United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 09-967**
	)	**Issued: January 19, 2010**
DEPARTMENT OF THE AIR FORCE, HEADQUARTERS, LACKLAND AIR FORCE BASE, TX, Employer	)	

Appearances:
Victor Octavio Enriquez, Esq., for the appellant
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 March 3, 2009 appellant filed a timely appeal from a June 18, 2008 merit decision of the Office of Workers' Compensation Programs concerning schedule award compensation and a November 19, 2008 nonmerit decision denying his request for further review of his claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has more than an 8 percent permanent impairment of his right arm, a 12 percent permanent impairment of his right leg and a 12 percent permanent impairment of his left leg, for which he received schedule awards; and (2) whether the Office properly denied his request for further review of his claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

The Office accepted that on May 1, 2006 appellant, then a 53-year-old air conditioning equipment mechanic, sustained closed dislocations of multiple lumbar, thoracic and cervical vertebrae when he was assaulted by a coworker. Appellant filed a claim for a schedule award due to his accepted employment injuries. In an August 24, 2007 decision, the Office denied his claim for schedule award compensation finding that he had not submitted sufficient medical evidence to establish that he had any permanent impairment related to the accepted back conditions.[1]

In a September 28, 2007 report, Dr. Daniel J. Boyle, an attending osteopath, stated that his impairment rating was based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He based impairment on functional deficits to the lower extremities. There was a difference in calf circumference -- 35.5 centimeters (cm) on the left and 34.0 cm on the right side. Dr. Boyle stated that the impairment for atrophy in the right leg would be five percent based on Table 17-6b on page 530 of the A.M.A., *Guides*. Under Tables 17-7 and 17-8 on pages 531 and 532, appellant had Grade 4 strength in both knees upon extension which equaled a 12 percent impairment in both legs for this deficit. He also had an additional 12 percent impairment in the right leg due to Grade 4 strength in the right knee upon flexion.

Dr. Boyle found that appellant had a total impairment in the left leg of 12 percent based on the strength deficit upon knee extension. In the right leg, appellant had a 5 percent impairment for atrophy, a 12 percent impairment for knee extension strength deficit and a 12 percent impairment for knee flexion strength deficit. Dr. Boyle noted that, according to Table 17-2 on page 526 of the A.M.A., *Guides*, impairment ratings for atrophy could not be combined with impairment ratings for strength deficits. He indicated that it was appropriate to use the Combined Values Chart on page 604 to combine the two 12 percent impairment ratings for knee extension strength deficit and knee flexion strength deficit. This calculation yielded a total impairment of appellant's right leg of 23 percent.

In an October 8, 2007 report, Dr. Boyle determined that appellant had a 17 percent impairment of his right arm due to limited motion of his right shoulder, elbow, wrist and thumb. These values were based on the combination of values for limited abduction and flexion of the right shoulder (eight percent rating); limited flexion of the right elbow (one percent rating); limited extension, flexion and ulnar deviation of the right wrist (seven percent rating) and limited motion at the interphalangeal joint of the right thumb (two percent rating). Dr. Boyle also indicated that appellant had a four percent rating due to limited left shoulder abduction, a five percent rating due to limited left shoulder flexion, a two percent rating due to limited left wrist flexion, a three percent rating due to limited left wrist extension, a one percent rating due to

[1] In an August 15, 2007 report, Dr. Robert S. Meador, a Board-certified internist serving as an Office medical adviser, indicated that the medical evidence did not show that appellant had a permanent impairment entitling him to schedule award compensation. He noted that Dr. Fred Guerra, an attending family practitioner, had indicated on December 6, 2006 that appellant had no permanent impairment of his extremities.

limited left wrist ulnar deviation and a three percent rating for limited motion of the metacarpophalangeal joint of the left thumb.[2]

In a December 12, 2007 decision, an Office hearing representative set aside the August 24, 2007 decision and remanded the case for further development. She determined that the September 28, 2007 report of Dr. Boyle necessitated further development of the medical evidence and directed an Office medical adviser to evaluate Dr. Boyle's report.

