United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 15-0707**
	)	**Issued: November 2, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Dagsboro, DE, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On January 23, 2015 appellant, through counsel, filed a timely appeal from a July 29, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP).[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 this case.

[1] Under the Board's *Rules of Procedures*, an appeal must be filed within 180 days from the date of the last OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from July 29, 2014 was January 25, 2015. As that date fell on a Sunday, the appeal was due on the next business day which was Monday, January 26, 2015. Since using February 2, 2015, the date the appeal was received by the Clerk of the Board, would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is January 23, 2015, which renders the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has established left lower extremity impairment greater than 10 percent impairment for which she previously received a schedule award.

On appeal, appellant's counsel contends that the most recent impartial medical examiner, Dr. Kates, did not resolve the conflict in the medical evidence as he simply agreed with the OWCP medical adviser. Counsel recommends that the case be remanded and referred for a new impartial medical examination.

FACTUAL HISTORY

This case has previously been before the Board. The facts as set forth in the Board's prior decision are incorporated herein. The relevant facts are set forth below.[3]

On October 6, 2003 OWCP issued a schedule award for six percent loss of use of the left leg. In a February 13, 2008 decision, the Board found that as the impartial medical examiner's opinion with regard to the schedule award was deficient, the conflict in medical evidence as to appellant's impairment had not been resolved and that the case should be remanded for further medical development. Such development was to include referral for another impartial medical examination with regard to appellant's impairment.

On June 25, 2009 OWCP referred appellant to Dr. Mark Levitsky, a Board-certified orthopedic surgeon, for a new impartial medical examination. In a July 29, 2009 report, Dr. Levitsky found that appellant had five percent permanent impairment which resulted in four percent impairment to her left lower extremity. In response to OWCP's requests for clarification, Dr. Levitsky submitted addendums on September 8 and October 15, 2009 wherein he reiterated his findings, indicated that they were based on Table 15-18 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2008) (A.M.A., *Guides*), and noted that he did not determine dermatomal sensory deficit due to the fact that appellant could barely tolerate even light touching of her legs with fingers. He further explained that she had five percent left lower extremity impairment which results in four percent whole body impairment.

In a decision dated November 17, 2009, OWCP found that the medical evidence established that appellant was entitled to a schedule award of four percent of the left lower extremity, and as she had already been paid based on six percent impairment, she was not entitled to an increased schedule award. However, in a February 24, 2010 decision, OWCP remanded the case, finding that Dr. Levitsky was unable to clarify his opinion despite two attempts, the conflict in the medical evidence was not resolved, and OWCP must refer appellant for another impartial medical examination.

[3] *D.W.*, Docket No. 07-1523 (issued February 13, 2008). On February 22, 2000 appellant, then a 25-year-old rural carrier, filed a traumatic injury claim alleging that on February 8, 2000 she was picking up a "tub of flats" when she felt a pain in her back, which gradually increased. OWCP accepted appellant's claim for herniated disc L5-S1 and resulting lumbar surgery.

On March 9, 2010 OWCP referred appellant to Dr. Jerry Case, a Board-certified orthopedic surgeon, for a new impartial medical examination. In an April 1, 2010 report, Dr. Case diagnosed status post laminectomy and discectomy L5-S1 (April 4, 2000) with residual left-sided sciatica. He concluded that based on the sixth edition of the A.M.A., *Guides*, appellant had nine percent permanent impairment of the left lower extremity.

On April 15, 2010 OWCP referred appellant's case to OWCP medical adviser. In an April 22, 2010 report, OWCP medical adviser Dr. Craig M. Uejo, a physician Board-certified in occupational medicine, concluded that Dr. Case did not accurately assign impairment based on the criteria of the sixth edition of the A.M.A, *Guides*. Dr. Uejo applied the A.M.A., *Guides* to Dr. Case's physical findings and calculated that appellant had five percent impairment of the left lower extremity.

