United States Department of Labor
Employees' Compensation Appeals Board

D.F., Appellant	)	
and	)	**Docket No. 09-1232**
	)	**Issued: June 16, 2010**
DEPARTMENT OF THE AIR FORCE, SCOTT AIR FORCE BASE, IL, Employer	)	

Appearances:
Alan J. Shapiro, 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 April 9, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated March 17, 2009, which affirmed the Office's November 12, 2008 schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant has more than a three percent impairment of the right lower extremity and more than a three percent impairment of the left lower extremity for which he received a schedule award.

FACTUAL HISTORY

On November 28, 2005 appellant, then a 41-year-old physical security specialist, filed a traumatic injury claim alleging that, on that same date, he lifted an office desk and sustained an abdominal hernia and a herniated disc in his low back. He did not initially stop work. The

Office accepted appellant's claim for the conditions of aggravation of L4-5 herniated disc and sciatica. It authorized L4-5 microdiscectomy performed on April 12, 2007.

A January 23, 2006 magnetic resonance imaging (MRI) scan read by Dr. Anand Singh, a Board-certified diagnostic radiologist, revealed a small central disc herniation at L4-5 with impingement on the right L5 nerve root. In a February 23, 2006 report, Dr. Joseph Sherrill, a Board-certified neurosurgeon, determined that appellant had a disc complex at L4-5 on the right which would require traction or surgery.

In a March 20, 2007 report, Dr. Paul Santiago, a neurosurgeon, indicated that appellant complained of back pain traveling down both legs, right worse than left. He diagnosed L5 radiculopathy on the right, possible partial radiculopathy on the left and L4-5 herniated nucleus pulposus and recommended surgery. In an April 12, 2007 operative report, Dr. Santiago noted performing a right L4-5 open microdiscectomy.

On January 2, 2008 appellant filed a Form CA-7 claim for a schedule award. In a January 25, 2008 report, Dr. Santiago indicated that immediately after surgery appellant's preoperative pain improved dramatically. However, since then, he noted that appellant related a recurrence of symptoms of pain and numbness and tingling from his buttocks down to his feet but denied weakness of the lower extremities. Dr. Santiago advised that diagnostic testing revealed no further herniation at L4-5 and a small right paracentral disc bulge without a significant neural impingement and a small central disc herniation with no significant central impingement at L5-S1. He found that appellant was status post right L4-5 open microdiscectomy for L5 radiculopathy and advised that he had previously been worked up for peripheral neuropathy "without any evidence of neuropathy on electrodiagnostic testing. Despite this, appellant may have a very mild neuropathy at present." Dr. Santiago advised that appellant reached maximum medical improvement and was not disabled.

In a May 21, 2008 report, Dr. Martin Fritzhand, a Board-certified urologist, noted appellant's history. He related that appellant had complaints of constant sharp low back pain radiating to both hips and both legs down to the toes, exacerbated by prolonged ambulation, standing, bending, stooping or lifting heavy objects. Dr. Fritzhand also noted that appellant had complaints of pain and numbness in both legs. He examined appellant and determined that he had limited range of motion, of the spine and diminished muscle strength. Dr. Fritzhand utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (5th ed. 2001). He referred to Table 17-37 to determine the maximum impairment value due to nerve deficits.[1] For the sciatic nerve, Dr. Fritzhand noted that the maximum impairment of the leg due to sensory loss and pain is 17 percent while the maximum value due to motor loss is 75 percent. He referred to Table 16-10 to rate the impairment for sensory loss.[2] Dr. Fritzhand determined that, under Table 16-10, appellant qualified for a grade of 3/5 or 50 percent deficit as she had difficulty performing some activities of daily living, which included performing some household chores, sports and extracurricular activities. Under the procedure in Table 16-10, he multiplied the 50 percent deficit by the 17 percent maximum

[1] A.M.A., *Guides* 552.

[2] *Id.* at 482.

impairment for sensory loss for the sciatic nerve which equated to 9 percent impairment. For motor loss, Dr. Fritzhand referred to Table 16-11 and determined that appellant qualified for a motor deficit of 4/5 or 25 percent.[3] Under the procedure in Table 16-11, he multiplied the 25 percent deficit by the 75 percent maximum impairment for motor loss for the sciatic nerve which equated to 19 percent impairment. Dr. Fritzhand referred to the Combined Values Chart and determined that appellant had an impairment of 26 percent for each leg.

