United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, NORTHPORT VA MEDICAL CENTER, Northport, NY, Employer**	)))))))))	**Docket No. 19-1670** **Issued: November 17, 2020**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 5, 2019 appellant filed a timely appeal from May 15 and July 10, 2019 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than four percent permanent impairment of his left lower extremity, for which he previously received a schedule award; (2) whether appellant received an overpayment of compensation in the amount of $7,127.90 for the period July 29 through November 7, 2018 for which he was without fault because he had previously received a schedule award for greater permanent impairment than his entitlement; and (3) whether OWCP properly denied waiver of recovery of the overpayment.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 1, 2012 appellant, then a 56-year-old food service worker, filed a traumatic injury claim (Form CA-1) alleging that he injured his lower back when he lifted a container of juice while in the performance of duty. He stopped work on March 12, 2012. OWCP accepted the claim for lumbar sprain. On September 26, 2012 appellant underwent OWCP-approved lumbar spine surgery which included a posterior spinal fusion instrumentation to L4-5; discectomy at L4-5; intervertebral fusion with placement of intervertebral cage at L4-5; laminectomy at L4-5; bone marrow iliac crest aspiration; and use of autograft, allograft, and fluoroscopy. OWCP paid appellant wage-loss compensation on the supplemental rolls from July 1, 2012 to March 9, 2013. Appellant returned to full-time employment with restrictions on March 1, 2013, but stopped work on September 15, 2014 due to reasons unrelated to his compensation claim.

OWCP later expanded acceptance of appellant's claim to include aggravation of preexisting degenerative disc disease at L4-5 and L5-S1.

On March 9, 2016 appellant underwent an insertion of dual lead trial spinal cord stimulating apparatus.

On September 20, 2016 appellant filed a claim for a schedule award (Form CA-7).

In a July 27, 2016 report, Dr. Nicholas Diamond, Board-certified in physical medicine and rehabilitation, noted appellant's history of injury and medical course. He also reviewed medical records appellant provided and detailed his physical examination of appellant. Appellant's physical examination revealed extensor halluces longus graded 4+/5 on the left side and 5/5 on the right side. Semmes-Weinstein monofilament testing revealed diminished sensibility involving the left L4, L5, and S1 nerve distribution. Dr. Diamond provided an impairment rating under Proposed Table 2 of *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), which is a supplemental publication of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] He noted that appellant had reached maximum medical improvement (MMI) as of the date of the examination. Citing to tables under the A.M.A., *Guides* to assess grade modifiers and setting forth his calculations under the net adjustment formula, Dr. Diamond found, after net adjustments: 5 percent impairment for a class 1 mild 4/5 motor strength deficit left extensor halluces longus; 3 percent impairment for class 1 moderate sensory deficit left L4 nerve root; 3 percent impairment for class 1 moderate sensory deficit left L5 nerve root; 3 percent impairment for class 1 sensory deficit left S1 nerve root; 13 percent impairment for class 1, moderate 3/5 motor strength deficit left hip flexors. This resulted in a final combined left lower extremity permanent impairment of 24 percent.

On November 11, 2016 Dr. Arnold T. Berman, a Board-certified orthopedist serving as a district medical adviser (DMA), reviewed the record and noted appellant's history of injury and treatment. He agreed that appellant reached MMI on July 27, 2016, the date of Dr. Diamond's examination. However, the DMA noted that the electromyogram (EMG) of record did not support Dr. Diamond's finding of left lower extremity weakness based upon L4, L5, and S1 nerve roots.

[2] A.M.A., *Guides* (6th ed. 2009).

