United States Department of Labor
Employees' Compensation Appeals Board

D.O., Appellant	)	
and	)	**Docket No. 19-1729**
	)	**Issued: November 3, 2020**
U.S. POSTAL SERVICE, KEARNY POST OFFICE, Kearny, NJ, Employer	)	

Appearances:
Michael D. Overman, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 15, 2019 appellant, through counsel, filed a timely appeal from a March 4, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). 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] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 21 percent permanent impairment of his left lower extremity (LLE) and 21 percent permanent impairment of his right lower extremity (RLE), for which he previously received a schedule award.

FACTUAL HISTORY

On March 9, 2009 appellant, then a 49-year-old mail handler, filed a notice of recurrence (Form CA-2a) alleging that on March 6, 2009 he sustained a recurrence of disability of his July 25, 2008 employment injury.[3] He explained that his original injury was never cured and that the status of his conditions had remained the same since July 25, 2008.

By letter dated March 23, 2019, OWCP converted appellant's recurrence claim to an occupational disease claim (Form CA-2), assigned OWCP File No. xxxxxx581. It accepted the occupational disease claim for aggravation of left-sided disc herniation at the L4-5 level superimposed on a preexisting right-sided herniation at the L5-S1 level and aggravation of lumbar radiculopathy superimposed on a preexisting right-sided L5-S1 disc herniation at the L5-S1 level.

On April 21, 2009 appellant returned to work in a full-time, limited-duty capacity.

On November 18, 2009 appellant underwent authorized back surgery for revision decompression of L4-5, L5-S1 with left-sided L4-5 and L5-S1 foraminotomies with discectomy, L4-5.

On January 27, 2016 appellant filed a claim for a schedule award (Form CA-7).

In an October 22, 2015 impairment rating report, Dr. Michael M. Cohen, an osteopath Board-certified in internal medicine and neurology, noted appellant's "March 6, 2009" employment injury and the medical records that he reviewed. He conducted a physical examination and observed that appellant was unable to perform heel or toe walking. Dr. Cohen noted paraspinal muscle spasm and tenderness bilaterally at L4-5. He reported that there was limited ankle dorsiflexion due to drop foot involving the RLE. Dr. Cohen also indicated that Semmes Weinstein monofilament testing revealed complete anesthesia at 6.65 mgs for the right lower extremity and diminished sensitivity to 4.56 mgs for the left lower extremity. He diagnosed aggravation of preexisting lumbar discectomy L4-5, repeated herniated disc at L4-5, herniated disc at L5-S1, and status post revision decompression at L4-5, L5-S1 with foraminotomy and discectomy.

Dr. Cohen referenced Table 2 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and *The Guides Newsletter*, Rating Spinal

[3] Appellant has a previously accepted traumatic injury claim under OWCP File No. xxxxxx582 for a July 25, 2008 employment injury that occurred when he hit his back on a railing while jumping off a porch to avoid two dogs who were chasing him. OWCP accepted that claim for contusion of back and subsequently expanded it to include bilateral disc herniations at L4-5 superimposed on a preexisting herniation at the L5-S1 level and lumbar radiculopathy.

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

Nerve Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*) and determined that appellant had 6 percent LLE permanent impairment due to severe sensory deficits at L4;[5] 6 percent LLE permanent impairment due to severe sensory deficit at L5;[6] 4 percent LLE permanent impairment due to severe sensory deficit at S1;[7] and 13 percent LLE permanent impairment due to moderate motor strength deficit at L5[8] for a combined total of 26 percent permanent LLE impairment. Regarding appellant's RLE, he calculated that appellant had 8 percent RLE permanent impairment due to very severe sensory deficit at L5;[9] 5 percent RLE permanent impairment due to very severe sensory deficit at S1;[10] 13 percent RLE permanent impairment due to very severe motor strength deficit at L5;[11] and 8 percent RLE permanent impairment due to moderate motor strength deficit at S1, adjusted to 10 percent,[12] for a combined total of 32 percent RLE permanent impairment. Dr. Cohen reported that appellant had reached maximum medical improvement (MMI) on October 22, 2015.