In a decision dated April 28, 2010, OWCP determined that the opinion of OWCP medical adviser represented the weight of the medical evidence and that as appellant was entitled to a schedule award for five percent and she had already received six percent, she was not entitled to an increased schedule award.

Appellant's counsel had Dr. Nicholas P. Diamond, an osteopath, who had previously given an opinion based on the 5th edition of the A.M.A., *Guides*, update his opinion to apply the sixth edition of the A.M.A., *Guides*. In an August 24, 2010 report, Dr. Diamond diagnosed L5-S1 herniated nucleus pulposus with free fragment according to a magnetic resonance imaging (MRI) scan; status post hemilaminectomy and discectomy L5-S1; and chronic residual left S1 radiculopathy. He found that pursuant to Table 16-12, appellant had class 1 grade 4/5 motor strength deficit left extensor hallucis longus (sciatic) which equaled nine percent impairment, which he adjusted based on a grade modifier of 2 for functional history and 2 for clinical studies which he noted yielded a net adjustment of 2, which equaled a left lower extremity impairment after net adjustment of 13 percent. Dr. Diamond also noted a class 1 sensory deficit of the left S1 nerve root (sciatic) for four percent, adjusted by the functional history modifier of 2 and the clinical studies modifier of 2, for a net adjustment of 2, which equaled a left lower extremity impairment after adjustment of nine percent, or a total combined left lower extremity impairment of 21 percent.[4]

Appellant, through counsel, requested a hearing, and the hearing was held on September 15, 2010.

In an April 5, 2011 decision, the hearing representative found that Dr. Case had not provided adequate rationale to carry the weight of medical opinion. The hearing representative also referenced the new report by Dr. Diamond, and remanded for OWCP to refer Dr. Diamond's report to the OWCP medical adviser for review.

Per the hearing representative's instructions, in an April 5, 2011 report, Dr. Christopher Brigham, the OWCP medical adviser and a physician Board-certified in occupational medicine, first discussed motor deficits, and noted that in proposed Table 2 of the A.M.A., *Guides Newsletter*, July/August 2009 (A.M.A., *Guides Newsletter*), a class 1 rating for mild motor

[4] A.M.A., *Guides* 535, Table 6-12.

deficits reported as 4/5 weakness of sensory nerve impairment there was a class rating for mild motor deficits reports as grade 4/5 weakness for the extensor halluces longus (EHL). He then found a functional history modifier of 0, as appellant was able to ambulate with a symmetrical gait and had not difficulty getting on and off the examination table. Dr. Brigham noted that physical examination modifier was excluded since this factor was used to assign the correct diagnostic severity. He assigned a grade modifier of 1 for clinical history based on imaging studies confirming mild pathology with disc injury at L5-S1. Dr. Brigham noted that the net adjustment compared to the diagnosis class was negative 1, which was a grade B and translated to three percent lower extremity impairment. He next addressed sensory deficit. Using proposed Table, 2, spinal nerve impairment, Dr. Brigham noted a moderate sensory deficit under a class 1 rating, resulted in two percent lower extremity impairment. He noted that as the functional history grade modifier should only be applied for highest diagnosed based impairment, this was not applicable and that the grade modifier for physical examination was also excluded since this factor was used to place appellant's condition in the correct diagnostic severity. With regard to the functional modifier for clinical studies, Dr. Brigham found a class 2 rating based on herniated nucleus pulposus at L5-S1, which would be consistent with possible S1 nerve root involvement. When applying the net adjustment of 0, he found that appellant remained a grade C with two percent lower extremity impairment. Combining the values, Dr. Brigham found five percent left lower extremity impairment.

By decision dated April 19, 2011, OWCP denied appellant's claim for an increased schedule award. It found that the opinion of Dr. Brigham was considered to be the weight of the medical evidence as he is an expert at applying the A.M.A. *Guides*.