Rather, the EMG only indicated left S1 radiculopathy. The DMA further noted that the 2016 physical examination findings by Dr. Jeffrey Epstein, a neurosurgery specialist, and Dr. Thomas Frederick Jan, an osteopath and a physical medicine and rehabilitation specialist, both indicated that there was no motor deficit and that Dr. Jan additionally indicated that there was no sensory deficit. The DMA concluded that the medical record did not support Dr. Diamond's opinion that there were motor and sensory deficits. He explained that appellant's L4-5 and L5-S1 levels were fused and, while this could violate L5 nerve root and S1 nerve root, it could not violate the L4 nerve root, where Dr. Diamond found weakness of the left foot flexors. Thus, due to multiple inconsistencies by Dr. Diamond, the DMA indicated that under Proposed Table 2 of *The Guides Newsletter*, that appellant had class 1, S1 nerve root left moderate sensory deficit for 3 percent impairment of the left lower extremity, after a +1 net adjustment. He noted that while this is not demonstrated or confirmed on EMG, it was possible because appellant had left-sided pain that could be pain emanating from the left L5 nerve root. Because of the possibility of pain at the left L5 nerve root, the DMA also found, under Proposed Table 2 of *The Guides Newsletter*, a one percent L5 left mild sensory lower extremity impairment, after a net adjustment of zero. Thus, the DMA opined that appellant had a total of four percent permanent impairment to the left lower extremity. He did not address Dr. Diamond's finding regarding 13 percent permanent impairment for class 1, moderate 3/5 motor strength deficit of appellant's left hip flexors. The DMA's impairment calculations are not of record.

In a May 16, 2017 report, Dr. Diamond disagreed with the DMA's reliance on the 2016 examination findings of Dr. Epstein and Dr. Frederick for impairment purposes, noting that the physicians failed to utilize certain methodologies to test sensory and motor deficits. He concluded that his 24 percent left lower extremity permanent impairment rating should stand.

In an August 1, 2017 letter, appellant, through counsel, contended that DMA Dr. Berman appeared to have ignored the findings of Dr. Shuriz Hishmeh, a Board-certified orthopedic surgeon, in determining appellant's impairment. Copies of Dr. Hishmeh's reports dated July 23, August 20, and November 5, 2014 were submitted. In his July 23, 2014 report, Dr. Hishmeh reported that appellant had increasing back pain and left leg radiculopathy. He diagnosed acquired spondylolisthesis and ordered both an EMG and magnetic resonance imaging (MRI) scan to see whether additional compression was causing his leg symptoms. In his August 20, 2014 report, Dr. Hishmeh reported that the August 14, 2014 MRI scan showed adequate decompression at L4-5 with some increased degeneration at L4-5 and L5-S1. He indicated that the EMG showed chronic left S1 irritation, but no compression on MRI scan. An impression of acquired spondylolisthesis was provided. In his November 5, 2014 report, Dr. Hishmeh indicated that appellant's motor to both extremities was 5/5 except to the left L3 and L4-5 which were 4/5; appellant was able to heel and toe walk without difficulty with a straight cane, but had a small limp. He noted that appellant had increasing back pain and left leg radiculopathy and that the pain management course was unsuccessful. Dr. Hishmeh reiterated that the EMG showed chronic left S1 irritation with no compression seen on MRI scan. He continued to provide an assessment of acquired spondylolisthesis.

On August 31, 2017 OWCP requested clarification from DMA Dr. Berman regarding his November 11, 2016 report. In a September 21, 2017 addendum report, Dr. Berman reviewed the record along with an updated August 31, 2017 statement of accepted facts (SOAF). He indicated that Dr. Hishmeh's examination was not previously forwarded for consideration. The DMA noted

that it was not unusual to find varying physical findings in patients with prior fusion surgery where symptomatology varies from day to day. Utilizing the findings of Dr. Hishmeh's November 5, 2014 examination the DMA applied the A.M.A., *Guides* and *The Guides Newsletter* and found that appellant had nine percent permanent impairment of the left lower extremity. He noted his assumption that the EMG showed a left S1 sensory deficit as was suggested in the report. The DMA found under Proposed Table 2, three percent left L3 mild motor deficit and five percent mild motor deficit of L5 nerve root for a total eight percent impairment based on motor deficit. Utilizing the findings of the EMG, he found one percent impairment for S1 mild sensory class 1. This resulted in a total of nine percent permanent impairment.

