

A December 10, 2004 magnetic resonance imaging (MRI) scan of the lumbar spine revealed a signal change in the disc at L4-5 and L5-S1 compatible with desiccation, minimal bulging at L4-5 and broad-based disc bulge at L5-S1 indenting the thecal sac. Appellant was treated by Dr. A.J. Bisson, a Board-certified physiatrist, from June 3, 2005 to August 29, 2008, who diagnosed pelvic sprain and strain and lumbar radiculopathy. On July 22, 2008 Dr. Bisson opined that she was at maximum medical improvement and could work with restrictions. An August 5, 2005 electromyogram (EMG) revealed no abnormalities. An October 28, 2005 lumbar CT scan revealed normal segments at L2-3 and L3-4, symptomatic L4-5 annular tear with small disc protrusion, collapse and resorption of disc space at L5-S1.

On September 10, 2008 appellant claimed a recurrence of disability. On December 18, 2008 OWCP denied the claim. In a July 8, 2009 decision, an OWCP hearing representative vacated the decision and remanded the case for further medical development.

Thereafter, OWCP referred appellant to a second opinion physician and a referee physician. In a March 22, 2010 report, Dr. C.L. Soo, a Board-certified orthopedic surgeon and referee physician,² noted examination findings of abnormal excessive tenderness over the lumbosacral junction as well as limited flexion, extension and rotation of the lumbar spine. Appellant had an intact sensory examination of the lower extremities, negative straight leg raises, while strength was normal and equal bilaterally from L2-S1 with some weakness over the right L5. Dr. Soo diagnosed lumbar degenerative disc disease aggravated by the November 2, 2004 work injury and a collapsed disc over L5-S1 not causally related to her work injury. He recommended a functional capacity evaluation, which revealed that appellant could do sedentary work for less than eight hours per day with lifting restrictions.

On August 20, 2010 OWCP accepted appellant's recurrence of disability commencing on September 16, 2008.³

In a September 16, 2010 EMG report of the lower extremities, Dr. M.E. Goodrich, a Board-certified radiologist, to whom appellant was referred to by her treating physician, opined that there was no evidence of bilateral tarsal tunnel syndrome or lumbosacral motor radiculopathy. Testing did not reveal evidence of acute or chronic denervation.

On July 27, 2011 appellant filed a claim for a schedule award. In a May 26, 2011 report, Dr. John W. Ellis, a Board-certified family practitioner, opined that pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) she had 30 percent impairment of the right leg and 16 percent impairment of the left leg.

In an August 17, 2011 report, an OWCP medical adviser noted that, while Dr. Ellis attributed impairment to motor and sensory deficits, this conflicted with evidence from Dr. Goodrich who found no electrodiagnostic evidence for lumbosacral radiculopathy and Dr. Soo who opined that appellant had intact sensation and normal and equal strength bilaterally with some possible weakness on the right big toe but no true weakness. He recommended a second opinion.

² Dr. Soo was chosen as a referee with regard to appellant's ability to work.

³ Appellant was removed from her position for cause by the employer effective February 26, 2011. She did not receive wage-loss compensation after February 25, 2011.

OWCP referred appellant to Dr. Shawn Smith, a Board-certified orthopedic surgeon, who indicated in a report dated September 20, 2011, that she had self-limited range of motion and nonphysiologic findings. Dr. Smith opined that appellant had evidence of diabetic peripheral neuropathy and tarsal tunnel symptoms. He opined that based on the physical examination above and the history provided as well as objective testing done that there was no spinal nerve lower extremity impairment. Dr. Smith determined that appellant reached maximum medical improvement on September 11, 2008. His report and the case record were referred to the medical adviser who, in a report dated October 6, 2011, used Dr. Smith's findings upon examination to determine that she sustained zero percent permanent impairment of the lower extremities in accordance with the A.M.A., *Guides*.⁴

In an October 19, 2011 decision, OWCP denied appellant's claim for a schedule award.

Appellant requested reconsideration and submitted additional medical evidence. In a report dated April 11, 2012, Dr. Ellis opined that she had 30 percent impairment of the right leg for sensory and motor deficits and 16 percent impairment of the left leg for sensory and motor deficits in accordance with the A.M.A., *Guides*. The impairment rating was duplicative of his May 26, 2011 report previously submitted.

In a decision dated August 8, 2012, OWCP denied modification of the prior decision.

