing representative determined that there were deficiencies in the report of Dr. Soo. She mentioned Dr. Hasting's June 20, 2007 report, and noted that he provided extensive rationale for his impairment rating. The Office hearing representative determined that additional development of the medical evidence was needed and remanded the case to the Office for this purpose.[6]

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[4] Under Table 17-8 of the A.M.A., *Guides*, each 5 percent whole person impairment for strength loss would translate to a 12 percent impairment of the right leg and the 7 percent whole person impairment for strength loss would translate to a 17 percent impairment of the right leg. Under Table 17-37, the 7 percent whole person impairment for sensory loss would translate to a 17 percent impairment of the right leg. *See* A.M.A., *Guides* 532, 552, Tables 17-8 and 17-37.

[5] Under Table 17-8, each 5 percent whole person impairment for strength loss would translate to a 12 percent impairment of the left leg, the 7 percent whole person impairment for strength loss would translate to a 17 percent impairment of the left leg and the 1 percent whole person impairment for strength loss would translate to a 2 percent impairment of the left leg. Under Table 17-37, the 7 percent whole person impairment for sensory loss would translate to a 17 percent impairment of the left leg. *See* A.M.A., *Guides* 532, 552, Tables 17-8 and 17-37.

[6] The Office hearing representative indicated that this development should include referral of Dr. Hasting's report to an Office medical adviser for evaluation.

In September 2007, the Office referred appellant to Dr. Michael S. Smith, a Board-certified orthopedic surgeon, for an examination and opinion on the extent of his permanent impairment.[7] In an October 11, 2007 report, Dr. Smith discussed appellant's medical history and reported findings on examination. He found that on examination appellant had 5/5 strength in his leg muscles. With respect to sensory testing, appellant had decreased sensation with pin roll, light touch and cotton swab testing in the anterior lateral aspects of both calves and over the dorsum of both feet into the first toe web spaces and posterior ankles. The lower extremities had decreased sensation in L5-S1 distributions of the anterior mid calves and posterior calves.

Dr. Smith stated that according to the fifth edition of the A.M.A., *Guides* appellant had a Grade 4 sensory impairment based on Table 16-10 for peripheral nerve injury as a result of the herniated disc. Using Table 17-37, based on Figures 17-8 and 17-9, appellant had a left lower extremity involvement of the left branch of the sciatic nerve, superficial peroneal and sural sensory nerves. Combining the maximum impairments for sensory nerve function for these lower extremity nerves (17, 5 and 2 percent, respectively) he came up with 24 percent total possible sensory impairment. After multiplying the Grade 4 sensory impairment (25 percent) in these nerves (based on Table 16-10) times the 24 percent value, Dr. Smith arrived at 6 percent left lower extremity impairment related to sensory deficit. With regard to the right lower extremity, he used the maximum sensory involvement of 5 percent for the superficial peroneal nerve and the 2 percent value for the sural nerves and derived 7 percent maximum multiple impairment which when multiplied by the Grade 4 sensory loss (25 percent) yielded a 1.75 percent impairment for right sensory nerve injury which rounded up to 2 percent. Dr. Smith found no loss of motor function in either leg.

On October 30, 2007 Dr. Ronald Blum, a Board-certified orthopedic surgeon serving as an Office medical adviser, reviewed Dr. Smith's analysis and indicated that appellant reached maximum medical improvement on February 25, 2008. He agreed with much of Dr. Smith's methodology. Dr. Blum applied the same calculations as Dr. Smith to determine that appellant had a two percent permanent impairment of the right leg. However, for the left leg, he indicated that Dr. Smith recommended sensory loss based on the findings in the sciatic, peroneal and sural nerves but noted that the common peroneal nerve and sural nerve are branches of the sciatic and posited that using the latter two nerves would result in duplication. Dr. Blum, therefore, only used sensory loss in the sciatic nerve distribution. He multiplied the 17 percent maximum value for sensory loss in that nerve times the Grade 4 sensory loss (25 percent) to yield a 4.25 value which rounded down to 4 percent impairment for the sensory loss associated with the sciatic nerve. Dr. Blum noted that appellant did not have any impairment due to motor loss and concluded that appellant had two percent permanent impairment of his right leg and four percent permanent impairment of his left leg.

