

**United States Department of Labor
Employees' Compensation Appeals Board**

R.H., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Brick, NJ, Employer**

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**Docket No. 12-116
Issued: July 2, 2012**

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, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 26, 2011 appellant, through his attorney, filed a timely appeal from a July 14, 2011 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 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 two percent impairment of each lower extremity, for which he received schedule awards.

On appeal, counsel contends that the opinion of the impartial medical examiner is insufficient to carry the weight of the medical opinion evidence. He was not properly selected from the Physicians Directory Service (PDS). Counsel contends that Dr. Gary N. Goldstein, a Board-certified orthopedic surgeon, was inappropriately bypassed because he could not perform an examination before September 2010. He states that Dr. Gregory S. Maslow, a Board-certified

¹ 5 U.S.C. § 8101 *et seq.*

orthopedic surgeon's examination was performed in June 2010 and that a three-month delay was insignificant given the length of time that had elapsed in the development of appellant's schedule award claim. Counsel asserts that Dr. Maslow's June 28, 2010 report is not consistent with the statement of accepted facts as he diagnosed a lumbar strain while appellant's claim was accepted for disc herniation at L5-S1 and lumbar spondylolisthesis. He did not provide an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) or discuss relevant findings. Counsel asserts that appellant's claim should be expanded to include deep vein thrombosis based on a May 22, 2010 medical report of Dr. Samuel E. Epstein, a Board-certified osteopath.² This condition should also be considered in his overall impairment rating for the lower extremities.

FACTUAL HISTORY

This case has previously been before the Board. In decisions dated June 21, 2004 and July 11, 2008, the Board set aside OWCP decisions dated June 16, 2003 and March 26, 2007 and remanded the case for further development of the medical evidence.³ The Board found an unresolved conflict on the issue of permanent impairment to appellant's lower extremities and directed OWCP to refer him to a new impartial medical specialist. The facts and history of the previous Board decisions are incorporated herein by reference.⁴ The facts and history relevant to the present appeal are set forth.

By letter dated August 15, 2008, OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Zohar Stark, a Board-certified orthopedic surgeon, for an impartial medical examination. In an August 28, 2008 report, Dr. Stark determined that appellant had five percent impairment of the left lower extremity under the fifth edition of the A.M.A., *Guides*.

On October 6, 2008 an OWCP medical adviser recommended that OWCP obtain a supplemental report from Dr. Stark to further address the tests he performed to support the sensory loss findings with regard to appellant's ankles, toes and knees. The medical adviser also

² In the May 22, 2010 report, Dr. Epstein obtained a history of appellant's medical background which included treatment for grade II spondylolisthesis with spinal stenosis and a herniated disc and decompression and arthroscopic right shoulder surgeries. He noted that appellant continued to have exacerbations of his low back and leg pain. Dr. Epstein advised that with time, the spondylolisthesis had progressed, the symptomatology in the back and legs had worsened and atrophy slowly developed in the legs. He further advised that because of immobility during an exacerbation of spondylolisthesis, spinal stenosis and sciatica, appellant developed deep venous thrombosis. His back pain worsened as he gained weight which caused the development of Type II diabetes. Weakness and atrophy due to lumbosacral spine problems caused appellant's legs to give way and a fall resulting in a medial meniscus tear of the right knee.

³ Docket Nos. 04-183 (issued June 21, 2004), 07-2234 (issued July 11, 2008).

⁴ OWCP accepted that on October 19, 1987 appellant, then a 28-year-old letter carrier, sustained a herniated disc and spondylolisthesis at L5-S1 while in the performance of duty. On June 28, 2001 he filed a claim for a schedule award. In a decision dated July 25, 2002, OWCP denied his schedule award claim. In a December 30, 2004 decision, OWCP granted appellant a schedule award for two percent impairment of the right lower extremity and no impairment of the left lower extremity. In a February 16, 2006 decision, an OWCP hearing representative affirmed the December 30, 2004 schedule award decision. In a March 26, 2007 decision, OWCP denied modification of the February 16, 2006 decision.

recommended that he provide all calculations used in support of his five percent left lower extremity impairment rating, including measurements for left thigh atrophy.

In a report dated October 15, 2008, Dr. Stark stated that he used a pinwheel to determine that appellant had decreased sensation from the ankles to the toes and from the ankles and knees bilaterally. His five percent impairment rating was based on Table 15-18, page 484 of the A.M.A., *Guides*. It was related to radiculopathy at L5-S1. The left thigh atrophy was secondary to ruptured tendon in the left quadriceps that he sustained in a 2006 fall that was not related to the accepted conditions. Dr. Stark stated that he did not consider this condition in determining work-related employment impairment.

