United States Department of Labor
Employees' Compensation Appeals Board

R.G., Appellant	)	
and	)	**Docket No. 10-1418**
	)	**Issued: April 25, 2011**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Newark, 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:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 28, 2010 appellant, through his attorney, filed a timely appeal of the January 27 and March 30, 2010 schedule award decisions of the Office of Workers' Compensation Programs. Pursuant to the Federal Employees' Compensation Act[1] and 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 13 percent impairment of the right lower extremity, for which he received a schedule award; and (2) whether he is entitled to a schedule award for permanent impairment of the left lower extremity.

On appeal, appellant's attorney contends that the medical opinion of an attending physician who found that appellant had greater impairment than that previously awarded by the Office should constitute the weight of the medical opinion evidence. He further contends that

[1] 5 U.S.C. § 8101 *et seq.*

the medical report of the impartial medical specialist is insufficient to constitute the weight of the medical opinion evidence because he was not properly selected from the Physicians Directory System (PDS) and failed to conduct a thorough physical and neurological examination. Counsel argues that the Office did not sufficiently explain why a qualified physician was bypassed under the PDS.

FACTUAL HISTORY

On November 6, 2003 appellant, then a 59-year-old transportation security screener, filed an occupational disease claim alleging that on September 23, 2003 he first became aware of his right sciatica. On October 27, 2003 he first realized that his condition was caused by lifting too many bags at work. Appellant stopped work on September 23, 2003. The Office accepted his claim for right sciatica and lumbosacral radiculitis. It authorized a percutaneous discectomy which was performed on September 28, 2004.

On April 17, 2006 appellant filed a claim for a schedule award. In a January 16, 2007 medical report, Dr. David O. Weiss, an attending Board-certified orthopedic surgeon, found that appellant had 46 percent impairment of the right lower extremity and 30 percent impairment of the left lower extremity due to sensory and motor deficits based on Table 15-15 and Table 15-18, page 424, Table 16-11, page 484 and Table 17-37, page 552 of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

On April 30, 2008 Dr. Henry J. Magliato, an Office medical adviser, reviewed the medical record, including Dr. Weiss' January 16, 2007 findings and determined that appellant had 10 percent impairment of the right lower extremity (A.M.A., *Guides* 424, 534, Table 15-15, Table 15-16, Table 18-1). He advised that appellant had no impairment of the left lower extremity as his accepted conditions were on the right side of the lumbar spine. Appellant reached maximum medical improvement on January 16, 2007.

By letter dated October 8, 2008, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Michael J. Katz, a Board-certified orthopedic surgeon, for a second opinion medical examination. In an October 29, 2008 report, Dr. Katz advised that appellant's bilateral leg symptoms appeared to be related to his lumbar spine. Utilizing Table 15-3 at page 384 of the fifth edition of the A.M.A., *Guides*, he determined that appellant had four percent impairment of each lower extremity.

On February 28, 2009 Dr. Andrew A. Merola, an Office medical adviser, reviewed the medical record, including Dr. Katz's October 29, 2009 findings. He noted that his impairment ratings related to the lumbar spine was not listed as a scheduled member of the body for which a schedule award was payable. Dr. Merola noted that Dr. Weiss' examination found motor loss and sensory deficits in appellant's lower extremity nerve roots which did not correlate with Dr. Katz's examination findings. He recommended an impartial medical examination based on the physicians' conflicting findings regarding impairment to appellant's right and left lower extremities. Dr. Merola advised that he reached maximum medical improvement on October 29, 2008.

By letter dated July 2, 2009, the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Salvatore J. Scalfani, a Board-certified orthopedic surgeon, for an impartial medical examination. The record contains a bypass form indicating that no qualified physicians were available in appellant's zip code. A search was conducted in a different zip code area. A bypass form indicated that Dr. Steven Scalfani, a Board-certified orthopedic surgeon, was bypassed for selection as an impartial medical specialist. The bypass notes portion of the form stated that, he was on vacation throughout July 2009. Another bypass form indicated that Dr. L. Paul Brief, a Board-certified orthopedic surgeon, was passed over for selection as his telephone number was not in service and telephone directory assistance had no further information. Another bypass form revealed that Dr. Norman I. Reis, a Board-certified orthopedic surgeon, was not selected as an impartial medical specialist because he was out sick and it was unknown as to when he would return to work. A bypass form which indicated that Dr. Jordan A. Simon, a Board-certified orthopedic surgeon, was a potential impartial medical specialist contained the name and claim number for a different claimant.