In a November 26, 2007 decision, the Office found that Dr. Blum properly analyzed appellant's leg impairment. It determined that, therefore, the evidence of record showed that appellant was not entitled to more than the schedule award compensation he received for 10 percent permanent impairment of his right leg. However, appellant was entitled to compensation for one percent permanent impairment of the right leg in addition to the compensation he had

[7] The Office clearly indicated that appellant was being referred to Dr. Smith for a second opinion examination.

already received for one percent permanent impairment of the right leg. In a December 3, 2007 decision, the Office granted appellant a schedule award for an additional one percent permanent impairment of the right leg.

Appellant requested a hearing before an Office hearing representative. At the March 14, 2008 hearing, he argued that Dr. Hasting's June 20, 2007 report provided the best assessment of the permanent impairment of his legs. In a May 27, 2008 decision, the Office hearing representative affirmed the Office's prior schedule award determinations. He stated that Dr. Smith served as an impartial medical specialist and found that the findings of Dr. Smith combined with Dr. Blum's analysis of these findings represented the weight of the medical evidence with respect to appellant's permanent impairment.[8]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[9] and its implementing regulations[10] 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.[11]

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."[12] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[13] There is no provision in the Act, the Office's regulations, or its procedures for designating a physician an impartial medical evaluator on an after-the-fact basis.[14] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of

[8] The Office hearing representative indicated that appellant submitted another copy of Dr. Hasting's June 20, 2007 report at the May 22, 2007 hearing, but he did not provide any discussion of the contents of this report.

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404 (1999).

[11] *Id*.

[12] 5 U.S.C. § 8123(a).

[13] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[14] *Joanne S. Rozelle*, 40 ECAB 931, 939 (1989).

such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[15]

ANALYSIS

In the present case, the Office accepted that appellant sustained an employment-related herniated disc at L5-S1 due to his job duties in 1997 and authorized low back surgeries which were performed on March 23, 1998 and December 11, 2000. Appellant received schedule award compensation for a 2 percent permanent impairment of his right leg and a 10 percent permanent impairment of his left leg.

The Board finds that the case is not in posture for decision due to a conflict in the medical evidence regarding the permanent impairment of appellant's legs. This conflict is between Dr. Hastings, an attending osteopath and Board-certified internist, on the one hand, and both Dr. Smith, a Board-certified orthopedic surgeon serving as an Office referral physician, and Dr. Blum, a Board-certified orthopedic surgeon serving as an Office medical adviser. In a May 27, 2008 Office decision, an Office hearing representative referred to Dr. Smith as an impartial medical specialist, but he actually served as an Office referral physician.[16] The Board has found that there is no provision in the Act, the Office's regulations or its procedures for designating a physician an impartial medical evaluator on an after-the-fact basis.[17]

In an October 11, 2007 report, Dr. Smith stated that according to the fifth edition of the A.M.A., *Guides* appellant had a Grade 4 sensory impairment based on Table 16-10 for peripheral nerve injury as a result of the herniated disc. Using Table 17-37, appellant had a left lower extremity involvement of the left branch of the sciatic nerve, superficial peroneal and sural sensory nerves. Combining the maximum impairments for sensory nerve function for these lower extremity nerves, (17, 5 and 2 percent, respectively) Dr. Smith came up with 24 percent total possible sensory impairment. After multiplying the Grade 4 sensory impairment (25 percent) in these nerves (based on Table 16-10) times the 24 percent value, Dr. Smith arrived at a 6 percent left lower extremity impairment related to sensory deficit.[18] With regard to the right lower extremity, he used the maximum sensory involvement of 5 percent for the superficial peroneal nerve and the 2 percent value for the sural nerves and derived 7 percent maximum multiple impairment which when multiplied by the Grade 4 sensory loss (25 percent) yielded a 1.75 percent impairment for right sensory nerve injury which rounded up to 2 percent. Dr. Smith

[15] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[16] At the time of the September 2007 referral to Dr. Smith, there was no conflict regarding appellant's then current leg impairment, which would have required referral to an impartial medical specialist. The Board notes that more than three years had passed since the production of the medical reports by Dr. Mayoza, an attending Board-certified orthopedic surgeon, and Dr. Shackelford, a Board-certified orthopedic surgeon serving as an Office referral physician, which had created a conflict regarding appellant's impairment at that earlier time. Moreover, the Office explicitly noted in September 2007 that Dr. Smith was to provide a second opinion and it did not attempt to implement the various procedures that would have been required for referral to an impartial medical specialist. *See supra* notes 12 and 13 and accompanying text describing conflicts between attending and Office physicians.

