United States Department of Labor
Employees' Compensation Appeals Board

G.E., Appellant	)	
and	)	**Docket No. 08-2423**
	)	**Issued: September 15, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburg, CA, 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
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 8, 2008 appellant filed a timely appeal from an Office of Workers' Compensation Programs' merit decision dated June 17, 2008. Under 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 more than a 13 percent permanent impairment to his left lower extremity.

FACTUAL HISTORY

Appellant, a 43-year-old letter carrier, filed a Form CA-2 claim for benefits on July 22, 2001, alleging that he developed a lower back condition casually related to factors of his employment. The Office accepted left-sided sciatica secondary to herniated disc at L5-S1. On June 10, 2002 appellant underwent surgery for L4-5 and L5-S1 revision, bilateral decompressions with laminectomies, partial medial facetectomies and foraminotomies; and an

L5-S1 posterior lumbar interbody fusion with right iliac crest bone graft. He returned to light duty on January 25, 2003.

In a report dated April 5, 2004, Dr. Jason A. Smith, a specialist in orthopedic and neurological surgery and appellant's treating physician, stated that he reviewed diagnostic tests which showed a solid fusion at L5-S1 from appellant's June 2002 lumbar surgery. He noted, however, that appellant was left with significant weakness to his left lower extremity and ongoing problems with paresthesias and pain in an L5-S1 distribution on the left. Dr. Smith also noted that appellant experienced sexual dysfunction because of his loss of function and ongoing pain. He opined that appellant had reached permanent and stationary status and was limited to performing light duty for six hours per day, five days a week, with restrictions on sitting, twisting, bending, stooping, kneeling or climbing, lifting more than 15 pounds and lifting more than 10 pounds above his shoulder.

On April 21, 2004 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of his left and right lower extremities.

In order to determine whether appellant had permanent impairment from his accepted lumbar condition, the Office referred him to Dr. Alan Kimelman, Board-certified in physical and rehabilitative medicine. In a June 4, 2004 report, Dr. Kimelman stated that appellant had numbness, which persisted continually in the lateral aspect of the left foot. He also noted that appellant developed a blister along the left foot due to loss of sensation. Dr. Kimelman indicated in a June 4, 2004 impairment rating form that appellant experienced mild pain and discomfort in the S1 nerve root and showed weakness of four on a scale of one to five based on active movement against gravity with some resistance. He also rated a four plus out of five for weakness of the hip abductors innervated at the L3-4 level.

In an impairment evaluation dated September 12, 2004, an Office medical adviser found that appellant had a 13 percent impairment of his right lower extremity based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) fifth edition. He stated:

> "[Dr. Kimelman's] report indicates that numbness persisted continually in the lateral aspect of the left foot and that the claimant developed a blister along the left foot due to loss of sensation. In the form report, the S1 nerve root is identified with pain described as present and mild. These subjective complaints, *i.e.*, pain and/or altered sensation that interfere with activity would be graded a maximal [G]rade [2] as per the Grading Scheme (Table 16-10, [p]age 482, fifth edition of the [A.M.A.,] *Guides*). This would be between a 61 and an 80 percent grade as per Table 15-15. One would recommend a mean or a 70 percent grade of a maximal 5 percent (Table 15-18) for S1 and 70 percent of this would be 3.5 percent or rounded off to an 4 percent impairment. Dr. Kimelman identifies $4^{+}/5$ weakness of the hip abductors innervated by L4, which would be assessed a maximal 34 percent impairment as per Table 15-18. Grade [4] weakness would be assessed a maximum of 25 percent grade as per Table 15-16 and 25 percent of 34 would equate with 8.5 percent or rounded off to a 9 percent impairment for the left hip abductor weakness. Records did not document any loss of hip, knee,

ankle, subtalar or toe range of motion for a zero percent impairment. Utilizing the Combined Values Chart, the 4 percent impairment for left lower extremity numbness and/or pain, combined with the 9 percent impairment for hip abductor weakness would be equivalent to a 13 percent impairment of the left lower extremity or leg. The records do not indicate right lower extremity, radicular symptoms or findings for a zero percent impairment. Date of maximum medical improvement would have occurred by the time of the June 4, 2004 evaluation, approaching two years following the second operative procedure."

On December 7, 2004 the Office granted appellant a schedule award for a 13 percent permanent impairment of the left lower extremity for the period November 17, 2004 to August 6, 2005, for a total of 37.44 weeks of compensation.[1]

In a letter received by the Office on December 14, 2006, appellant requested reconsideration.