On February 20, 2008 Dr. Henry Mobley, a Board-certified internist serving as an Office medical adviser, stated that Dr. Boyle's September 28, 2007 impairment rating was not performed in accordance with the standards of the A.M.A., *Guides.* He recommended that appellant be referred to another physician for an assessment of any impairment.

The Office referred appellant to Dr. James F. Hood, a Board-certified orthopedic surgeon. On March 24, 2008 Dr. Hood reported his findings on examination and stated that there would be no impairment rating for any strength or sensory deficits in the right or left upper extremity. He found that appellant had no muscle weakness, atrophy or significant changes in reflexes. Dr. Hood concluded that appellant had an 8 percent permanent impairment in his right arm and a 12 percent permanent impairment in each leg. He advised that the right arm impairment rating was based on limited shoulder motion, comprised of a two percent rating for 80 degrees of abduction, a two percent rating for 80 degrees of flexion, a one percent rating for 45 degrees of external rotation and a three percent rating for 20 degrees of internal rotation. Dr. Hood stated:

> "Turning then to the lower extremities, it is clear that this gentleman has an L5 radiculopathy bilaterally. Per Table 17-37, this is the common peroneal portion of the sciatic nerve.
>
> "For the left lower extremity, the motor deficit relating to the common peroneal nerve equals 42 percent. This would be multiplied by 25 percent or a Grade [4] weakness. This would equal 10.5 percent, rounded up to 11 percent.
>
> "For the mild sensory deficit (decreased sensation in the dorsum of the left foot), per Table 17-37, a 2 percent impairment would be multiplied by a 25 percent for the gradation of the sensory deficit. This would equal a 0.5 percent (rounded up to 1 percent).
>
> "Therefore, the impairment rating for the left lower extremity would be 12 percent lower extremity. The impairment rating for the right lower extremity is identical. It, too, would equal a 12 percent lower extremity."

In a June 2, 2008 report, the Office medical adviser agreed with Dr. Hood's impairment ratings of 8 percent permanent impairment to appellant's in his right arm and 12 percent permanent impairment to each leg.

[2] Dr. Boyle combined these values to equal a 25 percent impairment of the left arm, but the values would actually combine to equal 18 percent when using the Combined Values Chart on page 604 of the A.M.A., *Guides.*

In a June 18, 2008 decision, the Office granted appellant a schedule award for an 8 percent permanent impairment of his right arm, a 12 percent permanent impairment of his right leg and a 12 percent permanent impairment of his left leg. The awards ran for 94.08 weeks from June 8, 2008 to March 28, 2010.

Appellant requested reconsideration and submitted additional medical reports that did not provide any impairment assessment as well as several medical reports previously of record. His attorney argued that the Office did not adequately consider the reports of Dr. Boyle.

In a November 19, 2008 decision, the Office denied appellant's request for further review of the merits of his claim.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations[4] 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.[5]

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."[6] 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.[7]

ANALYSIS -- ISSUE 1

The Office accepted that on May 1, 2006 appellant sustained closed dislocations of multiple lumbar, thoracic and cervical vertebrae. In a June 18, 2008 decision, it granted him a schedule award for an 8 percent permanent impairment of his right arm, a 12 percent permanent impairment of his right leg and a 12 percent permanent impairment of his left leg. The Office based the award on the March 24, 2008 assessment of Dr. Hood, a Board-certified orthopedic surgeon serving as an Office referral physician. On June 2, 2008 Dr. Meador a Board-certified

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *Id*.

[6] 5 U.S.C. § 8123(a).

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

internist who served as an Office medical adviser, indicated that he agreed with Dr. Hood's method of assessing appellant's impairment.

The Board finds that there is a conflict in the medical evidence regarding the extent of appellant's permanent impairment, which requires that the case be remanded to the Office for further development of the medical evidence.