On November 4, 2008 OWCP's medical adviser reviewed the medical record. He found that appellant had no permanent impairment of the right lower extremity and two percent impairment of the left lower extremity based on the fifth edition of the A.M.A., *Guides*. The medical adviser further found that appellant reached maximum medical improvement on August 28, 2008.

In a November 5, 2008 decision, OWCP found that appellant had no more than two percent impairment of the right lower extremity. It stated that payment for a schedule award for the left lower extremity would be made in a decision under separate cover.⁵

By letter dated November 11, 2008, appellant, through his attorney, requested an oral hearing before an OWCP hearing representative.

In a July 24, 2009 decision, an OWCP hearing representative set aside the November 5, 2008 decision due to an unresolved conflict in medical opinion evidence regarding whether appellant's claim should be accepted for left thigh atrophy and the extent of permanent impairment of his left lower extremity due to this condition. The hearing representative remanded the case to OWCP for referral of appellant to a new impartial medical specialist.

By decision dated August 27, 2009, OWCP's hearing representative amended the July 24, 2009 decision to reflect that on remand, OWCP should obtain a supplemental report from Dr. Stark to address the causal relationship between appellant's left thigh atrophy and his accepted injuries and provide measurements for the condition and an impairment rating for the left lower extremity based on his findings.

In a September 10, 2009 report, Dr. Stark reiterated his opinion that appellant's left thigh atrophy was not caused or affected by his 2006 fall and resultant ruptured tendon in the left quadriceps tendon. Therefore, no measurements for the left thigh were contained in his records as thigh atrophy was not related to the accepted conditions.

⁵ The Board notes that the case record does not contain a separate decision issued by OWCP granting appellant a schedule award for two percent impairment of the left lower extremity. However, the record indicates that on November 7, 2008 it paid him \$4,180.32 in schedule award compensation for the period August 28 through October 7, 2008 with regard to his left lower extremity impairment.

In an October 16, 2009 decision, OWCP found that the medical evidence was insufficient to establish that appellant had left thigh atrophy due to his October 19, 1987 employment injuries and that he did not have more than two percent impairment of the left lower extremity.

By letter dated October 20, 2009, appellant's attorney requested an oral hearing.

In a May 11, 2010 decision, an OWCP hearing representative set aside the October 16, 2009 decision and remanded the case for further medical development. The hearing representative found that OWCP improperly substituted the opinion of an OWCP medical adviser for that of Dr. Stark in granting appellant a schedule award for two percent impairment of the left lower extremity. Further, it did not make a determination regarding any impairment to the right lower extremity. The hearing representative directed OWCP to refer appellant to a new impartial medical specialist to determine the extent of impairment to both lower extremities.

By letter dated May 25, 2010, OWCP referred appellant to Dr. Maslow for an impartial medical examination. Regarding Dr. Maslow's selection, the record contains an iFECs Report: MEO23—Appointment Schedule Notification referring appellant to Dr. Maslow for an impartial medical examination. Additionally, bypass forms for two other Board-certified orthopedic surgeons who were bypassed are of record. The forms reflect that Dr. Philip Kauffman, a podiatrist, was bypassed because he only treated the foot and Dr. Goldstein was bypassed because his office was not booking appointments until September 2010, which OWCP determined was not within a reasonable amount of time.

In a June 28, 2010 report, Dr. Maslow reviewed a history of the October 19, 1987 employment injuries and appellant's medical treatment and employment background. Dr. Maslow advised that appellant moved slowly getting on and off the examination table. He appeared to sit comfortably. Appellant hesitantly stood without his cane and somewhat swayed without it. His balance was good with both eyes opened and closed. Appellant walked slowly while heavily leaning on the cane without any definite analgesic component. Without the cane he took a few steps slowly and complained about back pain, and held himself somewhat hunched over. He faltered as he walked stating that, his back was going to give out on him. Appellant was unable to stand on his toes and heels or squat.

