United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 09-1290**
	)	**Issued: May 12, 2010**
DEPARTMENT OF THE ARMY, IMA HEADQUARTERS, Fort Dix, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director,

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 20, 2009 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated February 4, 2009. 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 sustained any permanent impairment of his upper or lower extremities.

FACTUAL HISTORY

On December 6, 1995 appellant, then a 57-year-old criminal investigator, twisted his neck and low back at work while subduing a prisoner. The Office accepted his claim for a lumbar sprain, lumbar radiculitis and permanent aggravation of these conditions. Appellant sustained a contusion to his buttocks and low back strain on June 12, 1996.[1] He filed a claim for

[1] File No. xxxxxx751.

a June 18, 2004 recurrence of disability related to the 1996 injury; however, the Office subsequently determined it was as a new injury.[2]

On December 9, 2005 the Office referred appellant for a second opinion to Dr. Jatin D. Gandhi, a Board-certified orthopedic surgeon. In a January 3, 2006 report, Dr. Gandhi reviewed appellant's history of injury and medical treatment. He found that appellant had mild tenderness over the cervical spine with no muscle spasm, mild tenderness in the interscapular region, mild tenderness in the trapezial region and no tenderness over the brachial plexus region. Regarding the low back, Dr. Gandhi found moderate tenderness over the lumbosacral region, the pelvis was level and there were no spasms of the paravertebral muscles. He noted moderate tenderness in the sacroiliac or sciatic region. On range of motion, flexion was 60 degrees, extension was 10 degrees and lateral flexion was 10 degrees. Dr. Gandhi advised that range of motion was painful. He noted that straight leg raising was 80 degrees on the left side and associated with lower back pain, a negative Faber test and normal hip range of movement. The neurological examination was symmetrical with no gross motor or sensory deficits. Dr. Gandhi diagnosed cervical sprain with degenerative disc disease and chronic lumbar sprain with radiculopathy. He opined that the chronic lumbar sprain with radiculopathy was work related and a permanent aggravation. However, Dr. Ghandi opined that there was no connection between the cervical sprain and the employment injury.

On August 28, 2007 appellant filed a claim for a schedule award. In a March 14, 2006 report, Dr. David Weiss, an osteopath, reviewed the history of injury and medical treatment. On range of motion, the cervical spine had forward flexion of 40/45 degrees, backward extension of 40/45 degrees, left rotation of 50/80 degrees, right rotation of 60/80 degrees, left lateral flexion of 30/45 degrees and right lateral flexion of 30/45 degrees. Dr. Weiss advised that appellant had pain on all ranges of motion and that the Spurling maneuver on the left produced axial pain but no radicular component. Appellant had normal gross motor strength of both arms and his sensory examination revealed a perceived sensory deficit over the C5 dermatome in both arms. He complained of constant neck pain and stiffness, radicular pain and weakness involving the arms, constant daily mid and low back pain and radicular symptoms involving the lower extremities. Dr. Weiss stated that appellant's activities of daily living were restricted. He advised that appellant ambulated with a noticeable widened gait. Dr. Weiss advised that appellant had a perceived sensory deficit over the L4 and L5 dermatomes in both legs.

In rating impairment, Dr. Weiss used the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (5th ed. 2001) (hereinafter A.M.A., *Guides*). Appellant had four percent impairment to both the right and left arms based on sensory loss of the C5 nerve root. Under Table 15-17 the maximum impairment for C5 nerve root impairment affecting an upper extremity is five percent. Dr. Weiss found, under Table 15-15, that the extent of sensory deficit was 80 percent or Grade 2. He multiplied the maximum value by the deficit grade to find four percent impairment to each arm. In rating impairment to both lower extremities at 13 percent, Dr. Weiss utilized Table 15-18 to identify nerve root impairment at L4 and L5 for which maximum 5 percent is allowed. Under Table 15-15, he allowed a sensory deficit of 80 percent or Grade 2, to find 8 percent total impairment to each leg due to L4 and L5 sensory loss. Dr. Weiss

[2] File No. xxxxxx108. This claim was later double into claim xxxxxx771.

then applied Table 17-8 to rate impairment for loss of strength in the right and left hip flexors which he characterized as Grade 4, allowing five percent impairment. Under the Combined Values Chart 8 percent impairment for pain combined with 5 percent impairment for loss of strength totaled 13 percent impairment of both legs.