In a July 20, 2009 report, Dr. Scalfani obtained a history of the employment injuries and appellant's medical treatment. He noted his complaints of numbness, discomfort and tingling in both legs, primarily in the right leg. Appellant had occasional discomfort in his lower back. He walked with a crutch due to his right leg pain. Dr. Scalfani described a full physical and neurological examination related to the lumbar spine and right and left lower extremities. There was some straightening of the normal lumbar lordosis. Appellant had no muscle spasm or significant back complaints. He had no muscle spasm on palpation. No trigger points palpated throughout the lumbar area. In a sitting position, appellant was able to elevate his right and left heel to 90 degrees with no complaints of back pain. In a supine position he had a bilateral negative straight leg raising test. Appellant was actively able to elevate his heel from the examining table from 0 to 70 degrees on both the right and left with no complaints of back pain. He had tenderness in the right groin and a positive Faber test. Appellant had locked limitation of external and internal rotation of the right hip consistent with a significantly arthritic right hip. There was no atrophy in the right lower extremity. Appellant had good and active dorsalis pedis pulses bilaterally. Dr. Scalfani provided measurements for the right and left mid-calves. He reported dull, but present reflexes at the knee and ankle. Pinwheel testing revealed no loss of sensation over both lower extremities contrary to appellant's contention that he had decreased sensitivity. Muscle strength was evaluated in the absence of atrophy. Muscle tone was measured between four and five on both the right and left lower extremities. Appellant ambulated with an antalgic gait. He could not stand on his heels and toes.

Dr. Scalfani diagnosed degenerative disc disease of the lumbosacral spine, herniated nucleus pulposus at L1-L2 based on a magnetic resonance imaging scan, discogenic disease of the lumbar spine at L4-L5 with bulging lumbar discs at L2-L3, L3-L4 and L4-L5 and osteoarthritis of the right hip. Appellant was postpercutaneous discectomy at L4-L5. Dr. Scalfani stated that much of his antalgic gait was primarily due to an arthritic right hip based on his limited range of motion findings. He found, based on Table 17-4 at page 570 of the sixth edition of the A.M.A., *Guides*, which was the lumbar spine regional grid for impairments to the lumbar spine, that appellant had a Class 1 impairment that represented nine percent impairment secondary to chronic lumbar herniated disc and inflammatory right sciatica. Dr. Scalfani concluded that appellant reached maximum benefits from treatment. Appellant needed further

evaluation for his significant right hip arthritis which was not causally related to his accepted employment injuries.

On August 7, 2009 Dr. Morley Slutsky, an Office medical adviser, reviewed the medical record, including Dr. Scalfani's February 21, 2006 findings. He determined that appellant had 13 percent impairment of the right lower extremity and no impairment of the left lower extremity based on the sixth edition of the A.M.A., *Guides*. Appellant reached maximum medical improvement on July 20, 2009. Dr. Slutsky stated that Dr. Scalfani failed to properly utilize the A.M.A., *Guides* in rating appellant's permanent impairment. He utilized Table 17 regarding the lumbar spine which was not accepted by the Office. Also, Dr. Scalfani did not provide net adjustment calculations and rationale. Dr. Slutsky found that appellant had no sensory impairment due to his employment-related sciatica as Dr. Scalfani reported no objective evidence of such loss (A.M.A., *Guides* 533, 534, Table 16-11, Table 16-12). He selected a grade modifier (GM) of 1 for 4/5 muscle strength deficit related to the employment-related lumbar radiculopathy in the absence of atrophy (A.M.A., *Guides* 533, 534, Table 16-11, Table 16-12). Dr. Slutsky selected a GM of two for appellant's functional history based on his antalgic limp and use of a crutch (A.M.A., *Guides* 516, Table 16-6). A physical examination GM was not relevant as neurologic findings were used to define impairment ranges (A.M.A., *Guides* 517, Table 16-7 and 533, Section 16.4(c)). Dr. Slutsky selected a clinical studies GM of two, classifying the right L4-5-S1 radiculopathy with denervation in the paraspinal muscles, mild distal sensory neuropathy, multilevel degenerative disc disease with a left paracentral herniation at the L1-2 and intranuclear tears at the L3-4, L4-5 and L5-S1 as moderate pathology (A.M.A., *Guides* 519, Table 16-8). The class diagnosis (CDX) applied was one and the GM applied was two for each factor, based on a moderate problem in accordance with Table 16-6, page 516 and Table 16-7, page 517. The net adjustment formula was (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX). Since the GM was two and the CDX was one, the formula resulted in 1 + 0 + 1 = 2 which moving two to the right of the default grade C, represented a grade E or 13 percent impairment of the right leg. Dr. Slutsky found that appellant had no left lower extremity impairment based on Dr. Slutsky's finding that a June 28, 2004 electromyogram/nerve conduction study (EMG/NCS) revealed no evidence of left leg radiculopathy.[2]