On January 29, 2016 Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, serving as an OWCP district medical adviser (DMA), reviewed Dr. Cohen's October 22, 2015 report and disagreed with his impairment rating. He contended that Dr. Cohen's use of "mild/moderate/ severe" categories was excessive and not consistent with the A.M.A., *Guides*. Utilizing Proposed Table 2 of *The Guides Newsletter*. Dr. Berman determined that appellant had 3 percent LLE permanent impairment due to moderate sensory deficits and 5 percent LLE permanent impairment due to mild motor deficit at L5 and 2 percent LLE permanent impairment due to moderate sensory deficits and 3 percent LLE permanent impairment due to mild motor deficit at S1, when "added because they are from the same table," totaled 13 percent permanent LLE impairment. Regarding appellant's RLE, he calculated that appellant had 3 percent RLE permanent impairment due to moderate sensory deficits and 13 percent RLE permanent impairment due to severe motor deficits at L5 and 2 percent RLE permanent impairment due to moderate sensory deficits and 3 percent RLE permanent impairment due to mild motor deficit at S1, when "added because they are from the same table," totaled 21 percent permanent RLE impairment. Dr. Berman reported that appellant had reached MMI on October 22, 2015.

In a June 8, 2016 supplemental report, Dr. Cohen expressed his disagreement with the February 22, 2016 DMA report and alleged that his original impairment rating was correct. He asserted that, according to the A.M.A., *Guides*, the Semmes Weinstein Monofilament testing was

[5] Dr. Cohen noted grade modifier for functional history (GMFH) of 2 and grade modifier for clinical studies (GMCS) of 3 for a net adjustment of +3.

[6] Dr. Cohen reported grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[7] Dr. Cohen noted grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[8] Dr. Cohen reported grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[9] Dr. Cohen noted grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[10] Dr. Cohen reported grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[11] Dr. Cohen noted grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

[12] Dr. Cohen reported grade modifiers of 2 (GMFH) and 3 (GMCS) for a net adjustment of +3.

the optimum choice for documenting sensory deficits. Dr. Cohen noted that, according to his physical examination, which incorporated the Semmes Weinstein Monofilament testing, appellant's deficits were graded as being mild, moderate, severe, or very severe.

In reports dated July 25 and September 20, 2016, Dr. Berman indicated that he had reviewed Dr. Cohen's June 8, 2016 report and asserted that Dr. Cohen's calculations were not consistent with appellant's preoperative or intraoperative findings.

OWCP found a conflict in the medical opinion evidence and referred appellant for an impartial medical examination. In a May 8, 2017 report, Dr. Robert Dennis, a Board-certified orthopedic surgeon serving as an impartial medical examiner, discussed appellant's history of injury and reviewed his medical records. He reported that appellant had reached MMI on November 18, 2015 approximately one year after appellant's lumbar surgery. Dr. Dennis related appellant's current complaints of difficulty walking on uneven surfaces and stairs and drop foot on both sides. Upon physical examination, he observed that appellant was able to stand on his toes, had difficulty maintaining one leg stance and with dorsiflexion of his ankle, and had severe weakness of the extension power of the great toe in both feet. Dr. Dennis reported that sensory examination of appellant's bilateral lower extremities revealed no sensory deficit in the L4 nerve root and diminished sensation in the L5 and S1 nerve roots. He indicated that appellant had diminished sense of light touch to a moderate degree at L5 and S1 with the sensory deficit being slightly greater at S1. Dr. Dennis related that manual motor strength testing of the plantarflexion was minimally diminished, which would be characterized as mild. He explained that he performed the same exact testing on both legs and found similar findings of both legs.