Appellant submitted an August 26, 2006 report from Dr. Smith, who accorded him a 23 percent impairment rating of the whole person for his accepted lumbar condition based on a diagnosis-related estimate (DRE), lumbar category 4 under the A.M.A., *Guides*. Dr. Smith based this rating on loss of motion resulting from appellant's successful arthrodesis; he indicated that he rated 23 percent impairment due to his ongoing residual weakness, pain and dysfunction. He noted that, with regard to appellant's impotence, which directly resulted from his injury, his condition fell within a Class 1 rating for permanent impairment due to penile disease under Table 7.5 of A.M.A., *Guides*, for a 10 percent impairment of the whole person. Using the Combined Values Chart at page 604 of the A.M.A., *Guides*, Dr. Smith combined the 23 percent whole person lumbar impairment with a 10 percent sexual dysfunction impairment, which resulted in a combined 31 percent impairment; a 3 percent discretionary award for pain; and an additional 3 percent impairment for "ongoing significant pain," which he believed was not well represented by the previously calculated impairment values, for an overall 37 percent whole body impairment.

In a November 23, 2005 report, Dr. H. Michael Jaffin, Board-certified in orthopedic surgery, stated:

"At the present time [appellant] has sustained impairment as follows: With respect to his lumbar spine he is a DRE lumbar spine category [3], with 13 percent whole person impairment with a history of herniated disc at the level that would be expected from objective clinical signs. There was surgery and it is now asymptomatic. Unfortunately, this does not cover his entire impairment because [appellant] is substantially symptomatic. He would get an additional three percent whole person impairment for pain. In addition to that [appellant] sustained one to

[1] By decision dated December 2, 2004, the Office reduced appellant's entitlement to wage-loss compensation in light of the fact that he had returned to light duty on April 7, 2004. As appellant had been receiving compensation based on his part-time work schedule since he returned to work, the Office determined that his schedule award would be paid beginning November 17, 2004, even though the date of maximum medical improvement was June 4, 2004. (AD 12/2/04).

two percent whole person impairment for calf atrophy. He would additionally have sustained seven percent whole person impairment for his antalgic limp. [Appellant] would also have sustained 10 percent whole person impairments for each flexion and extension knee weakness, 15 percent whole person impairment for plantar flexion weakness and three percent whole person impairment for great toe extension weakness on the left. Using the combined impairments chart on pages 604-605 of the A.M.A., [*Guides*] in combining [appellant's] above listed impairments, including 13 percent for DRE spine, [3] percent for pain, [2] percent for gait, [2] percent for atrophy, [7] percent for gait, 10 percent for knee flexion and extension weakness, 15 percent for plantar flexion weakness and [3] percent for great toe flexion and extension weakness, this patient sustained a 50 percent whole person impairment."

In an impairment evaluation dated January 28, 2007, an Office medical adviser recommended further development of the record in order to obtain clarification of the left lower extremity weakness noted in Dr. Jaffin's November 23, 2005 report and the left calf weakness and left gluteus weakness noted in Dr. Smith's August 28, 2006 report. He stated that appellant might be entitled to a significantly higher award involving the left lower extremity depending on this clarification and on any documentation of left lower extremity muscle weakness; he noted, however, that a rating for left calf atrophy could not be combined with a rating for left gastrocnemius or left plantar flexion ankle weakness, as this would be duplicating an award to assign a rating for both atrophy and weakness. The Office medical adviser therefore recommended that a narrative report he obtained which documented appellant's subjective complaints in detail and the manner in which they may or may not interfere with his activities. He stated that any weakness of the muscles involving the left lower extremity should be carefully measured, quantified and compared to the opposite or right lower extremity; he noted that a description of the individual's gait in detail could yield information which permitted an award under Table 17-5, *Lower Limb Impairment due to Gait Derangement*. In addition, the Office medical adviser noted that the medical records documented a sexual dysfunction, for which Dr. Smith recommended a 10 percent whole-person impairment pursuant to Table 17-2 1, *Criteria for Rating Neurologic Sexual Impairment*. He stated that, under the Federal (FECA) Procedure Manual, a 10 percent sexual whole-person impairment would be divided by the total for sexual impairment and urethral impairment of 28 percent to arrive at a 36 percent impairment of the penis for an award with this degree of sexual dysfunction. Dr. Smith opined that appellant's sexual dysfunction condition appeared to be related to the accepted lumbar intervertebral disc condition.