On August 11, 2009 the Office requested that Dr. Scalfani review Dr. Slutsky's August 7, 2009 report and provide whether he agreed with his findings. In an August 20, 2009 report, Dr. Scalfani agreed with Dr. Slutsky's opinion, noting that his own findings included 13 percent loss of use of the right lower extremity. He stated that, Dr. Slutsky's findings were essentially the same as his findings although the physician used a different method to calculate appellant's permanent impairment.

By decision dated September 11, 2009, the Office granted appellant a schedule award for 13 percent impairment of the right lower extremity for the period July 20, 2009 to April 8, 2010. It found that he had no impairment of the left lower extremity and denied his claim for a schedule award for that extremity.

[2] The June 28, 2004 EMG/NCS of appellant's legs and lumbar paraspinal muscles demonstrated right L4-5/S1 radiculopathy with denervation in the paraspinal muscles and mild prolonged sensory evoked responses that were consistent with mild distal sensory neuropathy.

In a September 18, 2009 letter, appellant, through counsel, requested an oral hearing before an Office hearing representative.

In a January 27, 2010 decision, an Office hearing representative affirmed in part and set aside in part the September 11, 2009 decision. He found that Dr. Scalfani's opinion regarding appellant's right lower extremity impairment was entitled to special weight accorded an impartial medical specialist. The hearing representative remanded the case to the Office for further development of the medical evidence to determine whether appellant had any impairment to his left lower extremity based on Dr. Scalfani's left lower extremity findings.

By letter dated February 5, 2010, the Office requested that Dr. Scalfani clarify whether appellant had any impairment of the left lower extremity based on the sixth edition of the A.M.A., *Guides*, noting his motor strength deficit findings on the left side and the results of the June 28, 2004 EMG/NCS. On March 15, 2010 Dr. Scalfani advised that although the June 25, 2004 EMG/NCS showed left-sided radiculopathy, his July 20, 2009 examination revealed no evidence of residual radiculopathy in the left lower extremity. He noted that subsequent to the EMG/NCS appellant underwent corrective lumbar surgery and was treated with several epidural injections. Dr. Scalfani further noted that on clinical examination, he only had subjective complaints of left-sided radiculopathy.

In a March 30, 2010 decision, the Office found that appellant did not have any permanent impairment of the left lower extremity based on Dr. Scalfani's March 15, 2010 impartial medical opinion.

LEGAL PRECEDENT -- ISSUES 1 & 2

The schedule award provision of the Act[3] and its implementing regulations[4] 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 of loss of use.[5] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[6] For Office decisions issued on or after May 1, 2009, the sixth edition of the A.M.A., *Guides* (6th ed. 2009) is used for evaluating permanent impairment.[7]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability

[3] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[4] 20 C.F.R. § 10.404.

[5] 5 U.S.C. § 8107(c)(19).

[6] *Supra* note 4.