Appellant requested a hearing. In a June 27, 2011 decision, the hearing representative remanded the case for a referee report to resolve the conflict between Drs. Diamond and Brigham with regard to appellant's impairment.

On August 30, 2011 OWCP referred appellant to Dr. Andrew Gelman, a Board-certified orthopedic surgeon, for an impartial medical examination. In a September 14, 2011 opinion, Dr. Gelman noted that, pursuant to the 6th edition of the A.M.A., *Guides*, he derived four percent lower extremity default and the adjustment parameters would increase this to six percent impairment.

On September 22, 2011 OWCP referred Dr. Gelman's report to Dr. Morley Slutsky, a physician Board-certified in occupational medicine and OWCP medical adviser, who noted on September 25, 2011 that he could not determine if Dr. Gelman properly applied the A.M.A., *Guides*, and that Dr. Gelman did not document detailed calculations. He suggested that the case be sent back to Dr. Gelman for clarification.

In an October 18, 2011 report, Dr. Gelman attempted to clarify his opinion. OWCP referred Dr. Gelman's supplemental report back to OWCP medical adviser, and in an October 27, 2011 report, Dr. Slutsky determined that based on Dr. Gelman's findings and the sixth edition of the A.M.A., *Guides*, appellant had a left lower extremity impairment of seven percent.

By decision dated November 14, 2011, OWCP issued appellant an award for an additional one percent impairment of the left lower extremity, for a total of seven percent impairment.

On November 18, 2011 appellant, through counsel, requested a hearing, which was held on March 28, 2012.

In a March 22, 2012 report, Dr. Diamond indicated that he stood by his statement that appellant sustained 21 percent impairment, and noted various criticisms of Dr. Gelman's report.

In a decision dated June 13, 2012, the hearing representative remanded the case with instructions that OWCP refer the medical records back to Dr. Gelman for another supplemental report addressing his review of the medical record to include Dr. Diamond's March 2012 report.

In a June 29, 2012 report, Dr. Gelman reported it was unclear how Dr. Diamond arrived at his conclusions and calculations. In an October, 4, 2012 report, Dr. Gelman, noted that he continued to disagree with Dr. Diamond's discussion and methodology. He maintained that appellant had a left lower extremity impairment rating of six percent due to the accepted diagnosis of L5-S1 herniated nucleus pulposus.

In an October 12, 2012 decision, OWCP determined that the weight of the evidence continued to rest with Dr. Gelman, the impartial medical examiner, and that therefore appellant was not entitled to an increased schedule award.

On October 23, 2012 appellant requested a hearing. This hearing was held on February 5, 2013.

Counsel contended at the hearing that there was a lack of documentation of the use of the Physician Directory System (PDS) to select the IME Dr. Gelman. He claimed this ran afoul of the appropriate procedure as established by OWCP.

By decision dated March 28, 2013, the hearing representative set aside the prior decision and remanded the case for referral to a new impartial medical examiner. OWCP determined that OWCP had neither documented Dr. Gelman's selection as impartial medical adviser, nor did it follow its own procedures with regard to referring appellant to Dr. Gelman.

On April 1, 2013 OWCP noted that there was a conflict in the medical evidence between appellant's physician, Dr. Diamond, and the OWCP medical adviser, Dr. Brigham, on the extent of injury-related impairment.

On April 9, 2013 OWCP referred appellant to Dr. Jonathan Louis Kates, a Board-certified orthopedic surgeon, for an impartial medical examination. In a June 10, 2013 report, Dr. Kates reviewed the medical evidence and conducted a physical examination. He applied proposed Table 2 of *The Guides Newsletter* and noted that appellant had a moderate sensory deficit related primarily to the S1 nerve root, which was an impairment class 1. Dr. Kates noted that the grade modifier for clinical studies pursuant to Table 16-8 due to EMG changes was grade 1. He then calculated that the grade modifier of clinical studies was 0, and that GMCS-CDX equals 0, which is grade 3, which equals two percent impairment. Dr. Kates noted that for

