

FACTUAL HISTORY

On March 21, 2006 appellant, then a 57-year-old manual distribution clerk, filed an occupational disease claim (Form CA-2) alleging that she experienced neck pain, a tingling sensation down her left arm, and pressure in her chest as a result of repetitive neck movement while casing mail. She did not stop work.

On March 7, 2007 OWCP accepted appellant's claim for aggravation of cervical spondylosis without myelopathy. It subsequently expanded her claim to include other specified disorder of bursae and tendons in the bilateral shoulder region, cervical disc syndrome, extrinsic asthma with acute exacerbation, lumbar sprain/strain, adjustment disorder with depressed mood, chronic pain syndrome, right shoulder keloid scar, lesion of the ulnar nerve of the right elbow, lumbar radiculitis, and displacement of lumbar intervertebral disc without myelopathy.

Appellant stopped work on January 27, 2008 and returned to work on February 11, 2008. OWCP paid appellant wage-loss compensation. On March 28, 2008 appellant began light duty as a modified mail processor working five hours a day. OWCP continued to pay appellant wage-loss compensation until February 12, 2010.

On March 2, 2010 and April 21, 2011 appellant received a schedule award for seven percent permanent impairment of the right upper extremity³ and eight percent permanent impairment of the left upper extremity⁴ as a result of her accepted bilateral shoulder conditions. OWCP granted an additional 21 percent permanent impairment of the right upper extremity⁵ on November 7, 2011 and additional permanent impairment of 26 percent to the left upper extremity⁶ on January 22, 2014.

On April 16, 2013 appellant underwent an electromyogram and nerve conduction velocity (EMG/NCV) testing of the lower extremities by Dr. Jairo D. Libreros-Cupido, a neurologist. Dr. Libreros-Cupido noted that the EMG/NCV revealed bilateral L4-5, L5-S1 radiculopathy and prolonged left H reflex compatible with L5-S1 radiculopathy.

³ The award was based on the January 12, 2010 medical report of Dr. Raul F. Nodal, a Board-certified neurologist, and the February 10, 2010 report of Dr. Howard P. Hogshead, a Board-certified orthopedic surgeon serving as OWCP's medical adviser.

⁴ The award was based on the February 28, 2011 medical report of Dr. Samy F. Bishai, an orthopedic surgeon, and the April 6, 2011 report of Dr. Hogshead, OWCP's medical adviser.

⁵ The award was based on the October 12, 2011 medical report of Dr. Bishai and the November 1, 2011 report of OWCP's medical adviser. He determined that appellant had 28 percent permanent impairment of the right upper extremity, but due to her previous award of 7 percent impairment, she was awarded 21 percent impairment. The award ran from August 22, 2011 to November 22, 2012.

⁶ The award was based on the July 8, 2013 medical report of Dr. Bishai and the December 13, 2013 and January 22, 2014 reports of OWCP's medical adviser. He determined that appellant had 34 percent impairment of the left upper extremity, but due to her previous award of 8 percent permanent impairment, she was granted an additional 26 percent permanent impairment. The award ran from July 8 to December 14, 2013.

Appellant received medical treatment from Dr. Bishai, an orthopedic surgeon. In a February 19, 2015 narrative report, Dr. Bishai related her complaints of back pain with radiation down the lower extremities, neck pain radiating down the upper extremity, and right and shoulder left shoulder joint pain. On examination he related that appellant's straight leg raise testing was 60 degrees on both sides and sciatic nerve stretching test was positive at 60 degrees on both sides. Dr. Bishai indicated that neurological examination of the lower extremities showed motor deficit of moderate intensity affecting the extensor hallicus longus and moderate sensory deficit of diminished sensation bilaterally on the lateral aspect of the thigh. He also noted that an April 16, 2013 EMG/NCV testing of the lower extremities showed bilateral L4-5 and L5-S1 radiculopathy. Dr. Bishai opined that appellant had bilateral radiculopathy of the L5 nerve root and signs and symptoms of radiculopathy of the S1 nerve root bilaterally.

