United States Department of Labor
Employees' Compensation Appeals Board

C.P., Appellant	)	
and	)	**Docket No. 11-1263**
	)	**Issued: March 15, 2012**
DEPARTMENT OF THE AIR FORCE, TINKER AIR FORCE BASE, OK, Employer	)	

Appearances:
Appellant, pro se
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 27, 2011 appellant filed a timely appeal from a December 8, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding his schedule award claim.[1] Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established more than 34 percent permanent impairment to his left leg, for which he received a schedule award.

[1] Appellant has not appealed a November 19, 2010 OWCP decision denying his recurrence claim. Thus, the Board will not review this decision.

[2] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

In October 1969, appellant, then a 35-year-old quality assurance specialist, filed a traumatic injury claim alleging that he initially injured his lower back while moving an 85-pound transmitter. He reinjured his back in December 1969 while delivering groceries as part of a base Christmas project. The claim was accepted for a lumbar strain and L5-S1 herniated disc, right side. Appellant underwent a laminectomy on January 14, 1970. He worked light duty until he retired in 1987. Thereafter, appellant worked part time for the Department of Corrections as a vocational teacher.

On September 10, 2009 appellant inquired about a schedule award and provided a February 5, 1971 report from Dr. Wayne B. Lockwood, a Board-certified orthopedic surgeon, who recommended 10 percent spine impairment. In an October 30, 2009 letter, OWCP advised him that its program does not recognize impairments to the spine. Appellant was informed that, if he sustained impairment to his lower extremities as a result of his work injury, a medical report containing an impairment evaluation consistent with the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) could be submitted for a schedule award determination.

On February 2, 2010 appellant requested a schedule award. In a January 18, 2010 report, Dr. M. Stephen Wilson, an orthopedic surgeon, noted the history of injury and reviewed medical records and set forth findings. He opined that appellant had a significant spine injury resulting in bilateral lower extremity radiculopathy with severe weakness and significant neuropathy due to his work-related accident. Dr. Wilson stated that appellant was at maximum medical improvement. For the right leg, he used Table 16-12, page 535 and determined that appellant had 21 percent impairment due to motor and sensory deficits of the femoral nerve; 54 percent due to motor and sensory deficits of the sciatic nerve; and 30 percent for motor and sensory deficits of the common peroneal nerve. Dr. Wilson combined the percentages under page 604 to find 75 percent total right leg impairment. For the left leg, he also used Table 16-12, page 535 and determined that appellant had 21 percent impairment due to motor and sensory deficits of the femoral nerve; 54 percent due to motor and sensory deficits of the sciatic nerve; and 40 percent for motor and sensory deficits of the common peroneal nerve. Dr. Wilson combined the percentages under page 604 to find 78 percent total impairment left leg.

On August 5, 2010 an OWCP medical adviser reviewed the medical record and Dr. Wilson's January 18, 2010 medical report for the purpose of determining impairment for the lower extremities. He opined that appellant reached maximum medical improvement on January 18, 2010, the date of Dr. Wilson's evaluation. The medical adviser stated that Dr. Wilson used peripheral nerves to determine impairment in the lower extremities. However, combining impairment based on the sciatic and common peroneal nerves constituted duplication.

The medical adviser recommended a second opinion evaluation. He also opined that, to rate radiculopathy, it was more appropriate to use *The Guides Newsletter*, July-August 2009.[3]

In a September 13, 2010 report, Dr. Wilson noted the history of injury, his review of medical record and set forth his examination finding. He opined that appellant reached maximum medical improvement. Dr. Wilson opined that appellant had 48 percent right leg impairment and 50 percent left leg impairment. For the right leg, he noted net adjustments and found 13 percent impairment due to moderate sensory and moderate motor deficits of the L3 spinal nerve; a 17 percent impairment due to moderate sensory and moderate motor deficits of the L4 nerve; 17 percent impairment due to moderate sensory and moderate motor deficits of the L5 nerve; 13 percent impairment due to moderate sensory and moderate motor deficits of the S1 nerve. Dr. Wilson showed his calculations under proposed Table 2 set forth in *The Guides Newsletter*[4] and combined the left leg impairments to find 48 percent total impairment. For the left leg, he noted net adjustments and found appellant had 13 percent impairment due to moderate sensory and moderate motor deficits of the L3 nerve; 17 percent impairment due to moderate sensory and moderate motor deficits of the L4 nerve; 17 percent impairment due to moderate sensory and severe motor deficits due to L5 spinal nerve; and 16 percent impairment due to moderate sensory and severe motor deficits of the S1 spinal nerve. Dr. Wilson showed his calculations under proposed Table 2 of the A.M.A., *Guides* and combined the left leg impairments to find 50 percent total impairment to the left leg. He further opined that appellant's impairment was causally related to appellant's work-related injury.