Appellant requested reconsideration. She submitted an EMG dated April 13, 2012, which revealed distal nerve conduction responses were of low amplitude or absent which may be seen as peripheral neuropathy although the slowing of nerve conduction velocities in neuropathy was not noted with no electrodiagnostic indication of active lumbosacral radiculopathy.

In an October 22, 2012 report, Dr. Ellis opined that appellant had 14 percent impairment of the right leg and 7 percent impairment of the left leg for sensory and motor deficits. He noted tightness of the lumbar paraspinal muscles, tenderness over the iliolumbar and sacroiliac ligaments, decreased sensation on the inner thigh and dorsal and lateral aspects of both feet consistent with L5 and S1 spinal nerve root impairment, weakness with flexion and extension of the knees, marked weakness on dorsiflexion and plantar flexion, positive straight leg raising bilaterally and antalgic gait. There was decreased sensation of L4, L5 and S1 spinal nerves bilaterally and reflexes were 1+ and equal bilaterally. Dr. Ellis noted diagnoses that right lumbosacral plexus impingement, back strain, deranged discs at L4-5 and L5-S1 and bilateral L4, L5 and S1 nerve root impairment. He referenced the spinal nerve root deficits under the *Guides Newsletter*, July/August 2009.⁵ Dr. Ellis utilized Table 2, Spinal Nerve Impairment, Lower Extremity found in the *Guides Newsletter*. For the right leg, he found 1 percent impairment for the L4 nerve root, 8 percent impairment for the L5 nerve root and 5 percent impairment for the S1 nerve root, for a total of 14 percent right leg impairment. For the left leg, Dr. Ellis found one percent impairment for the L4 nerve root, four percent impairment for the L5 nerve root and two percent impairment for the S1 nerve root, for a total of seven percent left leg impairment. He

⁴ A.M.A., *Guides* (6th ed. 2008).

⁵ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

attached a worksheet explaining the percentages attributed to sensory and motor deficit for each nerve root as well as grade modifiers for functional history and clinical studies.

In a January 11, 2013 report, an OWCP medical adviser reviewed Dr. Ellis' report and noted his impairment findings based on sensory and motor deficits. The medical adviser contrasted this with the report of Dr. Smith, who found normal strength and Dr. Soo who found intact sensory function. Based on this he advised that there was no basis on which to rate impairment.

OWCP found a conflict in the medical evidence and referred appellant to Dr. Sami R. Framjee, a Board-certified orthopedic surgeon, who indicated, in a March 8, 2013 report, that he reviewed the record and examined her. Dr. Framjee noted a history of her work-related injury and advised that she had reached maximum medical improvement. He noted appellant's history was significant for diabetes and Grave's disease. Dr. Framjee noted findings upon examination of a markedly overweight woman with complaints of pain on superficial touching. On a request that she undergo lumbar range of motion testing, appellant indicated that she was unable to do so but she had normal sitting balance. She resisted attempted straight leg raising but this was observed to be negative in sitting position. Sensory examination produced diffuse, nonorganic, inconsistent hypesthesia in the entire right leg. Sensory examination was normal on the left. Motor testing revealed nonorganic breakaway weakness in both lower extremities. Examination of the left knee revealed pain on superficial touch, range of motion of the left knee was carried out with resistive force, no instability and no meniscal signs. Log rolling of the hip produced no acute pain. Dr. Framjee noted that, after obtaining appellant's history, conducting an examination and reviewing medical records and radiographic studies, he found no evidence of any anatomical injury to appellant's lumbar spine or pelvis secondary to the work injury of November 2, 2004. Instead, he opined that her clinical picture was indicative of symptom magnification with multiple Waddell's signs. Therefore, Dr. Framjee opined that the physical examination was unreliable. He stated that no medical care was presently indicated secondary to the work injury. Dr. Framjee noted that the MRI scans of the lumbar spine were essentially within normal limits, that is age-appropriate and did not indicate any acute post-traumatic pathology secondary to the accident of November 2, 2004. He opined that if appellant sustained a contusion type injury to the lumbar spine and pelvis her symptoms should have resolved within four weeks of the accident. Dr. Framjee opined that in accordance with the A.M.A., *Guides* he was unable to find any evidence of permanent impairment of the lumbar spine, right or left lower extremity or the pelvis secondary to the accident of November 2, 2004. He indicated that appellant's clinical picture was nonorganic in nature.