Utilizing Proposed Table 2 of the A.M.A., *Guides* and *The Guides Newsletter*, Dr. Dennis determined that appellant had five percent RLE permanent impairment due to sensory deficits and five percent RLE permanent impairment due to motor deficits at L5 and four percent RLE permanent impairment due to sensory deficits and eight percent RLE permanent impairment due to motor deficits at S1. He calculated that appellant had a total of 9 percent RLE permanent impairment due to sensory deficits at L5-S1 and 13 percent RLE permanent impairment due to motor deficits at L5-S1 for a combined total of 22 percent RLE permanent impairment. Regarding appellant's LLE, Dr. Dennis determined that appellant had five percent LLE permanent impairment due to sensory deficits and five percent LLE permanent impairment due to motor deficits at L5 and four percent LLE permanent impairment due to sensory deficits, and nine percent LLE permanent impairment due to motor deficits at S1. Thus, he calculated that appellant had a combined sensory deficit of 9 percent and a combined motor deficit of 13 percent, which resulted in a combined total of 22 percent LLE permanent impairment.

On September 11, 2017 Dr. Berman reviewed Dr. Dennis' May 8, 2017 impartial medical examination report and agreed with his impairment rating of 22 percent permanent impairment each of the right and left lower extremities. He reported that the date of MMI was October 22, 2015.

By decision dated January 22, 2018, OWCP granted appellant a schedule award for 22 percent permanent impairment of each lower extremity. The award ran for 126.72 weeks from October 22, 2015 to March 27, 2018. OWCP noted that the schedule award was based on the May 8, 2017 report of Dr. Dennis, the impartial medical examiner.

In an April 18, 2018 decision, an OWCP hearing representative set aside the January 22, 2018 schedule award decision and remanded the case for OWCP to refer Dr. Dennis' impartial medical report to a different DMA as Dr. Berman was part of the original medical conflict and should not review the impartial medical examiner's IME's report.

In a June 22, 2018 report, Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a DMA indicated that he agreed with Dr. Dennis' May 8, 2017 impairment rating report, with the exception that according to Appendix A on page 605, combining appellant's 9 percent LLE permanent impairment for sensory deficits and 13 percent LLE permanent impairment for motor deficits resulted in a combined total of 21 percent LLE permanent impairment. Dr. Dennis advised that the correct method for combining these impairment ratings for sensory and motor deficits also resulted in 21 percent RLE permanent impairment.

In June 28, 2018 addendum report, Dr. Dennis indicated that Dr. Katz' DMA report was correct in determining that appellant's final impairment rating was 21 percent permanent impairment to each lower extremity. He revised his previous impairment rating in order to reflect the appropriate methodology for combining ratings. Dr. Dennis concluded that appellant had 21 percent LLE permanent impairment and 21 percent RLE permanent impairment due to his accepted spinal injury.

In a July 23, 2018 report, Dr. Katz noted that he agreed with Dr. Dennis' impairment rating of 21 percent permanent impairment of each lower extremity. He reported that the date of MMI was May 8, 2017, the date of Dr. Dennis' impartial medical examination.

In a *de novo* decision dated July 31, 2018, OWCP granted appellant a schedule award for 21 percent permanent impairment of each lower extremity. The award ran for 120.96 weeks from October 22, 2015 to February 13, 2018. OWCP noted that the schedule award was based on the May 8, 2017 and June 25, 2018 reports of Dr. Dennis, the impartial medical examiner.

On August 8, 2018 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review, which was held on December 18, 2018.

Appellant submitted an October 3, 2018 report by Dr. Cohen, who related that he had reviewed Dr. Dennis' May 8, 2017 and June 28, 2018 impartial medical reports and Dr. Katz' June 22, 2017 and July 23, 2018 DMA reports. Dr. Cohen reiterated that according to the A.M.A., *Guides* sensory impairment should be graded through sensibility testing such as Semmes Weinstein Monofilament testing (Table 15-3) and motor strength deficit testing should be graded on a scale of 0 to 5 according to Table 16-11, page 533. He discussed his disagreement with Dr. Dennis' characterization of appellant's sensory and motor deficits. Dr. Cohen explained that he disagreed with Dr. Dennis' finding that appellant only had a moderate sensory deficit in the left L5 nerve root since Dr. Dennis reported that appellant barely felt the filaments of any number lower than the stiffest. He also noted his disagreement with Dr. Dennis that appellant had a mild motor deficit in the left L5 nerve root since appellant's motor strength testing reflected severe impairment of the left L5 nerve root. Regarding appellant's right lower extremity, he further noted that he would rate appellant with very severe sensory deficit instead of Dr. Dennis' mild deficit. Dr. Cohen referenced the tables and calculations from his previous report and concluded that

appellant had 26 percent permanent impairment of the LLE and 30 percent permanent impairment of the RLE.[13]

In a December 11, 2018 statement, appellant related that the spinal nerve impairment that affected his legs had continued to worsen. He explained that in November 2017 his condition had worsened to the point that it was difficult to perform his job as a letter carrier so he decided to retire early.