On physical examination of the cervical spine, Dr. Maslow reported a well-healed scar with no evidence of infection. Appellant did not quite have full motion in all planes, but he had no spasm, tilt or ranging pain. Vertex compression testing caused low back pain. Appellant did not complain about radicular signs or symptoms in the upper extremities. Overhead exercise testing was negative for thoracic outlet impingement signs and symptoms bilaterally. On examination of the shoulders, appellant held them at equal height. There were previous surgical scars. Appellant had mild restriction of motion at the right shoulder by about 15 percent in all planes with a complaint of pain. He had no atrophy, spasm or droop. On palpation, there was no evidence of tenderness in either the musculature of the shoulders left or right or the bony structure of the shoulders. There was no sternal or sternoclavicular joint tenderness or tenderness at the acromial clavicular joint on either side. There was also no tenderness at the anterior acromial area or anterior glenoid on either side. There was no evidence of rotator cuff or biceps tendinitis and no impingement signs at either shoulder. There was no instability at either shoulder. Strength testing was normal at both shoulders, including testing of the shrug and

rotator cuff and deltoids. There was no sulcus or apprehension sign at either shoulder. On further examination of the upper extremities, Dr. Maslow reported full range of motion at the elbows, forearms and wrists bilaterally without a complaint of pain. There was no evidence of instability, synovitis or tendinitis at the elbow or wrist. There was no tenderness at de Quervain's point. There was no snuffbox tenderness. Color and temperature of the skin of the hands was normal. Neurologic examination of the upper extremities was normal in its entirety. Sensory examination to light touch was normal throughout both upper extremities. Strength testing was normal throughout both upper extremities with grip strength and pinch grip normal bilaterally. There was no intrinsic atrophy. Reflexes were intact and symmetric at the biceps, brachioradialis and triceps bilaterally. There was no Tinel's sign at the wrist or elbow, left or right. Wrist compression testing was negative bilaterally. On examination of the thoracic spine, Dr. Maslow found no abnormal curvatures. There was no tenderness to either palpation or percussion. There was no evidence of musculature spasm. An examination of the lumbar spine revealed tenderness in the low lumbar region. Appellant complained about severe pain to palpation in the midline at about L5 and in the paravertebrals, more on the right than on the left. He also complained about pain in the middle and upper lumbar region. There was no spasm, tilt or step-off. There was virtually full motion in the lumbar spine, attaining about 85 degrees of flexion and at least 90 degrees of the expected sideward bending and rotation, but appellant complained quite bitterly of pain in doing so. His extension was 100 degrees. Appellant had no buttocks, sciatic notch or sacroiliac joint tenderness on either side. There was no spasm, tilt or step-off in the lumbar spine. Examination of the lower extremities revealed chronic vena stasis changes in both lower extremities without overt skin breakdown. Appellant had one-half inch greater girth measured three inches below the tibial tubercle to the left lower leg. He advised Dr. Maslow that he had atrophy of the right thigh but on measurement three inches above the superior pole of the patella, the physician found equal circumferences of the thighs. The hips had normal range of motion bilaterally. Hip impaction testing was negative. The knees had full range of motion bilaterally. There was no instability, synovitis tendinitis or crepitus. There was no meniscal sign. The ankles had full range of motion and no instability, synovitis, tendinitis or crepitus. The calves were nontender. There was no Homan's sign. On neurologic examination of the lower extremities, Dr. Maslow reported intact reflexes. Sensory examination to light touch was normal throughout. Strength testing was normal throughout, including normal strength testing distally. Sitting root testing and straight leg raising examinations were both negative bilaterally.

Dr. Maslow advised that appellant had a lumbar strain as a result of the October 19, 1987 employment incident. He opined that a lumbar myelogram and postmyelographic computerized tomography scan showed preexistent spondylolisthesis at L5-S1 that any identified disc abnormality was thought to be a calcified disc and that problems clearly predated the accepted incident. Dr. Maslow noted that appellant had predominantly right lower extremity complaints. He opined that a 2003 nerve conduction velocity/electromyogram study (NCV/EMG) was not diagnostic of any radiculopathy that occurred on October 19, 1987. Dr. Maslow advised that his clinical examination did not reveal any objective evidence of permanent disability or impairment causally related to the accepted employment incident. Appellant had exaggerated gait abnormalities. He had no motor or reflex deficit and there was no evidence of sciatic stretch test abnormality. Appellant had some minimal asymmetry in the lower legs which Dr. Maslow stated was related to his chronic vena stasis and not to any neurologic deficit that was causally related to the employment incident. There was no evidence that appellant had either an

acceleration of a degenerative change at L5-S1 or a worsening of his listhesis. Dr. Maslow advised that he had long since reached maximum medical improvement with regard to the accepted injuries and had no permanent impairment to either the right or left lower extremity.