By decision dated February 9, 2007, the Office denied modification of the December 7, 2004 schedule award. It noted that both Dr. Jaffin and Dr. Smith submitted whole person impairment ratings, which are not permitted under the Federal Employees' Compensation Act. The Office noted that the Office medical adviser had stated in his January 28, 2007 report that additional medical evidence was needed to determine whether appellant was entitled to an additional schedule award. It therefore instructed that the Office medical adviser's report be sent to Dr. Smith for review so that he could clarify the issues the Office medical adviser referenced in his report, in order to aid in determining whether appellant was entitled to an additional schedule award. In addition, the Office noted that it had authorized Dr. Smith to refer appellant to an appropriate specialist to consider whether his sexual dysfunction condition was causally

related to his accepted back condition and to therefore determine whether he was entitled to treatment and/or an additional schedule award for this condition.

In a May 31, 2007 report, Dr. Roland J. Wong, Board-certified in urology, stated that appellant was referred because of erectile dysfunction. Appellant had related that, on May 3, 2001, while lifting a heavy box he developed back pain and subsequently was found to have a herniated disc. In January 2002, he had a discectomy but ruptured another disc. In June 2002, appellant had a fusion of L5-S1. He states that the level of his back pain is still 4 out of 10. Appellant stated that after the injury he has been unable to sustain an erection and states that prior to his injury he never had a problem with any erectile dysfunction. Dr. Wong concluded that his sexual dysfunction coincided with the time of injury. It was his opinion that the sexual dysfunction was the result of appellant's injury in which the nerve fibers for erection were damaged. Dr. Wong diagnosed organic impotence.

In a December 17, 2007 report, Dr. Smith noted that he had reviewed the Office medical adviser's January 28, 2007 report, after which he reiterated his previously rendered findings, conclusions and impairment rating. He recommended that the left lower extremity findings pertaining to Dr. Jaffin be referred to that physician for clarification regarding these points.

In a report dated May 13, 2008, the Office medical adviser stated that, based on the current medical evidence of record, appellant was not entitled to a schedule award for the left lower extremity greater than the award for 13 percent impairment previously awarded. He stated, however, that he had not received the detailed clarification that he had requested in his January 28, 2007 report. The Office medical adviser therefore recommended that clarification of the left lower extremity weakness be obtained as he stated in his January 28, 2007 report, which required that appellant be referred to an orthopedic surgeon for another evaluation to document his subjective complaints in detail and how they may or may not interfere with activity. He stated that any left or right lower extremity weakness should be identified in terms of which muscle groups are involved and quantified.

By decision dated June 17, 2008, the Office denied modification of the February 9, 2007 decision. It noted that it had provided Dr. Smith with a copy of the Office medical adviser's January 28, 2007 report and in response Dr. Smith had submitted his December 17, 2007 report. The Office found that this report was not sufficient to warrant an additional schedule award and modification of the February 9, 2007 decision. It also instructed the district office to address and develop the issue of whether appellant's erectile dysfunction condition developed as a consequence of his accepted lower back condition.

LEGAL PRECEDENT

The schedule award provision of the Act[2] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[3] However, the Act does not specify the manner in which the

[2] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[3] *Id*. at § 8107(c)(19).

percentage of loss of use of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* fifth edition as the standard to be used for evaluating schedule losses.[4] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[5]

ANALYSIS

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

The Office granted appellant an award for a 13 percent impairment for the left lower extremity based on the Office's medical adviser's September 12, 2004 report, in which he reviewed Dr. Kimelman's findings of numbness and loss of sensation in the lateral aspect of the left foot mild pain and discomfort in the S1 nerve root, 4/5 weakness based on active movement against gravity with some resistance and 4/5 weakness of the hip abductors innervated at the L3-4 level. The A.M.A., *Guides* sets out the method by which impairments are rated for these conditions at Chapter 15, subsection 12, at page 423, which states:

"If any neural impairment is identified, proceed with the following evaluation:

> (1) Identify the nerve(s) involved, based on the clinical evaluation and the dermatome distribution charts for the lower (Figure 15-1) … extremity….
>
> (2) Determine the extent of any sensory and motor loss due to nerve impairment, based on Tables 15-15 and 15-16.
>
> (3) Find the maximum impairment due to nerve dysfunction in … Table 15-18 for the lower extremity.
>
> (4) Multiply the severity of the sensory or motor deficit by the maximum value of the relevant nerve (Tables 15-17, 15-18). If there is both sensory and motor impairment of a nerve root, the impairment percents are combined (Combined Values Chart, p[age] 604) to determine the extremity impairment…."