OWCP referred appellant to Dr. Michael S. Smith, a Board-certified physiatrist, for a second opinion evaluation. In a November 2, 2010 report, Dr. Smith noted the history of injury, a review of the medical records and his examination findings. He diagnosed chronic left L4/5, L5 and S1 radiculopathy with history of lumbar laminectomy; severe degenerative lumbar disc disease; history of cervical stenosis with previous myelopathy with resolution of symptoms and superimposed generalized peripheral neuropathy in the lower extremities. Appellant had obvious elements of persistent lumbar radiculopathy at L4/5, L5, S1 that resulted in some motor impairment of L4, L5 and S1 and some sensory impairment in L4 and L5. Dr. Smith explained that impairments from the right leg were not included as appellant had more of a peripheral neuropathy and no sign of spinal nerve impairments. He noted that the impairment in the left leg was present by history after appellant's accident, reinjury, and surgery before the additional findings of peripheral neuropathy and cervical myelopathy. Dr. Smith opined that maximum medical improvement was reached on March 26, 2004, when appellant was found to have multilevel disc disease with mild lumbar stenosis at L3/4. For the L4 nerve, he utilized proposed Table 2 of the A.M.A., *Guides* and found a class 1 (mild sensory deficit) with a default value of 1 percent. Grade modifiers were determined to be 3 for Functional History (GMFH) and 1 for

[3] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibit 1, 4). Exhibit 1 provides that impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July-August 2009 edition of *The Guides Newsletter* published by the American Medical Association. The July-August 2009 edition of *The Guides Newsletter* is set forth at exhibit 4.

[4] *See id*.

Clinical Studies (GMCS).[5] Dr. Smith applied the net adjustment formula of (GMFH - CDX) (3-1) + (GMCS - CDX) (1-1) to find a net adjustment of 2. This resulted in class 1 with an adjustment of 2 from the default value C, which equaled class 1, grade E impairment of two percent. For moderate/severe motor deficit of L4 nerve, proposed Table 2 showed class 1 with default value of 13 percent impairment. Grade modifiers were 3 for functional history and 1 for clinical studies. The net adjustment was calculated to be 2 using the net adjustment formula of (GMFH - CDX) (3-1) + (GMCS - CDX) (1-1). The result was class 1 with net adjustment of 2 from the default value of C equaled class 1, grade E of 13 percent. For the L5 nerve, Dr. Smith found five percent moderate sensory impairment and nine percent mild motor deficit. A moderate sensory deficit for L5 nerve under proposed Table 2 was class 1 with a default value of three percent. Dr. Smith determined the grade modifiers for functional history was 3 and for clinical studies was 1. He found the net adjustment of (GMFH - CDX) (3-1) + (GMCS - CDX) (1-1) equaled 2. The result was a class 1 with a net adjustment of 2 or class 1, grade E of five percent. Under proposed Table 2, a mild motor deficit of L5 results in class 1, with a default value of five percent. Dr. Smith determined the grade modifiers for functional history was 3 and for clinical studies was 1. The net adjustment of (GMFH - CDX) (3-1) + (GMCS - CDX) (1-1) equaled 2. The result was a class 1 with net adjustment of 2 or class 1, grade E of nine percent. For the S1 nerve, Dr. Smith found 10 percent moderate motor impairment. Under proposed Table 2, a moderate motor deficit of S1 nerve was class 1 with a default value of eight percent. Grade modifier for functional history was 3 and clinical studies was 1. The net adjustment of (GMFH - CDX) (3-1) + (GMCS - CDX) (1-1) was 2. The result was class 1 with an adjustment of 2 from the default value C which equaled class 1, grade E or 10 percent. Dr. Smith stated that he combined the motor impairments of 10 + 13 + 9 to find 32 percent impairment for the spinal nerve involvement from L4 through S1 for motor impairment. For sensory impairment, he stated that he combined the two plus five to find seven percent total sensory impairment. Dr. Smith combined the motor impairment of 32 with sensory impairment of 7 to find 39 percent left leg impairment.