In a June 30, 2008 report, an Office medical adviser noted the reports of Dr. Santiago and Dr. Fritzhand. He indicated that appellant continued to have pain in the low back radiating into both legs. The Office medical adviser also advised that Dr. Santiago, the operating surgeon, found normal strength. He explained that, based on Dr. Santiago's evaluation, there was no objective evidence to support any residual lower extremity impairment. The Office medical adviser noted that Dr. Fritzhand found impairment based on sciatic nerve pathology. He explained that, in appellant's case, there was "nothing wrong with the sciatic nerve. If anything, the pathology is isolated to the L5 nerve root." The Office medical adviser explained that a follow-up lumbar spine MRI scan revealed that a large disc herniation in the lateral recess was no longer evident and that there was no other significant pathology. He opined that it was "difficult to explain [appellant's] current subjective complaints of pain." The medical adviser stated that the only impairment that appellant had would be impairment of three percent to each leg for residual pain in the L5 nerve root bilaterally. He explained that it was based upon a Grade 3 for pain in the distribution of the L5 nerve root according to Table 15-15 and Table 15-18.[4] The Office medical adviser further noted that appellant could squat, walk heel-to-toe and on the heels and toes and advised that there was little evidence to support any additional impairment for weakness. He stated that appellant reached maximum medical improvement on January 25, 2008, the date he was released from Dr. Santiago's care.

On August 13, 2008 the Office referred appellant along with a statement of accepted facts and the medical record to Dr. Marvin Mishkin, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Dr. Fritzhand and the Office medical adviser regarding the extent of appellant's impairment.

In a September 2, 2008 report, Dr. Mishkin noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He stated that appellant complained of constant back and bilateral leg pain to the toes with intermittent tingling and an occasional charley horse of the entire right leg. Dr. Mishkin observed that appellant could walk easily and without difficulty that he could walk and balance on his toes and heels without pain or evidence of motor weakness and had a normal gait. He found that appellant had equal circumference of the thighs and knees, a normal response to pinprick and light touch and negative straight leg raising. On standing, appellant could bend forward flexing his back to 50 degrees and then assume an upright posture and extend his back to 25 degrees. However, Dr. Mishkin noted that, when lying supine on the examining table he could sit upright. In doing this, appellant could flex his back beyond 90 degrees, flex his hips beyond 90 degrees and, with his knees extended, could bend forward so his fingertips touched his ankles. Dr. Mishkin noted that appellant could maintain that posture

[3] *Id.* at 484.

[4] *Id.* at 424.

without pain or discomfort or muscle spasm. He explained that he concurred with the Office medical adviser's impairment assessment and advised that appellant had an impairment of three percent for the right leg and three percent for the left leg based on the distribution at the L5 nerve root. Dr. Mishkin opined that he could "find no evidence of motor weakness of the lower extremities and no evidence of atrophy." He found that appellant had subjective complaints of pain in the back and lower extremities and subjective complaints of dysesthesia along the medial aspect of both calves. However, Dr. Mishkin explained that appellant's reflexes were symmetrical. He noted that the mobility of appellant's back was excellent, in that he could sit upright, bend forward and touch his toes. Dr. Mishkin explained that, despite chronic subjective complaints, there was no objective evidence. He advised that appellant could "stand on his toes and heels. Appellant can balance on either leg. He can walk with a normal gait. There is no muscle atrophy." Dr. Mishkin explained that appellant had active flexion of his back at the lumbar spine of 90 degrees, was able to bend forward and touch his toes and had active extension to 30 degrees. He also indicated that appellant did not have ankylosis of the joints.

On November 12, 2008 the Office granted appellant a schedule award for a three percent permanent impairment of the left lower extremity and a three percent permanent impairment of the right lower extremity. The award covered a period of 17.28 weeks from January 25 to May 24, 2008.

On November 17, 2008 appellant's representative requested a hearing, which was held on February 10, 2009. During the hearing appellant indicated that he did not have a history of back or leg problems prior to his work injury. Appellant's representative argued that Dr. Fritzhand's report supported a higher impairment.

In a December 18, 2008 report, Dr. Fritzhand indicated that the Office medical adviser and the impartial medical examiner only found impairment for sensory loss and did not allow for muscle weakness. He opined that appellant "certainly had muscle weakness involving both lower extremities." Dr. Fritzhand explained that the "finding of muscle weakness, especially in the 4-4+/5 range is not far from normal and can certainly vary on examination from physician to physician." He advised that appellant's muscle strength was not normal and justified a finding of 4-4+/5. Dr. Fritzhand also opined that the primary injured nerve secondary to appellant's low back injury was the sciatic nerve. He reviewed his prior calculation and explained that he referred to Figures 17-8, 17-9 and Table 17-37 to determine that this would result in impairment to each lower extremity of 26 percent.[5] Dr. Fritzhand opined that this most accurately represented appellant's injury impairment. He explained that appellant had a two-level disc herniation and that the L5 and S1 nerve roots were involved. Dr. Fritzhand also noted impairment could also be rated using tables that were less advantageous for appellant and referred to Tables 15-15, (using a 3/5 rating to grade for sensory impairment), Table 15-16 (using a 4/5 rating to grade motor/power deficit) and 15-18.[6] He explained that for the L5 nerve root -- 5 percent multiplied by a 50 percent grade was equal to 2.5 percent. Dr. Fritzhand also explained that 37 percent multiplied by a 25 percent grade was equal to 9.25 percent. For the S1 nerve root, he advised that 5 percent multiplied by a 50 percent grade was equal to 2.5 percent

[5] *Id*. at 551, 552.