Dr. Bishai referenced the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)⁷ and the July/August 2009 edition of *The Guides Newsletter*. He determined that, according to Table 17.4 on page 570 of the Lumbar Spine Regional Grid for Spinal Nerves, she had a class 2 diagnosis for sensory and motor deficits of the L5 nerve root. Dr. Bishai assigned grade modifiers of 2 for Functional History (GMFH) and Clinical Studies (GMCS) and 3 for Physical Examination (GMPE). He calculated that according to the net adjust formula appellant had a net adjustment of +1 or grade D. Dr. Bishai applied the proposed Table 2 for Spinal Nerve Impairments of the Lower Extremities in the July/August 2009 *The Guides Newsletter* and determined that she had 16 percent permanent impairment of the bilateral lower extremities due to moderate sensory and motor deficits of the L5 nerve root.

Dr. Bishai reported that appellant also had S1 nerve root radiculopathy. He indicated that according to Table 2 of the July/August 2009 *The Guides Newsletter* she had 12 percent permanent impairment of the lower extremities due to moderate sensory and motor deficits of the S1 nerve root. Dr. Bishai combined the impairment ratings for the conditions of L5 radiculopathy and S1 radiculopathy for a combined rating of 26 percent permanent impairment of each lower extremity. He reported that appellant had reached maximum medical improvement (MMI) as of that date.

On April 27, 2015 appellant submitted a claim for a schedule award (Form CA-7).

In a May 8, 2015 report, Dr. James Dyer, a Board-certified orthopedic surgeon and OWCP medical adviser, noted appellant's accepted conditions and objective findings of chronic lower back and leg pain. He related that an April 16, 2013 electrodiagnostic study confirmed mild bilateral radiculopathy at L4-5 and L5-S1 and that imaging demonstrated lumbar degenerative disc disease at L4-5 and L5-S1 with stenosis. Dr. Dyer indicated that according to the July/August 2009 *The Guides Newsletter* for spinal nerve root extremity impairment, appellant had two percent permanent impairment for mild sensory deficit and seven percent impairment for mild motor deficit of the L5 nerve root for a total of nine percent permanent impairment. He reported that she had one percent permanent impairment for mild sensory deficit and four percent permanent impairment for mild motor deficit at the S1 nerve root for a total of

⁷ A.M.A., *Guides* (6th ed. 2009).

five percent permanent impairment. Dr. Dyer calculated that appellant had total permanent impairment of 14 percent impairment for each lower extremity. He noted that Dr. Bishai assigned rating for moderate sensory motor deficit of the L5 and S1 nerve roots, instead of mild deficit.

By letter dated May 15, 2015, OWCP requested that Dr. Bishai review Dr. Dyer's May 8, 2015 report and provide comments on Dr. Dyer's impairment rating.

Dr. Bishai responded to OWCP's May 15, 2015 letter and provided a June 2, 2015 report. He explained that although Dr. Dyer believed that appellant had a mild case of radiculopathy, he found that she had moderate radiculopathy based on the electrodiagnostic studies and his clinical examination. Dr. Bishai indicated that appellant continued to complain of pain in her lower back with radiation down the legs. He noted that her condition had not changed a great deal since her last visit and provided examination findings similar to the February 19, 2015 report. Dr. Bishai recommended another electrodiagnostic study in order to clarify her condition.

In a June 10, 2015 report, Dr. Libreros-Cupido related appellant's complaints of low back pain and keloid scar in the right shoulder. Another electrodiagnostic study of the lower extremities was performed and he reported bilateral L4-5, L5-S1 radiculopathy and prolonged left H reflex compatible with left S1 radiculopathy unchanged from the April 16, 2013 electrodiagnostic study.

Dr. Bishai reviewed Dr. Libreros-Cupido's electrodiagnostic study and, in a report dated June 11, 2015, related that he maintained his initial impairment rating on February 19, 2015. He reported that his opinion stood that appellant had reached MMI as of February 19, 2015.

In a July 28, 2015 report, OWCP's medical adviser Dr. Hogshead related that, upon review of the medical evidence of record, the evidence of a lower extremity radiculopathy was questionable. He recommended a competent second opinion and a repeat electrodiagnostic study.