In a November 19, 2010 report, OWCP's medical adviser reviewed Dr. Smith's November 2, 2010 report for purposes of determining an impairment of the lower extremities. He noted agreeing with Dr. Smith's calculations for motor and sensory deficits of the L4, L5 and S1 nerves under proposed Table 2. However, the medical adviser opined that appellant had 34 percent total left lower extremity impairment. He stated that Dr. Smith should have combined the findings in each nerve root (15 percent for L4 nerve root, 14 percent for L5 nerve root, and 10 percent for S1 motor deficit) instead of adding the sensory and motor impairments of each nerve root.

By decision dated December 8, 2010, OWCP granted appellant a schedule award for 34 percent permanent loss of use of the left lower extremity. The award ran 97.92 weeks for the period March 26, 2004 to February 9, 2006.

[5] Grade modifier for physical examination was not used in the impairment since it was used to determine the spinal nerve impairment.

LEGAL PRECEDENT

The schedule award provision of FECA[6] and its implementing 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 or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[8] For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, Physical Examination (GMPE) and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

ANALYSIS

OWCP accepted that appellant had work-related lumbar strain and right-sided L5-S1 herniated disc, for which he underwent surgery on January 14, 1970. Appellant subsequently requested a schedule award. OWCP awarded him 34 percent left lower extremity impairment based on its medical adviser's review of the report of the second opinion examiner, Dr. Smith.

The Board finds that the case is not in posture for decision due to a conflict in medical opinion necessitating a referral to an impartial medical specialist.[13]

In his September 13, 2010 report, Dr. Wilson opined that appellant has 48 percent right lower extremity impairment and 50 percent left lower extremity impairment due to motor and sensory impairments of the L3, L4, L5 and S1 nerve roots from the accepted work injury. He

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[9] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 494-531.

[12] *Id.* at 521.

[13] 5 U.S.C. § 8123(a); *see Paul J. Navarette*, Docket No. 05-895 (issued July 11, 2005).

utilized the A.M.A., *Guides* rating scheme under proposed Table 2 and provided calculations for his impairment determinations.

Dr. Smith opined in his November 2, 2010 report that only impairment to the left leg was causally related to the accepted work injury and provided an explanation. He utilized the A.M.A., *Guides* rating scheme under proposed Table 2 and opined that appellant had 39 percent left lower extremity impairment. OWCP's medical adviser reviewed Dr. Smith's report and opined that appellant had 34 percent left leg impairment as Dr. Smith added rather than combine the findings in each nerve root. The medical adviser did not review or discuss Dr. Wilson's September 13, 2010 report.

The Board finds that a conflict in medical opinion exists between Drs. Wilson and Smith as to the extent of permanent impairment to appellant's lower extremities as there is no agreement on whether only the left leg or both legs are involved, and the extent of impairment of the left leg.[14] If there is a conflict in medical opinion between the employee's physician and the physician making the examination for the United States, OWCP shall appoint a third physician, known as a referee physician or impartial medical specialist, to make what is called a referee examination.[15] To resolve the present matter, OWCP shall remand the case, refer appellant for a referee examination, together with the medical record and a statement of accepted facts, to an appropriate Board-certified specialist and obtain a rationalized medical opinion regarding whether for impairment rating purposes appellant has work-related impairment of only the left leg or both legs and to rate the extent of permanent impairment of the proper lower extremity. After conducting such further development as it may find necessary, OWCP shall render an appropriate decision.

On appeal, appellant expressed his disagreement as to why Dr. Smith's evaluation was used over that of his physician, Dr. Wilson, and why he was not provided a schedule award for his right lower extremities. He further requested an explanation as to how his award was computed. As explained, the Board finds that the case is not in posture for decision due to a conflict in the medical evidence and must be remanded to an appropriate specialist to resolve the medical conflict.

CONCLUSION

The Board finds that the case is not in posture for decision.

[14] *See Paul J. Navarette*, *supra* note 13.

[15] *See* 5 U.S.C. § 8123(a); 20 C.F.R. § 10.321. *See also R.A.*, Docket No. 09-552 (issued November 13, 2009).

ORDER

IT IS HEREBY ORDERED THAT the December 8, 2010 decision of the Office of Workers' Compensation Programs be set aside and the case remanded for further action consistent with this decision of the Board.

Issued: March 15, 2012
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