[6] *Id.* at 424, 428.

and 20 percent multiplied by a 25 percent grade was equal to 6.25 percent. Dr. Fritzhand utilized the Combined Values Chart[7] and opined that appellant's permanent impairment to each lower extremity in this scenario would be 20 percent. He found that appellant's impairment to each lower extremity ranged from 20 to 26 percent depending upon which tables and figures were utilized. Dr. Fritzhand recommended that "some sort of compromise" be made in appellant's best interest.

By decision dated March 17, 2009, the Office hearing representative affirmed the Office's November 12, 2008 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[8] set forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[9] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[10] The Act's implementing regulations has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule award losses.[11]

The Act[12] provides that if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.[13] In cases where the Office has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[14]

ANALYSIS

The Office accepted appellant's claim, the conditions of aggravation of L4-5 herniated disc and sciatica. A microdiscectomy was performed on April 12, 2007.

The Office determined that a conflict of medical opinion existed between Dr. Fritzhand, who supported an impairment of 26 percent to the right lower extremity and 26 percent to the left

[7] *Id.* at 604.

[8] 5 U.S.C. §§ 8101-8193.

[9] *Id.* at § 8107.

[10] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[11] 20 C.F.R. § 10.404.

[12] 5 U.S.C. §§ 8101-8193, 8123(a).

[13] *Id.* at § 8123(a); *Shirley Steib*, 46 ECAB 309, 317 (1994).

[14] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

lower extremity and the Office medical adviser, who supported 3 percent impairment for each leg. Therefore, it properly referred appellant to Dr. Mishkin, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict.

When a case is referred to an impartial medical examiner 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.[15] The Office relied upon the opinion of Dr. Mishkin in determining that appellant had a three percent permanent impairment of the right lower extremity and a three percent permanent impairment of the left lower extremity.

In a September 2, 2008 report, Dr. Mishkin noted appellant's history of injury and treatment and conducted a physical examination. While he noted that appellant had subjective complaints that, included constant back and bilateral leg pain to the toes, his examination revealed that appellant could walk easily and without difficulty and that he could walk and balance on his toes and on his heels without pain or evidence of motor weakness. Dr. Mishkin also determined that appellant's gate was normal, that there was no atrophy, that he had a normal response to pinprick and light touch and a negative SLR. He opined that he could "find no evidence of motor weakness of the lower extremities and no evidence of atrophy." Dr. Mishkin noted that appellant had subjective complaints of pain in the back and lower extremities and subjective complaints of dysesthesia along the medial aspect of both calves. However, his reflexes were normal. Dr. Mishkin also determined that the mobility of appellant's back was excellent, in that he could sit upright, bend forward and touch his toes. He explained that, despite the subjective complaints of a chronic nature, there was no objective evidence. Dr. Mishkin concluded that, based on the distribution at the L5 nerve root, appellant had impairment of three percent to the right lower extremity and three percent to the left lower extremity. According to Table 15-18, the maximum percentage loss of function due to sensory deficit or pain is five percent.[16] Under Table 15-15, the Board notes that a Grade 3 for pain in the distribution of the L5 nerve root would receive a maximum sensory deficit of 60 percent.[17] As set forth in the procedure for Table 15-15, the severity of the sensory deficit multiplied by the maximum impairment value of the L5 nerve root (60 percent times 5 percent) which results in an impairment of 3 percent for sensory loss. Dr. Mishkin concluded that appellant would be entitled to receive an impairment of three percent to each lower extremity.

The Board finds that Dr. Mishkin's opinion is entitled to special weight as his reports are sufficiently well rationalized and based upon a proper factual background. The Office properly relied upon his report in finding that appellant was entitled to an impairment of three percent to the right lower extremity and three percent to the left lower extremity. Dr. Mishkin examined appellant, reviewed his medical records and reported accurate medical and employment histories. He found no basis on which to attribute any greater impairment. There is no probative medical

[15] *Richard R. LeMay*, 56 ECAB 341 (2005).

[16] A.M.A., *Guides* 424.

[17] *Id.*

evidence of record establishing that appellant has more than three percent impairment to the right lower extremity and three percent impairment to the left lower extremity.

Subsequent to the examination by Dr. Mishkin, appellant submitted the December 18, 2008 report of Dr. Fritzhand, who elaborated on his findings and presented several methods for calculating sensory or motor impairment. He did not reexamine appellant, but merely provided alternative calculations and also reiterated previous findings regarding appellant's condition. As Dr. Mishkin had been on one side of the conflict in the medical opinion that, the impartial specialist resolved, his report was insufficient to overcome the special weight accorded the impartial specialist or to create a new medical conflict.[18]

The Board finds that the medical evidence does not establish that appellant was entitled to more than a three percent impairment of the right lower extremity and more than a three percent impairment of the left for which he has already received an award.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than a three percent impairment of the right lower extremity and more than a three percent impairment of the left lower extremity for which he received a schedule award.

[18] *Alice J. Tysinger*, 51 ECAB 638 (2000); *Barbara J. Warren*, 51 ECAB 413 (2000).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated March 17, 2009 and November 12, 2008 are affirmed.

Issued: June 16, 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