the L5 nerve root, there is a mild motor deficit, which is also class 1. He noted a grade modifier for functional history adjustment of 1 as she has antalgic gait and a grade modifier for physical examination was not utilized because it was used to determine her impairment class. Dr. Kates noted a grade modifier for clinical studies of class 2 based on Table 16-8 of the A.M.A., *Guides*, and that this resulted in a net adjustment of 1, which is a grade D. He noted that this correlated on the proposed table for spinal nerves as seven percent deficit and when combined with 2 percent deficit for the S1 spinal nerve resulted in nine percent total deficit for extremity.

On July 18, 2013 OWCP referred the case to the OWCP medical adviser. Dr. Slutsky noted his agreement with most of Dr. Kates' rating with the exception of the sensory findings. He noted that Dr. Kates noted that there was an area of paresthesia in the left S1 distribution, and that this equaled a mild sensory finding using Table 16-11, page 533 of the A.M.A., *Guides*. Dr. Slutsky stated that in order for a moderate loss to be present there must be deficits in light touch testing, which Dr. Kates did not document. He asked that Dr. Kates clarify this issue. Dr. Slutsky then provided his own calculations. He noted that pursuant to proposed Table 2 of *The Guides Newsletter*, sensory class mild severity is placed in class 1 with a grade C level to equal 1 percent of the left lower extremity. With regard to the left L5 lumbar nerve, applying Table 16-11 of the A.M.A., *Guides*, Dr. Slutsky found 4/5 left L5 strength, equal to severity 1 (mild finding). With regard to motor class, pursuant to *The Guides Newsletter*, he found a mild L5 motor strength loss which is placed into class I with the default grade C equal to five percent. Dr. Slutsky noted grade modifiers of 1 for functional history, thereby disagreeing with Dr. Kates who found the functional history did not apply. He noted that appellant had an antalgic gait and no mention regarding use of external orthotic device, and concluded appellant was eligible for a grade modifier of 1. Dr. Slutsky agreed with Dr. Kates that the physical examination modifier was irrelevant as neurologic findings were used to define impairment range. For clinical studies, he assigned a grade modifier of 2, noting surgery found a large lateral recess and evidence of degenerative disc disease involving the L4-5 and L5-S1 disc space levels, and that intraoperatively there was a large disc fragment compressing on the nerve roots. Dr. Slutsky determined that the grade modifiers resulted in a net adjustment of 1 for a final grade C of sensory adjustment. For motor net adjustment, he noted a class of diagnosis of 1, functional history of 1, clinical studies of 2 for a net adjustment of 1 for a final grade of D. Dr. Slutsky concluded that appellant had a final sensory impairment of one percent and a final motor impairment of nine percent, which equaled 10 percent impairment of the left lower extremity.

On July 26, 2013 OWCP issued an increased award for additional 3 percent impairment of the left lower extremity, for a total of 10 percent. By letter dated August 1, 2013, appellant requested a hearing, which was held on June 9, 2014.

In a September 27, 2013 decision, the hearing representative remanded the case for clarification from Dr. Kates, noting that OWCP medical adviser may not resolve the conflict in medical evidence.

By letter dated December 20, 2013, OWCP requested that Dr. Kates clarify whether appellant had a mild sensory finding or moderate loss (which required light touch testing) in accordance with Table 16-11, page 533 of the sixth edition of the A.M.A., *Guides*. In a January 28, 2014 response, Dr. Kates indicated that OWCP's evaluation was correct in that his findings indicate a mild sensory finding as opposed to a moderate finding based on Table 16-11

of the A.M.A., *Guides*, and that he concurred with the recalculation of final permanent partial disability.

In a February 25, 2014 decision, OWCP determined that appellant was not entitled to impairment greater than 10 percent she had already received.