The Office medical adviser adhered to the method outlined above by calculating a Grade 2 sensory deficit at S1 pursuant to Table 15-15 at page 424 of the A.M.A., *Guides*, then utilizing Table 15-18 at page 424, which yielded a 70 percent impairment, multiplied by a maximal 5 percent impairment for S1, which equates to a 3.5 percent impairment. He then rounded off this figure for a four percent impairment for S1 nerve dysfunction. The Office medical adviser then applied appellant's four plus out of five sensory deficit at L4 pursuant to Table 15-15, which translated to a 34 percent impairment at Table 15-18. He then multiplied this figure by a Grade 4, 25 percent weakness at Table 15-16, which yielded an 8.5 percent impairment for left hip abductor weakness, which he rounded off to 9 percent. The Office medical adviser added

[4] 20 C.F.R. § 10.404.

[5] *Veronica Williams*, 56 ECAB 367, 370 (2005).

4 percent for left lower extremity numbness and/or pain, for a total 13 percent lower extremity impairment. The Office properly based its December 7, 2004 schedule award on the 13 percent impairment rating rendered by the Office medical adviser, who took Dr. Kimelman's findings on examination and made calculations based on these findings, pursuant to the applicable standards and tables of the A.M.A., *Guides*.

Appellant requested reconsideration and submitted reports from Drs. Smith and Jaffin. In his January 28, 2007 report, the Office medical adviser stated that appellant might be entitled to a significantly higher award involving the left lower extremity based on findings of left lower extremity weakness, left calf weakness and left gluteus weakness made by these physicians. He recommended further development and clarification of these issues through an additional narrative report, which would thoroughly document appellant's subjective complaints of pain and determine if they were sufficient to warrant an additional schedule award for the left lower extremity. However, the Office issued a decision based on February 9, 2007, in which it noted the Office medical adviser's recommendations for further development of the medical evidence but denied modification of the original schedule award based on the available evidence of record. It instructed the district office to send a copy of the Office medical adviser's January 28, 2007 report to Dr. Smith so that he could review it and make the suggested clarifications; however, Dr. Smith merely reiterated his previously stated findings in his December 17, 2007 report. The case file was referred back to the Office medical adviser, who noted in a May 13, 2008 report that he had not received the detailed clarification he had requested in his original report. The Office medical adviser restated his recommendation that the Office further develop the medical evidence and obtain clarification of the left lower extremity. In addition, he specifically instructed that appellant be referred to an orthopedic surgeon for another evaluation to identify and quantify any left or right lower extremity weakness, document his subjective complaints in detail and specify the manner in which they may or may not interfere with activity, in order to fully determine whether appellant was entitled to an additional award for left lower extremity impairment. In its June 17, 2008 decision, however, the Office again did not address the Office medical adviser's recommendation and failed to follow the instruction to further develop the medical evidence. The Board therefore finds that the Office erred by ignoring the Office medical adviser's recommendation to refer appellant to an orthopedic specialist, a referral which the Office medical adviser believed was required to determine the proper degree of left lower extremity impairment appellant sustained due to his accepted lower back condition.

The reports from Drs. Jaffin and Smith, however, did not explain how these physicians correlated any impairment findings with the A.M.A. *Guides*. In addition, these reports do not conform to the A.M.A., *Guides*, as they do not relate their findings to the applicable tables and charts of the A.M.A., *Guides*.[6] Therefore, these reports do not establish that appellant is entitled to an additional schedule award. As Drs. Jaffin and Smith offered a mere conclusion regarding the degree of appellant's impairment, without explaining the basis for each rating factor,

[6] While Drs. Jaffin and Smith assessed a whole man impairment, the Act does not allow for "whole man" impairment schedule awards. *Janae J. Tripplette*, 54 ECAB 792 (2003).

the Office properly found that their opinions did not present a basis for an additional schedule award for the left lower extremity.[7]

The Board therefore sets aside the June 17, 2008 Office decision and remands for referral of appellant, the case record and a statement of accepted facts to an appropriate medical specialist to evaluate the appropriate percentage of impairment in his left lower extremity based on left lower extremity weakness, left calf weakness and left gluteus weakness. On remand, the Office should instruct the impartial medical specialist to clearly indicate the specific background and protocols of the A.M.A., *Guides* upon which he based his opinion. After such further development of the record as it deems necessary, it shall issue a *de novo* decision.[8]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 17, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to the Office for further action consistent with this decision of the Board.

Issued: September 15, 2009
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

[7] The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *See Peter C. Belkind*, 56 ECAB 580, 585 (2005).

[8] The Board notes that the Office has already referred the case for further development regarding the issue of whether appellant's sexual dysfunction condition is causally related to his accepted lumbosacral condition and therefore provides a basis for an additional schedule award.