On December 4, 2017 OWCP declared a conflict in medical opinion between appellant's physician, Dr. Diamond, and DMA Dr. Berman with regard to the extent of appellant's permanent impairment due to the accepted employment injury.

OWCP subsequently expanded acceptance of the claim to include the condition of failed back surgery syndrome.

To resolve the medical conflict in opinion, OWCP referred appellant, an updated SOAF, and a list of questions to impartial medical examiner (IME) Dr. E. Gregory Fisher, a Board-certified orthopedic surgeon, on May 10, 2018 for an impartial medical evaluation.

In a report dated May 14, 2018, Dr. Fisher noted appellant's history of injury and his review of the medical records and the SOAF. He opined that appellant had reached MMI on March 10, 2016, when appellant's trial spinal cord stimulator was removed without successful relief of pain. Dr. Fisher noted that electrodiagnostic testing revealed S1 radiculopathy and, while there were no EMG/nerve conduction velocity (NCV) studies regarding the L5 nerve root, the clinical examination showed slight decreased sensation over the left distal calf. He also noted appellant's physical examination findings of May 10, 2018. Referencing *The Guides Newsletter*, Dr. Fisher calculated a rating of four percent permanent impairment of the left lower extremity due to sensory deficits at L5 and S1. He explained that appellant's positive EMG showed an S1 radiculopathy and he had a moderate sensory deficit at the S1 nerve root. The moderate sensory deficit would fall into class 1, grade 2 for two percent default permanent impairment, however, the grade modifier adjustment for a moderate sensory deficit would result in a grade D, rather than grade C impairment of three percent permanent impairment for moderate sensory deficit of the S1 nerve root. Regarding the L5 nerve root, on clinical examination appellant had a mild sensory deficit, for a class 1, grade C one percent permanent impairment. These values were combined to result in a total of four percent permanent impairment of the left lower extremity. Dr. Fisher also noted that appellant had no loss of motor strength of the hips and no evidence of weakness of the extensor halluces longus.

OWCP provided DMA Dr. Berman a copy of Dr. Fisher's report for his review. In a July 30, 2018 report, Dr. Berman calculated nine percent permanent impairment of the left lower extremity. The DMA explained that Dr. Hishmeh's report supported three percent permanent impairment for left L3 weakness, five percent permanent impairment for L4-5 nerve root mild motor deficit, and one percent permanent impairment for S1 mild sensory deficit. He concluded that after review of Dr. Fisher's May 14, 2018 report, whose impairment rating was identical to his November 11, 2016 report, appellant had nine percent permanent impairment of the left lower

extremity based on Dr. Hishmeh's November 5, 2014 findings of not only L5 and S1 nerve root impairment, but also permanent impairment arising from the L3 and L4 nerve roots. The DMA noted that the date of MMI was changed to May 10, 2018, the date of Dr. Fisher's report.

By decision dated September 26, 2018, OWCP granted appellant a schedule award for nine percent permanent impairment of the left lower extremity. The period of the award ran for 25.92 weeks from May 10 to November 7, 2018. OWCP paid appellant $12,830.29 in schedule award compensation.

On October 23, 2018 appellant requested a review of the written record before a representative of OWCP's Branch of Hearings and Review.

OWCP thereafter received a December 12, 2018 report from Dr. Diamond, who noted that he agreed with the DMA's finding that appellant had five percent permanent impairment of the left L5 nerve root due to mild deficit, but he indicated that according to appellant's July 27, 2016 examination appellant had a moderate sensory deficit of the S1 nerve root. Dr. Diamond concluded that he stood by his prior opinion that appellant had 24 percent permanent impairment of the left lower extremity.

By decision dated February 6, 2019, the hearing representative set aside OWCP's September 26, 2018 schedule award decision and remanded the case for further development. The hearing representative found OWCP inappropriately sent Dr. Fisher's IME report to DMA Dr. Berman, as he was part of the conflict in medical opinion and a DMA is precluded from resolving a conflict in medical opinion. The hearing representative directed OWCP to provide Dr. Fisher with Dr. Diamond's addendum report dated December 12, 2018 and request that he provide a supplemental opinion addressing specific questions concerning appellant's permanent impairment rating.