OWCP referred appellant, along with a statement of accepted facts and the medical record, to Dr. William Dinenberg, a Board-certified orthopedic surgeon, for a second opinion examination in order to conduct an electrodiagnostic study of appellant's bilateral lower extremities and provide an opinion regarding her entitlement to a schedule award.

In a September 2, 2015 report, Dr. Dinenberg described appellant's work injury and noted her accepted conditions. He related her current complaints of back pain radiating down the bilateral lower extremities and of weakness in the bilateral lower extremity. Dr. Dinenberg discussed appellant's medical records. Upon examination, he observed 5/5 strength of the hip flexors, quadriceps, hamstrings, gastroc soleus, tibialis anterior, and extensor hallucis longus bilateral. Dr. Dinenberg also reported decreased sensation to light touch and insensate to light touch beginning several centimeters above the knee joint and extending to include appellant's foot bilateral in a stocking distribution. Straight leg raise testing was negative bilaterally. Dr. Dinenberg reported that lumbar flexion was to 30 degrees and extension to 10 degrees. He also noted tenderness on lumbosacral spine to palpation in the paraspinous region both on the

left, right, and midline. Dr. Dinenberg diagnosed lumbar sprain and strain without evidence of radiculopathy.

Dr. Dinenberg reported that appellant's objective findings included diminished range of motion of the lumbar spine and tenderness of the lumbar spine to palpation. He also noted that the sensory examination was nonanatomic with decreased sensation in the stocking distribution. Dr. Dinenberg indicated that appellant could perform the job of modified mail processor with restrictions. He recommended a functional capacity evaluation and noted that an electrodiagnostic study would be performed. Dr. Dinenberg reported that appellant had reached MMI on February 19, 2015, as previously noted by Dr. Bishai.

In a September 16, 2015 report, Dr. Thomas Newman, a Board-certified neurologist, noted that he conducted EMG/NCV testing of appellant's lower extremities and lumbar paraspinal muscles that day. He related that she had a history of lower back pain with pain in both lower extremities. Dr. Newman indicated that, on brief examination, he observed no intrinsic atrophy. He reported that the EMG/NCV study was normal. Dr. Newman indicated that there was no electrical evidence of nerve entrapment, peripheral neuropathy, or lumbar radiculopathy present.

Dr. Dinenberg reviewed Dr. Newman's September 16, 2015 electrodiagnostic study and related, in a September 23, 2015 addendum report, that the results demonstrated a normal electrodiagnostic study of both lower extremities with no electrodiagnostic evidence of nerve entrapment or generalized peripheral neuropathy. He reiterated that after his physical examination of appellant, his impression was that she had a lumbar sprain without evidence of radiculopathy on examination. Dr. Dinenberg explained that given the normal results of the September 16, 2015 EMG/NCV study and no evidence of radiculopathy during his examination on August 21, 2015, she had no permanent impairment of her bilateral lower extremities. He completed a work capacity evaluation form, which indicated that appellant was capable of working full time with restrictions.

In an October 19, 2015 report, OWCP's medical adviser, Dr. Hogshead, again reviewed appellant's records, including Dr. Dinenberg's September 2 and 23, 2015 reports, and noted that there had been no evidence of radiculopathy of the bilateral lower extremities during the physical examination and electrodiagnostic study. He agreed with Dr. Dinenberg's conclusion that she had no permanent impairment of the bilateral lower extremities due to her accepted lumbar condition.

OWCP denied appellant's claim for schedule award in a decision dated December 9, 2015. It determined that the medical evidence of record was insufficient to establish permanent impairment of the bilateral lumbar extremities due to her accepted lumbar condition. OWCP noted that, according to Dr. Dinenberg's August 21, 2015 second opinion report, Dr. Newman's September 16, 2015 EMG/NCV study report, and the October 19, 2015 report of OWCP's medical adviser, there was no evidence of nerve entrapment, peripheral neuropathy, or lumbar radiculopathy.