In a February 14, 2014 report, OWCP medical adviser, Dr. Slutsky, noted that he agreed with Dr. Kates' agreement with Dr. Slutsky's prior opinion that the final impairment to the left lower extremity was 10 percent. He reiterated his prior calculations as set forth in his prior report of July 23, 2013, and concluded that appellant had 10 percent impairment of her left lower extremity based on 1 percent impairment for sensory deficits in S1 and 9 percent for motor deficits in L5.

By decision dated February 25, 2014, OWCP found that appellant was not entitled to a schedule award greater than 10 percent for which she was previously paid.

On February 28, 2014 appellant requested a hearing, which was held on June 9, 2014.

On June 6, 2014 Dr. David Weiss, an osteopath and partner of Dr. Diamond, updated prior medical opinions from his office. He disagreed with Drs. Slutsky and Kates, and argued that there was no error on the degree of motor strength deficit found on physical examination versus the motor strength deficit used when calculating the impairment. Dr. Weiss noted that based on *The Guides Newsletter* and the physical examination according to Dr. Kates on June 10, 2013, he calculated a class 1 mild sensory deficit left S1 nerve root of 1 percent with grade modifiers for functional history of 1 and clinical studies of 2, which yielded a net adjustment of 1, or a left lower extremity after net adjustment of 1 percent. He also found a class 1 moderate motor strength deficit of the left extensor halluces longus (L5) of 13 percent, which after modifiers of 1 for functional history and 2 for clinical studies, yielded a net adjustment of 1, for a left lower extremity impairment due to motor strength deficit of 13 percent, or a final combined left lower extremity impairment of 14 percent.

By decision dated July 29, 2014, hearing representative affirmed OWCP's February 25, 2014 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing regulations[6] 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 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. OWCP evaluates the degree of permanent impairment according to the standards

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

set forth in the specified edition of the A.M.A., *Guides*.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] For impairment ratings calculated on or after May 1, 2009, the sixth edition 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] A schedule award is not payable for the loss, or loss of use, of a part of the body that is not specifically enumerated under FECA.[11]

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.[12]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter*, Rating Spinal Nerve Impairment Using the Sixth Edition (July/August 2009) is to be applied.[13] The Board has long recognized the discretion of OWCP to adopt and utilize various editions of the A.M.A., *Guides* for assessing permanent impairment.[14] In particular, the Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter*, as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[15]

[7] *Id.*

[8] *See id.; Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

[11] *M.P.*, Docket No. 14-777 (issued July 18, 2014).

[12] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[13] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010).

[14] *D.S.*, Docket No. 14-12 (issued March 18, 2014).

[15] *R.L.*, Docket No. 14-1479 (issued October 28, 2014); *see also E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

An opinion on permanent impairment is of limited probative value if it is not derived in accordance with the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses.[16]

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.[17]

ANALYSIS

OWCP accepted appellant's claim for L5-S1 herniated disc. On October 6, 2003 it issued a schedule award for six percent loss of use of the left leg. On November 14, 2011 OWCP issued an award for a total of seven percent impairment to appellant's left lower extremity. On July 26, 2013 OWCP issued an additional schedule award for a total impairment to appellant's left lower extremity of 10 percent. Appellant's requests for an increased schedule award have been denied.

Initially, the Board notes that OWCP had significant difficulty with obtaining a properly scheduled, well-rationalized, impartial medical examination. Initially, on February 13, 2008 the Board remanded this case to OWCP for a new impartial medical examination.[18] Since that time, impartial medical examinations by Drs. Levitsky and Case have been rejected as these physicians were unable to provide a sufficiently well-rationalized opinion with regard to appellant's impairment of her left lower extremity, despite multiple attempts to do so.[19] The opinion of Dr. Gelman was rejected as OWCP did not properly follow its procedures in obtaining his opinion.[20] Multiple OWCP medical advisers have considered appellant's claim, including Drs. Brigham, Uejo, and Slutsky. However, while an OWCP medical adviser may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility and not that of the medical adviser.[21] The Board notes that none of the

[16] *See James Kennedy, Jr.*, 40 ECAB 620, 626 (1989) (finding that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule loses is of little probative value in determining the extent of a claimant's permanent impairment).