In a March 25, 2019 addendum report, Dr. Fisher noted his review of the additional evidence in conjunction with his May 10, 2018 examination of appellant. He indicated that, on his May 14, 2018 examination, appellant had no muscle atrophy over the left thigh or calf, no muscle weakness with the motor power of 5/5 in both lower extremities, and decreased sensation over the lateral aspect of the distal calf and the lateral dorsal aspect of the left foot only. Dr. Fisher again opined that appellant had four percent permanent impairment of his left lower extremity and set forth his calculations under *The Guides Newsletter.* For the S1 nerve root, he found that appellant had class 1, grade C moderate sensory deficit or two percent lower extremity impairment. Based on the adjustment and grade modifiers in Chapter 16, pages 515, 516, and 518, he had net adjustment of one, which equated to grade D or three percent lower extremity impairment. For the L5 nerve root, Dr. Fisher found class 1, grade C for a mild sensory deficit or one percent lower extremity impairment. He indicated that appellant had no net adjustment under the adjustment grids and modifiers. Thus, Dr. Fisher concluded that the mild sensory deficit for the L5 nerve root remained at one percent lower extremity impairment. Using the Combined Values Chart, he found that appellant had four percent permanent impairment of the left lower extremity.

Dr. Fisher indicated that he disagreed with the opinion of DMA Dr. Berman, who based his impairment on a 2014 report from another physician and did not examine appellant himself. He indicated that appellant's surgical procedure involved only the L4-5 level. However,

Dr. Fisher's 2018 examination revealed sensory deficits over L5 and S1. He concluded that his May 2018 examination resulted in an impairment rating of four percent permanent left lower extremity impairment.

In an April 5, 2019 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA, concurred with Dr. Fisher's May 14, 2018 and March 27, 2019 findings of four percent permanent impairment of the left lower extremity. Using Dr. Fisher's examination findings with Proposed Table 2 in *The Guides Newsletter*, the DMA found that for the S1 nerve root, appellant had a class 1, grade C moderate sensory deficit, or two percent lower extremity impairment. Under Table 16-6, Table 16-7, and Table 16-8 of the A.M.A., *Guides*, the DMA found a grade modifier for functional history (GMFH) of 1, that a grade modifier for physical examination (GMPE) was not applicable, and a grade modifier for clinical studies (GMCS) of 2. Applying the net adjustment formula, he found net adjustment of 1, which equated to grade D or three percent lower extremity impairment. For the L5 nerve root, the DMA found class 1, grade C for a mild sensory deficit or one percent lower extremity impairment. Under Table 16-6, Table 16-7 and Table 16-8 of the A.M.A., *Guides*, he found a GMFH of 1; that a GMPE was not applicable; and a GMCS of 1, which equated to no net adjustment. This resulted in one percent final lower extremity impairment for the mild sensory deficit of the L5 nerve root. Using the Combined Values Chart at page 604 of the A.M.A., *Guides*, the DMA found four percent total permanent impairment of the left lower extremity. He further advised that the key diagnostic factors utilized in his determination of diagnosis-based impairment (DBI) for the accepted conditions were not eligible for an alternative range of motion (ROM) impairment calculation based on the A.M.A., *Guides.* The DMA also opined that the date of MMI was May 10, 2018, the date Dr. Fisher examined appellant.

By decision dated May 15, 2019, OWCP issued a schedule award for four percent permanent impairment of the left lower extremity. It found the weight of the medical evidence rested with the May 14, 2018 and March 27, 2019 opinions of Dr. Fisher and the April 5 and 19, 2019 opinions of DMA Dr. Katz. The award ran for 11.52 weeks for the period May 10 to July 29, 2018. OWCP noted that the amended schedule award equaled a payment of $5,702.39. It advised that payment would not be released as appellant was previously incorrectly paid for nine percent permanent impairment of the left lower extremity, which was five percent greater than his actual entitlement and therefore represented an overpayment of compensation.