On November 2, 2007 an Office medical adviser noted that appellant twisted his lower back and neck on December 6, 1995. While appellant's primary complaints concerned his low back, the cervical spine had not been treated in recent years. The medical adviser noted that Dr. Gandhi had diagnosed cervical sprain with degenerative disc disease and a chronic lumbar sprain with radiculopathy; however, he found that there was no cervical or lumbar spine sensory or motor deficit. He advised that there was a conflict in medical opinion between Dr. Ghandi and Dr. Weiss, who found sensory deficit involving the C5 nerve root together with sensory impairment of the L4 and L5 nerve roots with motor loss of both hip flexors. The medical adviser stated that the hip flexors were innervated by L2, and there was no evidence of L2 involvement. He also stated that diagnostic testing did not reveal degenerative changes and there were no objective findings from the physical examination, only note of appellant's sensory complaints. The medical adviser recommend against finding any impairment to either the arms or legs.

The Office found a conflict between Dr. Ghandi and Dr. Weiss as to the nature and extent of permanent impairment to appellant's arms and legs. On March 7, 2008 it referred appellant with a statement of accepted facts and the medical record to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for an impartial medical evaluation.

On March 13, 2008 appellant's representative stated that he had received a letter scheduling appellant for examination by Dr. Stark. He requested a copy of the letter to the physician, the statement of accepted facts and a copy of Dr. Stark's report when received.

In a March 20, 2008 report, Dr. Stark reviewed appellant's history of injury and medical treatment. He noted that appellant was able to walk with a normal reciprocating heel/toe gait, and in calcaneus and equinus gaits. Appellant described pain on ambulation. Cervical spine examination revealed tenderness on palpation over the spinous processes of C6 and C7 with no tenderness over the paracervical musculature. On range of motion, Dr. Stark found that it was preserved through the cervical spine. Appellant had normal forward flexion of 45 degrees, extension to 45 degree, rotation of 70 degrees on the left and right and lateral bending of 40 degrees on both sides. Although he complained of pain on extremes of motion, there was no sensory or motor deficit to the arms. Dr. Stark explained that deep tendon reflexes to the upper extremities were present and equal bilaterally. On examination of the mid and lower back, appellant had local tenderness on palpation over the spinous process of T6 through 19, tenderness over the spinous process of the lumbar vertebrae and tenderness over the left paradorsal muscles and over the paralumbar musculature bilaterally. Dr. Stark advised that range of motion of the lumbar spine was equal to flexion of 70 degrees, extension of 30 degrees and lateral flexion of 25 degrees on each side. He explained that the sitting root test was negative and straight leg raising was equal to 80 degrees bilaterally. Dr. Stark noted that appellant complained of back pain on extreme straight leg raising. There were no sensory or motor deficits to the lower extremities and the reflexes of the lower extremities were present and

equal bilaterally. There was no documentation to support that appellant sustained a neurological deficit as a result of the work-related injuries. Dr. Stark noted that the medical records supported that appellant had discogenic disc disease of his cervical and lumbar spines with lumbar spinal stenosis. Although Dr. Weiss made neurological findings involving the upper and lower extremities, Dr. Stark did not find evidence of such deficits on examination of appellant. Dr. Stark noted that Dr. Gandhi did not report any neurological findings. Based on the absence of any neurological deficit or muscle weakness in the upper or lower extremities, Dr. Stark found that appellant had no permanent impairment in relation to the accepted injuries. He advised that appellant reached maximum medical improvement on January 3, 2006, the date of his examination by Dr. Gandhi.