On June 8, 2016 appellant, through her representative, requested reconsideration. In an attached statement, the representative reviewed her history of injury and how OWCP had

handled her schedule award claim. He alleged that the medical reports and opinions of OWCP's referral physicians were not thorough and were not more probative than the reports of appellant's treating physicians. The representative further asserted that EMG/NCV testing may be normal in patients who had radiculopathy. He explained that the main reason to perform the EMG/NCV study was to rule out any other conditions that may mimic radiculopathy. The representative further noted that Dr. Dyer, an OWCP medical adviser, did not dispute appellant's diagnosis of radiculopathy, but merely found a lesser degree of impairment. He noted that he was enclosing medical reports, which clearly showed that appellant's condition had not changed and that she still suffered a permanent impairment to her lower extremities.

In reports dated December 9, 2015 to May 31, 2016, Dr. Bishai indicated that appellant continued to complain of severe pain in her lower back with radiation down the legs and pain in her neck with radiation to the upper extremities. He reported that neurological examination of the lower extremities showed motor deficit of moderate intensity affecting the extensor hallucis longus and moderate sensory deficit of diminished sensation bilaterally on the lateral aspect of the thigh. Dr. Bishai opined that based on his examination and Dr. Libberos-Cupido's electrodiagnostic study, appellant had bilateral radiculopathy of the L5 nerve root and signs and symptoms of radiculopathy of the ankle plantar flexors and moderate sensory deficit affecting the posterior aspect of the leg and the lateral aspect of the foot on both sides. He indicated that he disagreed with Dr. Dinenberg's conclusions and noted that Dr. Dinenberg spent only 10 minutes doing an examination of a very complicated case. Dr. Bishai opined that appellant's condition had not changed since the last examination and asserted that he continued to stand behind his initial impairment rating.

In a July 22, 2016 report, Dr. Jovito Estaris, Board-certified in occupational and preventive medicine and an OWCP medical adviser, reviewed the record and discussed appellant's medical reports. He indicated that, although Dr. Bishai mentioned moderate sensory deficits and moderate motor deficits of appellant's bilateral lower extremities, there had been no new objective examination testing performed to support those findings. Dr. Estaris further noted that Dr. Dinenberg had not noted the "stocking glove" decrease sensation over appellant's lower extremities on his examination and that Dr. Newman's EMG/NCV study was normal. He reported that he agreed with Dr. Dinenberg that she had no ratable impairment of the lower extremities secondary to her accepted lumbar condition. Dr. Estaris concluded that, since there was no radiculopathy by medical examination or clinical studies, there was no impairment pursuant to the July/August 2009 edition of *The Guides Newsletter*.

By decision dated July 27, 2016, OWCP denied modification of its December 9, 2015 denial decision. It found that the weight of the medical evidence rested with the July 22, 2016 report of Dr. Estaris, OWCP's medical adviser, who determined that appellant had no ratable impairment of the lower extremities secondary to her lumbar condition.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations 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.⁸ FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as the appropriate standards for evaluating schedule losses.⁹ The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.¹⁰

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, under FECA a schedule award is not payable for injury to the spine.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.¹³ For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment (July/August 2009 edition) of the sixth edition is to be applied.¹⁴ 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.¹⁵ 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

⁸ 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

⁹ 20 C.F.R. § 10.404 (1999); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002). For decisions issued after May 1, 2009, the sixth edition will be applied. *B.M.*, Docket No. 09-2231 (issued May 14, 2010).

¹⁰ *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

¹¹ *Pamela J. Darling*, 49 ECAB 286 (1998).

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

¹³ *Supra* note 10 at Chapter 3.700, Exhibit 4 (January 2010).

¹⁴ *Supra* note 10 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

¹⁵ *D.S.*, Docket No. 14-0012 (issued March 18, 2014).

in the spine.¹⁶ FECA approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities.¹⁷

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.¹⁸ 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.¹⁹ When there exists 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.²⁰

ANALYSIS

OWCP accepted appellant's March 21, 2006 occupational disease claim for various conditions, including lumbar radiculitis, lumbar strain/sprain, and displacement of lumbar intervertebral disc without myelopathy. On April 27, 2015 appellant filed a claim for a schedule award based on the February 19, 2015 report of Dr. Bishai, her treating physician, who opined that she had 26 percent permanent impairment of each lower extremity for bilateral radiculopathy of the lower extremities secondary to her lumbar condition. OWCP denied her schedule award claim and determined that the weight of the medical evidence rested with the July 22, 2016 report of Dr. Estaris, OWCP's medical adviser, who determined that she had no ratable impairment of the lower extremities secondary to her lumbar condition.