[7] *Id.*

and Health (ICF).[8] Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

Section 8123(a) of the Act provides that, 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.[10] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[11] 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 such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12]

It is well established that Office procedures provide that an impartial medical specialist must be selected from a rotational list of qualified Board-certified specialists, including those certified by the American Medical Association and American Osteopathic Association.[13] The physician selected as the impartial specialist must be one wholly free to make an independent evaluation and judgment. To achieve this end, the Office has developed procedures for the selection of the impartial medical specialist designed to provide adequate safeguards against the appearance that the selected physician's opinion was biased or prejudiced.[14] The procedures contemplate that impartial medical specialists will be selected from Board-certified specialists in the appropriate geographical area on a strict rotating basis in order to negate any appearance that preferential treatment exists between a particular physician and the Office.[15] The Federal (FECA) Procedure Manual (the procedure manual) provides that the selection of referee physicians (impartial medical specialists) is made through a strict rotational system using appropriate medical directories. The procedure manual provides that the PDS should be used for this purpose wherever possible.[16] The PDS is a set of stand-alone software programs designed to

[8] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id.* at 494-531.

[10] 5 U.S.C. § 8123(a).

[11] 20 C.F.R. § 10.321.

[12] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[13] *See A.R.*, Docket No. 09-1566 (issued June 2, 2010); *LaDonna M. Andrews*, 55 ECAB 301 (2004).

[14] *See A.R., supra* note 13; *Raymond J. Brown*, 52 ECAB 192 (2001).

[15] *B.P.*, Docket No. 08-1457 (issued February 2, 2009).

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

support the scheduling of second opinion and referee examinations.[17] The PDS database of physicians is obtained from the American Board of Medical Specialties which contains the names of physicians who are Board-certified in certain specialties. It is well established that, when 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 proper factual and medical background must be given special weight.[18]

In some instances, an Office medical adviser's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the A.M.A., *Guides*. In this instance, a detailed opinion by the Office medical adviser which gives a percentage based on reported findings and the A.M.A., *Guides* may constitute the weight of the medical evidence.[19]

ANALYSIS -- ISSUES 1 & 2

The Office accepted appellant's claim for right sciatica and lumbosacral radiculitis. It authorized his September 28, 2004 percutaneous discectomy. Due to a conflict between appellant's physician, Dr. Weiss, who found that appellant had 46 percent impairment of the right lower extremity and 30 percent impairment of the left lower extremity, and Dr. Katz, an Office referral physician, who found that appellant had 4 percent impairment of each lower extremity, the Office referred appellant to Dr. Scalfani, as the impartial medical specialist to resolve the conflict in medical opinion.

First the Board will address counsel's contention on appeal that the Office did not properly select Dr. Salvatore Scalfani as the impartial medical specialist under the PDS as it failed to provide sufficient explanation for bypassing Dr. Jordan A. Simon, a qualified Board-certified orthopedic surgeon. The record regarding Dr. Scalfani's selection as the impartial medical specialist reflects that Dr. Simon was considered as a potential impartial medical specialist by the Office in a claim not related to appellant. The bypass form contained the name and file number for a different claimant. The record further reflects that there were no qualified physicians in appellant's zip code. A search of a different zip code identified Dr. Steven Scalfani, a Board-certified orthopedic surgeon, who was bypassed because he was on vacation throughout July 2009, the time of the Office's referral. Dr. Brief, a Board-certified orthopedic surgeon, was passed over for selection as an impartial medical specialist as his telephone number was not in service and no additional information was available from telephone directory assistance. Dr. Reis, a Board-certified orthopedic surgeon, was bypassed as he was unavailable due to sickness and uncertainty as to when he would return to work. The Board finds that there is no evidence that the Office did not select Dr. Salvatore Scalfani from the PDS or that it failed to comply with its rotational procedures. Appellant did not provide any probative evidence to

[17] *Id.* at Chapter 3.500.7 (September 1995, May 2003).

[18] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

[19] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.7(h) (April 1993).

demonstrate bias on the part of the doctor. The Board has held that an impartial medical specialist properly selected under the Office's rotational procedures will be presumed unbiased and the party seeking disqualification bears the substantial burden of proving otherwise. Mere allegations are insufficient to establish bias.[20] Accordingly, the evidence does not establish an error in the selection of Dr. Salvatore Scalfani as an impartial medical examiner.