On July 23, 2010 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical record. He noted that Dr. Maslow found no objective neurological impairment of either lower extremity emanating from the lumbar spine. Dr. Magliato noted that Dr. Maslow did not mention the sixth edition of the A.M.A., *Guides*, but stated that since there was no objective evidence of lower extremity radiculopathy on examination, even if the physician had consulted the peripheral nerve table, appellant had zero percent bilateral lower extremity impairment under the A.M.A., *Guides*. He concluded that he probably reached maximum medical improvement on August 28, 2008.

In an August 6, 2010 decision, OWCP found that the medical opinion of Dr. Maslow represented the weight of the medical evidence in finding that appellant had no more than two percent impairment of each lower extremity based on the sixth edition of the (A.M.A., *Guides*).

By letter dated August 12, 2010, appellant's attorney requested an oral hearing.

In a February 28, 2011 decision, an OWCP hearing representative affirmed the August 6, 2010 decision. The hearing representative found that the opinion of Dr. Maslow represented the weight of the medical evidence.

By letter dated March 15, 2011, appellant, through his attorney, requested reconsideration. In a June 6, 2001 report, later updated on February 18, 2011, Dr. David Weiss, an osteopath, listed a history of the October 19, 1987 employment injuries and appellant's medical treatment. Dr. Weiss noted his complaints which included daily and constant low back pain and stiffness, radicular pain going down the right lower extremity, numbness in the right foot, numbness and pins and needles sensation going down the left lower extremity, and exacerbation of pain due to changes in the weather, coughing and sneezing. He listed findings on physical examination of the right and left lower extremities and lumbar spine. Dr. Weiss diagnosed chronic post-traumatic lumbosacral strain and sprain, grade II spondylolisthesis at L4-S1, a herniated disc at L5-S1 and lumbar radiculitis. Utilizing the sixth edition of the A.M.A., *Guides*, he determined that appellant had 19 percent impairment of the right lower extremity and 2 percent impairment of the left lower extremity.

On June 22, 2011 Dr. Magliato reviewed the medical record, including Dr. Weiss' June 6, 2001 findings. He advised that an accurate impairment rating under the sixth edition of the A.M.A., *Guides* could not be determined based on a physical examination that was performed 10 years prior. Dr. Magliato recommended that OWCP accept Dr. Maslow's findings as they were based on a current medical examination that was performed on June 22, 2010.

In a July 14, 2011 decision, OWCP denied modification of the February 28, 2011 decision.

LEGAL PRECEDENT

The schedule award provision of FECA,⁶ and its implementing federal regulations,⁷ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions and organs of the body. FECA, 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.⁸ The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁹ Effective May 1, 2009, FECA adopted the sixth edition of the A.M.A., *Guides*¹⁰ as the appropriate edition for all awards issued after that date.¹¹

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.¹² Neither FECA nor the implementing regulations authorize the payment of a schedule award for the permanent loss of use of the back or spine.¹³ The Board has recognized that a claimant may be entitled to a schedule award for a permanent impairment to an extremity even though the cause of the impairment originates in the back or spine.¹⁴

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.¹⁵ OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures.¹⁶

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH),

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ *Ausbon N. Johnson*, 50 ECAB 304 (1999).

⁹ 20 C.F.R. § 10.404; *Mark A. Holloway*, 55 ECAB 321, 325 (2004).

¹⁰ A.M.A., *Guides* (6th ed. 2009).

¹¹ Federal (FECA) Procedure Manual, Part 3 -- Claims, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹² *C.E.*, Docket No. 11-637 (issued October 14, 2011); *William Edwin Muir*, 27 ECAB 579 (1976).

¹³ FECA specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

¹⁴ *F.W.*, Docket No. 11-191 (issued October 17, 2011); *see also Thomas J. Englehart*, 50 ECAB 319 (1999).

¹⁵ *Rozella L. Skinner*, 37 ECAB 398 (1986).

¹⁶ FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, *supra* note 11.

Physical Examination (GMPE) and Clinical Studies (GMCS).¹⁷ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).¹⁸

Section 8123(a) of FECA 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.¹⁹ 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 OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.²⁰ 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.²¹

It is well established that OWCP 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.²² The physician selected as the impartial specialist must be one wholly free to make an independent evaluation and judgment. To achieve this end, OWCP 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.²³ 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 OWCP.²⁴ 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.²⁵ The PDS is a set of stand-alone software programs designed to support the scheduling of second opinion and referee examinations.²⁶ The PDS database of physicians is obtained from the American Board of Medical Specialties which contains the

¹⁷ A.M.A., *Guides* 494-531.