[17] *See supra* note 14 and accompanying text.

[18] *See* A.M.A., *Guides* 482, 552, Tables 16-10, 17-37.

found no loss of motor function in either leg. In an October 30, 2007 report, Dr. Blum applied the same calculations as Dr. Smith to determine that appellant had a two percent permanent impairment of the right leg. For the left leg, he indicated that the only impairment was due to sensory loss in the sciatic nerve distribution. Dr. Blum multiplied the 17 percent maximum value for sensory loss in that nerve times the Grade 4 sensory loss (25 percent) to yield a 4.25 value, which rounded down to 4 percent impairment for the sensory loss associated with the sciatic nerve. He also found no loss of motor function in either leg.

In contrast, Dr. Hastings determined that appellant had a greater degree of impairment in both legs. He not only found that appellant had a higher impairment in both legs due to sensory loss, but he also found that appellant had significant impairment in both legs due to strength loss whereas both Dr. Smith and Dr. Blum found no such losses. Applying Table 17-8 of the A.M.A., *Guides* for strength loss and Table 17-37 for sensory loss, Dr. Hastings concluded that appellant had a five percent whole person impairment due to right quadriceps weakness; a five percent whole person impairment due to right ankle dorsiflexion weakness; a seven percent whole person impairment due to right ankle planter flexion weakness and a seven percent whole person impairment on the right due to neurosensory loss over the right foot and ankle as a result of sciatic neuropathy related to his back injury and subsequent surgeries. Under Table 17-8 of the A.M.A., *Guides*, each 5 percent whole person impairment for strength loss would translate to a 12 percent impairment of the right leg and the 7 percent whole person impairment for strength loss would translate to a 17 percent impairment of the right leg. Under Table 17-37, the 7 percent whole person impairment for sensory loss would translate to a 17 percent impairment of the right leg.[19] Dr. Hastings also determined that appellant had a five percent whole person impairment due to left quadriceps weakness; a five percent whole person impairment due to left hamstring weakness; a five percent whole person impairment due to left dorsiflexion weakness; a seven percent whole person impairment due to left planter flexion weakness; a one percent whole person impairment due to left extensor hallucis longus weakness and a seven percent whole person impairment on the left due to neurosensory loss as a result of sciatic neuropathy related to his back injury and subsequent surgeries. Under Table 17-8, each 5 percent whole person impairment for strength loss would translate to a 12 percent impairment of the left leg, the 7 percent whole person impairment for strength loss would translate to a 17 percent impairment of the left leg, and the 1 percent whole person impairment for strength loss would translate to a 2 percent impairment of the left leg. Under Table 17-37, the 7 percent whole person impairment for sensory loss would translate to a 17 percent impairment of the left leg.[20]

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence regarding the permanent impairment of appellant's legs. On remand, the Office should refer appellant along with the case file and the statement of

[19] *See* A.M.A., *Guides* 532, 552, Tables 17-8 and 17-37.

[20] *See id.* The Board notes that Dr. Hastings' opinion with respect to sensory loss in appellant's legs also differed from those of Dr. Smith and Dr. Blum in that he only found sensory loss in appellant's sciatic nerves. However, Dr. Hastings found that the impairment in these nerves were greater than the total sensory loss found by Dr. Smith and Dr. Blum. While he did not fully explain why he found such a high level of sensory loss in appellant's legs, at the very least his report creates a conflict with those of Drs. Smith and Blum regarding the strength losses in his legs.

accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After such further development as it deems necessary, the Office should issue an appropriate decision regarding appellant's leg impairment.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant met his burden of proof to establish that he has more than a 2 percent permanent impairment of his right leg and a 10 percent permanent impairment of his left leg, for which he received schedule awards. Due to a conflict in the medical evidence, the case is remanded to the Office for further development of the medical evidence to be followed by an appropriate Office decision.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' May 27, 2008 decision is set aside and the case remanded to the Office for proceedings consistent with this decision of the Board.

Issued: September 23, 2009
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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