The Board finds that this case is not in posture for decision as there is an unresolved conflict in medical opinion.

In support of her schedule award claim, appellant submitted the February 19, 2015 report of Dr. Bishai, who found that she had 26 percent permanent impairment of each lower extremity pursuant to the A.M.A., *Guides*. Dr. Bishai utilized Table 2 of the July/August 2009 edition of *The Guides Newsletter* and based his conclusions on findings of moderate sensory and motor deficit of the L5 and S1 nerve roots. In a May 8, 2015 report, Dr. Dyer, an OWCP medical adviser, reviewed Dr. Bishai's February 19, 2015 impairment rating and determined that appellant had 14 percent permanent impairment of each lower extremity based on findings of mild sensory and motor deficits. In a June 11, 2015 report, Dr. Bishai disagreed with Dr. Dyer's impairment rating. He noted that a June 10, 2015 EMG/NCV study of the lower extremities

¹⁶ See *E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

¹⁷ See *supra* note 10 at Chapter 2.808.5(c)(3) (February 2013).

¹⁸ 5 U.S.C. § 8123(a); see *R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

¹⁹ 20 C.F.R. § 10.321.

²⁰ *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

confirmed his initial February 19, 2015 impairment rating. Dr. Hogshead, a second OWCP medical adviser, reviewed the record and recommended a second opinion examination with an electrodiagnostic study.

Dr. Dinenberg, a second opinion physician, in reports dated September 2 and 23, 2015 found that the sensory examination was nonanatomic with decreased sensation in the stocking distribution. He also noted that a September 16, 2015 EMG/NCV study was normal with no electrical evidence of nerve entrapment, peripheral neuropathy, or lumbar radiculopathy. A third medical adviser, Dr. Estaris, reviewed Dr. Dinenberg's second opinion reports and, the medical record and, in a July 22, 2016 report, agreed with Dr. Dinenberg that appellant had no ratable permanent impairment of the bilateral lower extremities secondary to her accepted lumbar condition. He explained that since there was insufficient evidence of radiculopathy in her bilateral lower extremities she had no ratable impairment of the bilateral lower extremities pursuant to the July/August 2009 edition of *The Guides Newsletter*.

The Board finds that there is an unresolved conflict in the medical evidence between appellant's treating physicians and OWCP's referral physicians regarding permanent impairment of the bilateral lower extremities. Appellant's treating physician, Dr. Bishai opined that appellant had 26 percent permanent impairment of each lower extremity due to findings of moderate sensory and motor deficit. He based his opinion on examination findings and electrodiagnostic studies by Dr. Libreros-Cupido dated August 16, 2013 and June 10, 2015.

Dr. Dyer, an OWCP medical adviser, found a 14 percent permanent impairment of each lower extremity due to mild sensory and motor deficit in her lower extremities. OWCP's second opinion physician, Dr. Dinenberg, and medical adviser, Dr. Estaris, however, determined that appellant had no ratable impairment of the lower extremities secondary to her accepted lumbar conditions, based on physical examination and the September 16, 2015 electrodiagnostic testing.

Accordingly, the Board finds a conflict in medical evidence as to whether appellant has any permanent impairment in her lower extremities after applying the A.M.A., *Guides*.

As noted above, if there is disagreement between a claimant's physician and OWCP's referral physician, OWCP will appoint a referee physician or impartial medical specialist who shall make an examination.²¹ As there is an unresolved conflict in the medical evidence, the case must be remanded to OWCP for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence in accordance with 5 U.S.C. § 8123(a). After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

²¹ *Supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the July 27, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this opinion.

Issued: April 26, 2017
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board