On April 22, 2008 the Office medical adviser agreed with the findings by Dr. Stark. He noted that, while Dr. Weiss found impairments involving appellant's right arm and both lower extremities, this determination was in conflict with the opinion of Dr. Ghandi. The Office medical adviser stated that Dr. Stark did not support the abnormal neurological defects that formed the basis for the impairment rating of Dr. Weiss. He also noted that the records did not mention any neurological defects in the extremities.

In a June 4, 2008 decision, the Office denied appellant's schedule award claim, finding that the weight of medical opinion did not establish any permanent impairment to his upper or lower extremities.

On June 16, 2008 appellant's attorney requested a hearing that was held on November 19, 2008. Appellant addressed his employment history and noted being on limited duty for five years before retiring. He contended that the examination by Dr. Stark took a few minutes and that the physician did not listen to his description of his history. Counsel contended that a conflict in medical opinion did not exist as Dr. Ghandi did not evaluate appellant with regard to the schedule award claim. She questioned whether Dr. Stark had been properly selected as other physicians were bypassed.

In a February 4, 2009 decision, an Office hearing representative affirmed the June 4, 2008 decision. She found that Dr. Stark was properly selected as the impartial specialist and that his medical opinion was entitled to special weight. She noted that the conflict had arisen between Dr. Weiss and the Office medical adviser.

LEGAL PRECEDENT

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

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulation 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] 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.[7]

ANALYSIS

The Board finds that this case is not in posture due to an unresolved conflict in medical opinion. The Office found a conflict between Dr. Weiss, an attending physician, who found that appellant had impairment to both arms and legs, and Dr. Gandhi, the second opinion physician. The Board notes, however, that the record does not establish that appellant was referred to Dr. Gandhi for an opinion on permanent impairment for schedule award purposes.[8] For this reason, the Board finds that Dr. Stark served as a second opinion examiner and not an impartial medical specialist.

An Office medical adviser reviewed the impairment rating of Dr. Weiss and noted that he would not recommend impairment to any of appellant's extremities. The Office informed appellant on March 7, 2008 that a conflict had arisen between Dr. Weiss and Dr. Gandhi regarding the extent of his work-related condition and whether he had permanent impairment. Appellant was referred to Dr. Stark for an impartial medical examination. As Dr. Gandhi did not provide an opinion on permanent impairment for schedule award purposes, Dr. Stark may not be considered as an impartial medical specialist with regard to the extent of ratable impairment related to appellant's accepted conditions.[9]

Although the Office subsequently noted that the conflict had arisen between Dr. Weiss and the Office medical adviser and Dr. Gandhi, the Board has held that there is no provision under the Act or Office's procedures for designating a physician an impartial medical specialist

[5] A.M.A., *Guides* (5th ed. 2001).

[6] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*, 45 ECAB 207, 210 (1993).

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

[8] Appellant did not file a claim a schedule award until a year after Dr. Gandhi issued his report. A copy of the referral letter to Dr. Ghandi is not of record.

[9] However, his report may be considered for its own intrinsic value. *See Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996). Inasmuch as Dr. Stark is not considered to be an impartial specialist, it is not necessary to address appellant's arguments regarding the propriety of the process employed by the Office to select Dr. Stark as an impartial specialist.

on an after-the-fact basis.[10] Therefore, an unresolved conflict exists between the findings of Dr. Weiss and those of Dr. Stark. The case will be remanded to the Office to refer appellant to an impartial medical specialist for examination and opinion on the nature and extent of any impairment related to the accepted conditions. After such further development as it deems necessary, the Office should issue an appropriate decision on appellant's claim for a schedule award.

CONCLUSION

The Board finds that the case is not in posture for a decision due to an unresolved conflict in medical opinion.

ORDER

IT IS HEREBY ORDERED THAT the February 4, 2009 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded for proceedings consistent with this decision of the Board.

Issued: May 12, 2010
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

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