On June 10, 2019 OWCP issued a preliminary determination that an overpayment of compensation in the amount of $7,127.90 occurred because appellant had received a schedule award for nine percent permanent impairment of the left lower extremity, when he was only entitled to four percent permanent impairment of the left lower extremity, resulting in an overpayment for the remaining five percent lower extremity impairment received. It further advised him of its preliminary determination that he was without fault in the creation of the overpayment. OWCP requested that appellant complete the enclosed overpayment recovery questionnaire (Form OWCP-20) and submit supporting financial documentation. It notified him that failure to submit the requested information within 30 days would result in the denial of waiver of recovery of the overpayment. Additionally, OWCP notified appellant that, within 30 days of the date of the letter, he could request a telephone conference, a final decision based on the written evidence, or a prerecoupment hearing. No response was received.

By decision dated July 10, 2019, OWCP finalized the preliminary determination that appellant received an overpayment of compensation, for which he was without fault, in the amount of $7,127,90 for the period July 29 through November 7, 2018. A detailed calculation of the $7,127.90 overpayment was provided. OWCP denied waiver of recovery of the overpayment and directed that the overpayment be recovered in full.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[3] and its implementing federal regulations,[4] 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.[5] For decisions issued after May 1, 2009, the sixth edition will be used.[6]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[7] Furthermore, the back is specifically excluded from the definition of organ under FECA.[8] 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.[9]

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* provides an alternative approach to rating spinal nerve impairment, under the July/August 2009 edition of *The Guides Newsletter*.[10] OWCP has adopted this approach for rating permanent impairment of the upper or

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] *Id.* at § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *id*. at Chapter 3.700, Exhibit 1 (January 2010).

[7] *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *K.Y.*, Docket No. 18-0730 (issued August 21, 2019); *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[8] *See* 5 U.S.C. § 8101(19).

[9] *D.L.*, Docket No. 20-0059 (issued July 8, 2020); *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[10] *D.L.*, *id.*; FECA Transmittal No. 10-04 (issued January 9, 2010); *supra* note 6 at Chapter 3.700, Exhibit 1 (January 2010); *The Guides Newsletter* is included as Exhibit 4.

lower extremities caused by a spinal injury.[11] Specifically, it will address lower extremity impairments originating in the spine through Table 16-11[12] and upper extremity impairments originating in the spine through Table 15-14.[13]

In addressing upper or lower extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* require identifying the impairment class of diagnosis (CDX), which is then adjusted by the GMFH and the GMCS. The effective net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[14]

Section 8123(a) 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.[15] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.[16] Where a case is referred to an IME for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.[17]

ANALYSIS -- ISSUE 1

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

While Dr. Diamond assigned 13 percent permanent impairment for motor strength deficit of the left hip flexors, Dr. Berman did not address this aspect of Dr. Diamond's permanent impairment evaluation in either of his reports. In his addendum report dated September 21, 2017 Dr. Berman noted that he had not previously reviewed Dr. Hishmeh's reports, which also suggested impairment arising from the L3 and L4 nerve roots. Dr. Diamond then assigned a permanent impairment rating for mild motor deficit arising from the L3 nerve root, but did not further address the L4 nerve root findings of record. The Board further notes that Dr. Hishmeh indicated that the EMG showed chronic left S1 nerve root irritation with no compression on MRI scan. In his July 27, 2016 report, Dr. Diamond opined that appellant had a moderate left S1 nerve root irritation, which he used to calculate appellant's impairment, in addition to motor impairments. In his September 21, 2017 addendum report, DMA Dr. Berman, indicated that he utilized the findings of Dr. Hishmeh's November 5, 2014 examination and the EMG. However,

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[11] *Id.*

[12] *Supra* note 2 at 533.

[13] *Id.* at 425.

[14] *See supra* note 6 at Chapter 3.700, Exhibit 4 (January 2010).

[15] 5 U.S.C. § 8123(a).