In a report dated March 19, 2013, an OWCP medical adviser used Dr. Framjee's findings pursuant to the A.M.A., *Guides* and determined that appellant sustained zero percent permanent impairment of the lower extremities. The medical adviser indicated that he was unable to find any evidence of permanent impairment of the lumbar spine, right or left lower extremity or the pelvis secondary to the accident of November 2, 2004 and that her clinical picture was nonorganic in nature.

In a decision dated March 28, 2013, OWCP denied modification of the decision dated August 8, 2012 denying appellant's claim for a schedule award based on the report of the referee physician Dr. Framjee who found no basis for a schedule award.

LEGAL PRECEDENT

Section 8107 of the FECA⁶ 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 or functions of the body. However, FECA 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.⁸ For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.⁹

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.¹⁰ In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.¹¹

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.¹² 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 which memorializes proposed tables outlined in the July/August 2009 *Guides Newsletter*.¹³

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 and resolve the conflict of medical evidence.¹⁴

⁶ 5 U.S.C. § 8107.

⁷ 20 C.F.R. § 10.404.

⁸ *Id.* at § 10.404(a).

⁹ FECA Bulletin No. 09-03 (issued March 15, 2009).

¹⁰ *Pamela J. Darling*, 49 ECAB 286 (1998).

¹¹ *Thomas J. Engelhart*, 50 ECAB 319 (1999).

¹² *Rozella L. Skinner*, 37 ECAB 398 (1986).

¹³ *See supra* note 3.

¹⁴ 5 U.S.C. § 8123(a); *M.S.*, 58 ECAB 328 (2007).

ANALYSIS

Appellant's claim was accepted by OWCP for pelvis sprain, leg numbness and degeneration of the lumbar and lumbosacral intervertebral. On July 27, 2011 she filed a claim for a schedule award. Appellant submitted evidence from her physician, Dr. Ellis, who opined that she had 14 percent impairment of the right lower extremity and 7 percent impairment of the left lower extremity for sensory and motor deficits in accordance with the A.M.A., *Guides* causally related to the November 2, 2004 work injury. However, Dr. Smith, an OWCP referral physician, found normal strength and no basis to rate impairment. Likewise, Dr. Soo a previous impartial specialist on a different issue found intact sensation and motor strength bilaterally. In a January 11, 2013 report, an OWCP medical adviser indicated that appellant had no permanent impairment as a result of the November 2, 2004 work injury. Consequently, OWCP found that a conflict existed in the medical evidence regarding whether appellant had permanent impairment of the legs due to her work injury and referred her to Dr. Framjee to resolve the conflict.

Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.¹⁵

The Board finds that, under the circumstances of this case, the opinion of Dr. Framjee is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight and establishes that appellant sustained no permanent impairment of the lower extremities causally related to the November 2, 2004 work injury.

Dr. Framjee reviewed appellant's history, reported findings and noted an essentially normal physical examination. He noted that her history was significant for diabetes and Grave's disease. Dr. Framjee noted that, after obtaining appellant's history, conducting a physical examination and reviewing medical records and radiographic studies, he found no evidence of any anatomical injury to her lumbar spine or pelvis secondary to the work injury of November 2, 2004. Rather, Dr. Framjee opined that her clinical picture was indicative of symptom magnification with multiple Waddell's signs. Therefore, he opined that the physical examination was unreliable and not a basis for rating permanent impairment. Dr. Framjee explained that MRI scans of the lumbar spine were essentially normal given appellant's age and did not indicate any acute post-traumatic pathology secondary to the November 2, 2004 injury. He opined that if she sustained a contusion type injury to the lumbar spine and pelvis her symptoms should have resolved within four weeks of the accident. Dr. Framjee opined that in accordance with the A.M.A., *Guides* he was unable to find any evidence of permanent impairment of the lumbar spine, right or left lower extremity or the pelvis secondary to the work injury of November 2, 2004. He indicated that appellant's clinical picture was nonorganic in nature. Dr. Framjee found no objective basis on which to rate impairment due to the accepted conditions.

The Board finds that Dr. Framjee properly determined that there was no basis under the A.M.A., *Guides* for a schedule award.

¹⁵ *Aubrey Belnavis*, 37 ECAB 206 (1985). See 5 U.S.C. § 8123(a).

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 is not entitled to a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the March 28, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 25, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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