[17] *Manuel Gill*, 52 ECAB 282 (2001).

[18] *See supra* note 2.

[19] When OWCP secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, OWCP has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion. If the specialist is unable or unwilling to clarify or elaborate on his or her opinion as requested, the case should be referred to another appropriate impartial medical specialist. *Guiseppe Aversa*, 55 ECAB 164 (2003).

[20] The Board has held that OWCP has an affirmative obligation to assure that it followed its selection procedures in referring appellant for an impartial medical examination. *J.S.*, Docket No. 14-648 (issued July 16, 2014).

[21] *R.M.*, Docket No. 13-1221 (issued February 24, 2014).

aforementioned physicians found that appellant had impairment greater than 10 percent of her left lower extremity.

On April 1, 2013 OWCP found that there remained an unresolved conflict between the opinions of Dr. Diamond, appellant's physician, and Dr. Brigham, an OWCP medical adviser, with regard to the degree of impairment to appellant's left lower extremity. OWCP referred appellant to Dr. Kates for an impartial medical examination. In a June 10, 2013 medical opinion, Dr. Kates applied the sixth edition of the A.M.A., *Guides*, including *The Guides Newsletter*, and determined that appellant had nine percent total deficit of the left lower extremity. In reaching this conclusion, Dr. Kates noted that appellant had a moderate sensory deficit related primarily to the S1 nerve root, and that this was class 1. Dr. Kates found no grade modifier for physical examination because the sensory change was used to determine impairment class, and found that the functional history grade modifier did not apply to the S1 nerve root. He found a grade modifier for clinical studies due to EMG changes of grade 1. He then applied the formula, GMCS-CDX which resulted in 0, which is a grade 3, and equaled two percent impairment under *The Guides Newsletter*. With regard to the L5 nerve root, he found a mild deficit, which was a class 1. He then applied the grade modifier for functional history of 1 as she had an antalgic gait and a grade modifier of clinical studies for class 2. Applying the formula, Dr. Kates found a net adjustment of 1, which was a grade D, which correlated to seven percent impairment to appellant's left lower extremity. He then combined the two percent impairment with the seven percent impairment and found that appellant had total nine percent impairment of the extremity.

This case was then referred to Dr. Slutsky, OWCP medical adviser, and in a July 23, 2013 report, Dr. Slutsky noted that he agreed with most of Dr. Kates' rating with the exception of the sensory findings. Dr. Slutsky noted that Dr. Kates found that appellant had intact sharp and light touch testing in the lower extremities and that there was an area of paresthesia in the left S1 distribution. Dr. Slutsky noted that this equaled a mild sensory finding using the criteria set forth in Table 16-11 of the A.M.A., *Guides*. He recommended that OWCP ask Dr. Kates clarify his opinion. In a January 28, 2014 letter, Dr. Kates reported that OWCP was correct in that the findings in his report indicate a mild sensory finding as opposed to a moderate finding based on Table 16-11 of the A.M.A., *Guides*. Dr. Kates noted that he concurred with the recalculation of final permanent partial disability by the medical adviser.

On February 14, 2014 Dr. Slutksy reiterated the calculations he first presented in his June 10, 2013 report. As of the date of the February 14, 2014 report, Dr. Kates no longer held the position that appellant was entitled to two percent impairment due to moderate sensory deficit. Rather, Drs. Slutsky and Kates agreed that appellant had a mild sensory finding for S1, which equaled a class 1 impairment, and that when grade modifiers were added of 1 for clinical studies, yielded a grade C rating of one percent.