In a September 28, 2007 report, Dr. Boyle concluded that appellant had a 12 percent permanent impairment of his left leg and a 23 percent permanent impairment of his right leg. He found that, under Tables 17-7 and 17-8 on pages 531 and 532 of the A.M.A., *Guides*, appellant had Grade 4 strength in both knees upon extension which equaled a 12 percent impairment in both legs for this deficit. Appellant also had an additional 12 impairment in the right leg due to Grade 4 strength in the right knee upon flexion. Dr. Boyle indicated that it was appropriate to use the Combined Values Chart on page 604 of the A.M.A., *Guides* to combine the two 12 percent impairment ratings for knee extension strength deficit and knee flexion strength deficit. This calculation yielded a total impairment of appellant's right leg of 23 percent.

Moreover, in an October 8, 2007 report, Dr. Boyle determined that appellant had a 17 percent impairment of his right arm due to limited motion of his right shoulder, elbow, wrist and thumb. These values were based on the combination of values for limited abduction and flexion of the right shoulder (eight percent rating); limited flexion of the right elbow (one percent rating); limited extension, flexion and ulnar deviation of the right wrist (seven percent rating) and limited motion at the interphalangeal joint of the right thumb (two percent rating).[8] Dr. Boyle also indicated that appellant had a four percent rating due to limited left shoulder abduction, a five percent rating due to limited left shoulder flexion, a two percent rating due to limited left wrist flexion, a three percent rating due to limited left wrist extension, a one percent rating due to limited left wrist ulnar deviation and three percent rating for limited motion of the metacarpophalangeal joint of the left thumb.[9]

In contrast, Dr. Hood determined on March 24, 2008 that appellant had an 8 percent permanent impairment in his right arm and a 12 percent permanent impairment in each leg. He indicated that appellant had an impairment rating of eight percent for the right arm due to limited shoulder motion, comprised of a two percent rating for 80 degrees of abduction, a two percent rating for 80 degrees of flexion, a one percent rating for 45 degrees of external rotation and a three percent rating for 20 degrees of internal rotation. Dr. Hood stated that appellant had an L5 radiculopathy bilaterally and posited that, using Table 17-37 on page 552 of the A.M.A., *Guides*, that his Grade 4 sensory loss (equal to 20 percent) associated with the common peroneal portion of the left sciatic nerve equaled an 11 percent impairment of the left leg. He further found that appellant's Grade 4 sensory loss (equal to 20 percent) manifested by decreased sensation in the dorsum of the left foot equaled a 1 percent impairment of the left leg. Dr. Hood determined that the rating scheme for the right leg was identical and therefore found that appellant also had a

[8] *See* A.M.A., *Guides* 451-79.

[9] Dr. Boyle combined these values to equal a 25 percent impairment of the left arm, but the values would actually combine to equal 18 when using the Combined Values Chart on page 604 of the A.M.A., *Guides*.

12 percent impairment of his right leg. On June 2, 2008 Dr. Meador indicated that he agreed with Dr. Hood's method of assessing appellant's impairment.

The case will must be remanded to refer appellant to an impartial medical specialist to resolve the conflict in the medical opinion evidence between the Dr. Boyle and Dr. Hood regarding the extent of appellant's permanent impairment.[10] After such further development as the Office deems necessary, it should issue an appropriate decision regarding the extent of the permanent impairment to appellant's extremities.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant has more than an 8 percent permanent impairment of his right arm, a 12 percent permanent impairment of his right leg and a 12 percent permanent impairment of his left leg, for which he received schedule awards.[11] The case is remanded to the Office for further development.

[10] The Board further notes that it remains unclear whether the Office ever adequately considered Dr. Boyle's October 8, 2007 assessment of appellant's upper extremity impairment. Appellant has not received a schedule ward for left arm impairment and on remand the Office should consider whether he has permanent impairment of his left arm.

[11] Given the Board's finding with respect to the merit issue of this case, it is not necessary for the Board to consider the nonmerit issue.

ORDER

IT IS HEREBY ORDERED THAT the November 19 and June 18, 2008 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: January 19, 2010
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