In a February 21, 2006 report, Dr. Scalfani found, based on the sixth edition of the A.M.A., *Guides*, that appellant had nine percent impairment of the lumbar spine secondary to chronic lumbar herniated disc and inflammatory right sciatica (A.M.A., *Guides* 570, Table 17-4). He listed his essentially normal findings on physical and neurological examination with some straightening of the normal lumbar lordosis, tenderness in the right groin, a positive Faber test, locked limitation of external and internal rotation of the right hip consistent with a significantly arthritic right hip, dull, but present reflexes at the knee and ankle, ambulation with an antalgic gait and inability to stand on his heels and toes. Dr. Scalfani determined that appellant had nine percent impairment secondary to his chronic lumbar herniated disc and inflammatory right sciatica (A.M.A., *Guides* 570, Table 17-4). However, neither the Act nor its regulations provide for a schedule award for loss of use of the back. The schedule award provisions of the Act include the extremities and a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of such impairment originates in the spine.[21]

The Office's procedures state that an Office medical adviser must review the report to verify correct application of the A.M.A., *Guides* and confirm the percentage of permanent impairment as well as specify his reasons for assigning a certain percentage of loss of use to the measurements or factors provided by an examining physician.[22] In this case, Dr. Slutsky properly stated that appellant was not entitled to a schedule award for impairment of the lumbar spine.[23] He also properly noted that Dr. Scalfani did not provide net adjustment calculations and rationale in support of his impairment rating. Dr. Slutsky found that appellant had no sensory impairment due to his employment-related sciatica as Dr. Scalfani did report any objective of such loss (A.M.A., *Guides* 533, 534, Table 16-11, Table 16-12). He selected a GM of one as appellant had 4/5 muscle strength deficit related to the employment-related lumbar radiculopathy in the absence of atrophy (A.M.A., *Guides* 533, 534, Table 16-11, Table 16-12). Dr. Slutsky selected a GMFH of two (A.M.A., *Guides* 516, Table 16-6) and a GMCS of two classifying the right L4-5-S1 radiculopathy with denervation in the paraspinal muscles, mild distal sensory neuropathy, multilevel degenerative disc disease with a left paracentral herniation at the L1-2 and intranuclear tears at the L3-4, L4-5 and L5-S1 as moderate pathology (A.M.A., *Guides* 519, Table 16-8). He advised that a GM for his physical examination was not relevant as neurologic findings were used to define impairment ranges (A.M.A., *Guides* 517, 533, Table 16-7, Section 16.4(c)). Dr. Slutsky calculated a net adjustment of two resulting in grade E which represented

[20] *See L.W.*, 59 ECAB 471 (2008).

[21] *J.Q.*, 59 ECAB 366 (2008).

[22] *R.S.*, Docket No. 09-1331 (issued April 5, 2010). *Supra* note 19 at Chapter 2.810.7(c) (April 1993).

[23] *J.Q., supra* note 21.

13 percent right lower extremity impairment. He found that appellant had no left lower extremity impairment as there was no objective evidence of left leg radiculopathy based on the June 28, 2004 EMG/NCS.

Dr. Scalfani was asked by the Office to provide a supplemental report stating whether he agreed with Dr. Slutsky's findings. On August 20, 2009 Dr. Scalfani agreed with Dr. Slutsky's opinion that appellant had 13 percent impairment of the right lower extremity stating that, his own findings included 13 percent loss of use of the right lower extremity. However, the Board notes that Dr. Scalfani did not identify any specific tables or figures of the A.M.A., *Guides* which he used to calculate his impairment rating. In a subsequent report, Dr. Scalfani advised that appellant had no impairment of the left lower extremity as there was no objective evidence on physical examination to support his subjective complaint of residual left-sided radiculopathy.

As Dr. Slutsky utilized Dr. Scalfani's objective clinical findings to compare them with impairment criteria listed in the sixth edition of the A.M.A., *Guides*, the Board finds that appellant has no more than 13 percent impairment of the right lower extremity and no impairment of the left lower extremity.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than 13 percent impairment of the right lower extremity, for which he received a schedule award. The Board further finds that appellant is not entitled to a schedule award for permanent impairment of the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the March 30 and January 27, 2010 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: April 25, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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