The Board therefore finds that appellant had one percent impairment based upon the S1 spinal nerve as Drs. Slutsky and Kates properly applied *The Guides Newsletter,* proposed Table 2, in reaching this calculation. However, there is confusion in the reports with regard to the findings with regard to the L5 motor deficit. Dr. Kates, in his June 10, 2013 report, noted that appellant was entitled to a class 1 deficit for a mild motor deficit to the L5 nerve root. He noted that when grade modifiers were applied, appellant had a net adjustment of 1, which was a grade D impairment, which equaled seven percent impairment. When Dr. Slutsky reviewed the report,

he found the class of diagnosis was 1, with grade modifiers for functional history of 1 and clinical studies of 2, this yielded a net adjustment of 1, or a final grade of D. He then concluded that appellant had a final motor impairment of 9 percent and a final sensory impairment of 1 percent, which equaled 10 percent impairment. However, Dr. Slutsky is mistaken. Pursuant to *The Guides Newsletter,* a grade D impairment for mild motor deficit for L5 is seven percent, which is the amount that Dr. Kates correctly found. Therefore, when *The Guides Newsletter* is properly applied, appellant would have one percent impairment for sensory deficit to S1 and seven percent impairment for motor deficit to L5, for a combined impairment of eight percent.[22] As 8 percent is less than the 10 percent schedule award of the left lower extremity issued by OWCP, appellant had no more than 10 percent impairment, and the Board finds that OWCP properly denied appellant a schedule award of greater than 10 percent of the left lower extremity.

The Board finds that the weight of the medical evidence rests with the opinions of the impartial medical examiner, Dr. Kates. The Board rejects counsel's argument that the case must be remanded yet again due to Dr. Kates not providing an opinion sufficient to constitute the weight of the medical evidence. Although Dr. Kates' letter of January 28, 2014 is brief, he clearly reports that he concurred with the adjustment to his calculations, noting that his report supported mild sensory findings, not moderate. The Board finds that Dr. Kates' opinion of June 19, 2013, as modified by his January 28, 2014 letter, was well-rationalized. The Board finds that Dr. Kates, as the impartial medical specialist, properly explained his conclusion with regard to impairment, and his report is entitled to special weight.[23]

On appeal counsel contends that the reports of Dr. Weiss and Diamond represent the weight of the medical evidence. The Board rejects this argument. OWCP referred appellant to Dr. Kates to resolve the conflict between Dr. Diamond and Dr. Brigham with regard to the extent of appellant's impairment to her left lower extremity. Counsel submitted a June 6, 2014 report by Dr. Weiss, an associate of Dr. Diamond, in support of his contention that appellant was entitled to 14 percent impairment of the left lower extremity. Dr. Weiss calculated that appellant was entitled to a left lower extremity impairment based on mild sensory deficit of the left S1 nerve root of 1 percent, which is the same amount found by Dr. Kates and Dr. Slutsky. The difference is that Dr. Weiss found impairment of 13 percent of her left lower extremity based on moderate motor strength for L5. This issue was resolved by the impartial medical examiner, Dr. Kates, who determined that appellant had a mild motor deficit, not a moderate deficit. Dr. Weiss and his associate Dr. Diamond were on one side of the conflict of the medical opinion that the impartial medical specialist, Dr. Kates, resolved. Subsequent reports from a physician who was on one side of a medical conflict that an impartial specialist resolved are generally insufficient to overcome the weight accorded to the report of the impartial medical specialist or to create a new conflict.[24] The Board notes that the findings of Dr. Weiss are not based on any new physical examination. Rather, Dr. Weiss merely provided calculations based on examination findings already in evidence.

[22] A.M.A., *Guides* 604.

[23] *See Barbara J. Warren*, 51 ECAB 413 (2000).

[24] *S.B.*, Docket No. 14-1703 (issued February 13, 2015).

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 an increased schedule award for her left lower extremity greater than 10 percent impairment for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated July 29, 2014 is affirmed.

Issued: November 2, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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