¹⁸ *Id.* at 521.

¹⁹ 5 U.S.C. § 8123(a).

²⁰ 20 C.F.R. § 10.321.

²¹ *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

²² *See LaDonna M. Andrews*, 55 ECAB 301 (2004); *A.R.*, Docket No. 09-1566 (issued June 2, 2010).

²³ *See Raymond J. Brown*, 52 ECAB 192 (2001); *A.R.*, *supra* note 22.

²⁴ *B.P.*, Docket No. 08-1457 (issued February 2, 2009).

²⁵ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4b (May 2003).

²⁶ *Id.* at Chapter 3.500.7 (September 1995, May 2003).

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.²⁷

ANALYSIS

OWCP accepted appellant's claim for a herniated disc and spondylolisthesis at L4-S1. On December 30, 2004 appellant received a schedule award for two percent impairment of the right lower extremity. On August 6, 2010 he received a schedule award for two percent impairment of the left lower extremity. The Board finds that appellant did not meet his burden of proof to establish that he sustained greater impairment.

Counsel contended on appeal that OWCP did not properly select Dr. Maslow as the impartial medical specialist as Dr. Goldstein was bypassed because he was unable to schedule an examination before September 2010. He asserted that the reason given for the bypass of Dr. Goldstein was not sufficient because a three-month delay between the date of Dr. Maslow's examination on June 28 and September 2010, the date available for an examination to be performed by Dr. Goldstein, was insignificant. The bypass note indicated that appellant's case had been remanded and Dr. Goldstein's office was unable to schedule an appointment in a reasonable amount of time as patients were not being scheduled for medical examinations until September 2010. There is no evidence to establish that OWCP's decision to bypass Dr. Goldstein was inappropriate or unreasonable given that appellant's case had been remanded for further development by the hearing representative on May 11, 2010. Dr. Maslow was able to conduct an examination sooner than Dr. Goldstein. Appellant did not submit evidence to establish that OWCP's decision to bypass Dr. Goldstein was inappropriate or in violation of established procedures. There is no evidence that Dr. Goldstein was improperly bypassed by OWCP.²⁸ The Board finds that Dr. Maslow was properly selected as the impartial medical examiner.

In a June 28, 2010 report, Dr. Maslow opined that appellant did not have any impairment of either lower extremity causally related to the October 19, 1987 employment injuries and that he had reached maximum medical improvement. Dr. Maslow reviewed a history of the accepted injuries and appellant's medical treatment and records. On examination, he provided essentially normal findings on physical and neurological examination of the bilateral upper and lower extremities and cervical, thoracic and lumbar spines with the exception of slow gait, decreased range of motion of the cervical spine and bilateral shoulders, tenderness in the low to upper lumbar region, severe pain to palpation in the midline at L5 and in the paravertebrals, more on the right than left, and chronic vena stasis changes in both lower extremities without overt skin breakdown. Dr. Maslow found that appellant had a lumbar strain causally related to the October 19, 1987 employment incident. He advised that a lumbar myelogram and postmyelographic CT scan revealed preexistent spondylolisthesis at L5-S1 and that any identified disc abnormality represented a calcified disc and any problems clearly predated the

²⁷ *Gloria J. Godfrey, supra* note 21.

²⁸ *See generally, E.M., Docket No. 11-1373* (issued February 3, 2012).

accepted incident. Dr. Maslow further advised that despite appellant's predominantly right lower extremity complaints, a 2003 NCV/EMG was not diagnostic of any radiculopathy that occurred on October 19, 1987. He opined that his clinical examination findings did not reveal any objective evidence of permanent disability or impairment causally related to the accepted employment incident. Dr. Maslow explained that appellant had exaggerated gait abnormalities and no motor or reflex deficit. He further explained that there was no evidence of sciatic stretch test abnormality. Dr. Maslow noted that, although appellant had some minimal asymmetry in the lower legs, this condition was related to his chronic vena stasis and not to any neurologic deficit causally related to the employment incident. Lastly, he explained that there was no evidence that he had either an acceleration of a degenerative change at L5-S1 or a worsening of his listhesis.