[16] *E.M.*, Docket No. 19-1535 (issued August 27, 2020); *C.R.*, Docket No. 18-1285 (issued February 12, 2019); *James P. Roberts*, 31 ECAB 1010 (1980).

[17] *Id.*

he rated appellant's chronic left S1 nerve root irritation as mild and assigned one percent permanent impairment, whereas he had previously assigned three percent permanent impairment for moderate S1 sensory impairment in his November 11, 2016 report. DMA Dr. Berman provided insufficient rationale for his opinion that appellant had a less severe S1 nerve root irritation based upon Dr. Hishmeh's reports. As such he failed to adequately explain his impairment ratings. For example, DMA Dr. Berman failed to indicate how the grade modifiers were determined in his application of the net adjustment formula in determining the S1 and L5 nerve sensory deficit percentages. Therefore, for these reasons, the Board finds that Dr. Berman's opinion was not of equal weight and was thus insufficient to create a conflict with the July 27, 2016 report of Dr. Diamond.

As no true conflict existed in the medical evidence at the time of the referral to Dr. Fisher, the Board finds that his report may not be afforded the special weight of an IME and should instead be considered for its own intrinsic value.[18] The referral to Dr. Fisher is therefore considered to be for a second opinion evaluation.[19]

In reports dated May 14, 2018 and March 25, 2019, Dr. Fisher noted his review of the SOAF and the medical record. He found no muscle atrophy over the left thigh or calf, no muscle weakness with the motor power of 5/5 in both lower extremities, and decreased sensation over the lateral aspect of the distal calf and the lateral dorsal aspect of the left foot only. Dr. Fisher opined that appellant had four percent permanent impairment of the left lower extremity due to the accepted spinal conditions, pursuant to the rating method found in *The Guides Newsletter*.[20] Under Proposed Table 2, Dr. Fisher opined that appellant's moderate sensory deficit associated with the S1 nerve root fell under class 1 with a default value of two percent impairment. He indicated that the net adjustment formula resulted in a net adjustment of one. Dr. Fisher also found that, under Proposed Table 2, appellant's mild sensory deficit associated with the L5 nerve root fell under class 1 with a default value of one percent with no adjustment under the net adjustment formula. Thus, he concluded that appellant had one percent permanent impairment of his left lower extremity due to sensory deficit associated with the L5 nerve root. Dr. Fisher combined the permanent impairment values associated with the S1 and L5 nerve roots and concluded that appellant had four percent permanent impairment of his left lower extremity.

The Board therefore finds that a conflict in medical opinion now exists between Dr. Diamond and Dr. Fisher regarding the extent of appellant's permanent impairment. Therefore, the case must be remanded to OWCP for referral of appellant to an IME for resolution of the

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[18] *See R.B.*, Docket No. 20-0109 (issued June 25, 2020); *see also F.R.*, Docket No. 17-1711 (issued September 6, 2018).

[19] *See M.G.*, Docket No. 19-1627 (issued April 17, 2020); *S.M.*, Docket No. 19-0397 (issued August 7, 2019) (the Board found that at the time of the referral for an impartial medical examination there was no conflict in medical opinion evidence; therefore, the referral was for a second opinion examination); *see also Cleopatra McDougal-Saddler*, 47 ECAB 480 (1996) (the Board found that, as there was no conflict in medical opinion evidence, the report of the physician designated as the IME was not afforded the special weight of the evidence, but instead considered for its own intrinsic value as he was a second opinion specialist).

[20] *Supra* note 6 at Chapter 3.700, Exhibit 4 (January 2010).

conflict in medical opinion evidence in accordance with 5 U.S.C. § 8123(a).[21] After such further development as OWCP deems necessary, it shall issue a *de novo* decision.[22]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the July 10 and May 15, 2019 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 17, 2020
Washington, DC

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

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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

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[21] *M.G.*, *supra* note 19; *L.W.*, Docket No. 19-0722 (issued November 20, 2019).

[22] In light of the Board's disposition in Issue 1, Issues 2 and 3 are rendered moot.