The Board finds that Dr. Maslow's opinion is sufficiently well rationalized and based upon a proper factual and medical background. Dr. Maslow's report was of sufficient detail such that others reviewing the file could clearly visualize the impairment.²⁹ The weight of the medical opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of physician's knowledge of the facts of the case, the medical history provided the care of analysis manifested and the medical rationale expressed in support of stated conclusions.³⁰ Dr. Maslow fully discussed the history of injury and related his comprehensive examination findings in support of his opinion that appellant did not have any permanent impairment causally related to his accepted conditions. Thus, his report represents the special weight of the medical evidence.

Dr. Magliato, OWCP's medical adviser properly applied the A.M.A., *Guides* to Dr. Maslow's report to find that there was no basis for permanent impairment of the right or left lower extremity causally related to appellant's accepted herniated disc and spondylolisthesis at L5-S1.

The record does not contain any medical evidence that establishes greater impairment in accordance with the sixth edition of the A.M.A., *Guides*. The Board finds that appellant has not established more than two percent impairment of each lower extremity.

Dr. Weiss' June 6, 2001 report, updated on February 18, 2011, rated 19 percent impairment of the right lower extremity and 2 percent impairment of the left lower extremity. The 19 percent updated rating of February 18, 2011 appears to be based on his June 6, 2001 report. The addendum report was appended to the earlier report. Given the time lapse of almost 10 years, the Board finds such a rating to be of diminished probative value. He listed findings on physical examination and advised that appellant had chronic post-traumatic lumbosacral strain and sprain, grade II spondylolisthesis at L4-S1, herniated disc at L5-S1 and lumbar radiculitis causally related to the October 19, 1987 employment injuries. The Board notes that appellant's claim has not been accepted for the diagnosed lumbar conditions. As stated, OWCP accepted only a herniated disc and spondylolisthesis at L5-S1. For conditions not accepted by OWCP as being employment related, it is appellant's burden to provide rationalized medical evidence

²⁹ See *Robert B. Rozelle*, 44 ECAB 616 (1993).

³⁰ See *Ann C. Leanza*, 48 ECAB 115 (1996).

sufficient to establish causal relation.³¹ Dr. Weiss did not provide any medical rationale explaining why the diagnosed conditions were caused by the accepted injuries and, thus, his opinion is insufficient to establish causal relationship.³² As Dr. Weiss did not provide an impairment rating based on appellant's accepted conditions, the Board finds that his report is insufficient to outweigh the special weight accorded to Dr. Maslow's impartial medical report or to create a new conflict.

On appeal, appellant's counsel contended that Dr. Maslow's diagnosis of lumbar strain is not consistent with the statement of accepted facts which listed disc herniation and spondylolisthesis at L5-S1 as accepted conditions. Dr. Maslow provided a thorough evaluation of the case based on an accurate review of appellant's medical background. While Dr. Maslow credited appellant's lumbar strain to the October 19, 1987 employment injury, he found no acceleration of the accepted degenerative L5-S1 and listhesis conditions and properly determined that appellant had no permanent impairment of either lower extremity. Counsel further contended that Dr. Maslow failed to provide an impairment rating in accordance with the sixth edition of the A.M.A. *Guides* or discuss his relevant findings. As noted, Dr. Maslow clearly discussed his findings on examination and explained why appellant had no lower extremity impairment.

Counsel contends that Dr. Epstein's May 22, 2010 report is sufficient to accept appellant's claim for deep vein thrombosis, which should be considered in rating impairment of his lower extremities. Dr. Epstein found that appellant developed deep vein thrombosis as a result of immobility during an exacerbation of his spondylolisthesis, spinal stenosis and sciatica. He stated that weakness and atrophy due to his lumbosacral spine problems caused his legs to give way and a fall resulting in a medial meniscus tear of the right knee. Dr. Epstein did not address whether the diagnosed conditions were caused by the October 19, 1987 employment injury, thereby rendering it of diminished probative value. Lacking medical rationale on the issue of causal relationship, the Board finds that Dr. Epstein's report is insufficient to establish that appellant sustained an employment-related injury.³³

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than two percent impairment of each lower extremity, for which he received schedule awards.

³¹ *Alice J. Tysinger*, 51 ECAB 638 (2000).

³² *Deborah L. Beatty*, 54 ECAB 340 (2003).

³³ *T.F.*, 58 ECAB 128 (2006).

ORDER

IT IS HEREBY ORDERED THAT the July 14, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 2, 2012
Washington, DC

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

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

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