By decision dated March 4, 2019, an OWCP hearing representative affirmed the July 31, 2018 schedule award decision.

LEGAL PRECEDENT

The schedule award provisions of FECA[14] and its implementing regulations[15] 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 of a member 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 and the Board has concurred in such adoption.[16] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[17]

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.[18] Furthermore, the back is specifically excluded from the definition of organ under FECA.[19] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairment consistent with sixth edition methodology. For peripheral nerve impairments to the

[13] Dr. Cohen revised his calculations for appellant's motor deficit for the right S1 nerve. He noted that appellant had moderate motor deficit for a default value of eight percent and a GMFH of 2 and a GMCS of 1 for a net adjustment of zero.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

[16] *Id*. at § 10.404 (a); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010).

[18] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[19] *See id.* at § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that the July/August 2009 edition of *The Guides Newsletter* is to be applied.[20]

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.[21] This is called an impartial medical examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22] 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.[23]

ANALYSIS

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

OWCP found a conflict in the medical opinion evidence between appellant's treating physician, Dr. Cohen, and its DMA, Dr. Berman, regarding permanent impairment of the lower extremities due to appellant's accepted spinal injury. It properly referred appellant and the case record to Dr. Dennis pursuant to 5 U.S.C. § 8123(a) for an impartial medical examination in order to resolve the conflict in medical opinion. In his May 8, 2017 report, Dr. Dennis reviewed appellant's history of injury, the relevant medical evidence, and provided physical examination findings. He related that sensory examination revealed no sensory deficits at L4 and diminished sensation to a moderate degree in the L5 and S1 nerve roots with slightly greater sensory deficit at S1. Utilizing Proposed Table 2 of the A.M.A., *Guides* and *The Guides Newsletter*, Dr. Dennis determined that appellant had 5 percent RLE permanent impairment due to sensory deficits at L5; 5 percent RLE permanent impairment due to motor deficits at L5; 4 percent RLE permanent impairment due to sensory deficits at S1; and 8 percent RLE permanent impairment due to motor deficits at S1 for a combined total of 22 percent RLE permanent impairment. Regarding appellant's LLE, he determined that appellant had 5 percent LLE permanent impairment due to sensory deficits at L5; 5 percent LLE permanent impairment due to motor deficits at L5; 4 percent LLE permanent impairment due to sensory at S1; and 9 percent LLE permanent impairment due to motor deficits at S1, which resulted in a combined total of 22 percent LLE permanent impairment. In a June 28, 2018 addendum report, Dr. Dennis clarified that, according to the appropriate methodology for combining ratings, appellant had a final impairment rating of 21 percent to each lower extremity.

[20] *Supra* note 17 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[21] 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).

[22] 20 C.F.R. § 10.321.

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

The Board finds, however, that Dr. Dennis did not adequately explain his opinion in accordance with the relevant standards. While Dr. Dennis provided physical examination findings, he failed to provide any discussion of the relevant portion of the A.M.A., *Guides* and *The Guides Newsletter* he used in finding that appellant had no more than 21 percent RLE and LLE permanent impairment.[24] He did not adequately explain how he classified appellant's sensory or motor deficits based on severity, did not discuss grade modifiers for functional history or clinical studies, and did not adjust the impairment based on the net adjustment formula.[25]

In a situation where 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 and/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.[26] For the above-described reason, the Board finds that the opinion of Dr. Dennis requires clarification. Therefore, the case is remanded to OWCP for referral of the case record, a statement of accepted facts (SOAF), and, if necessary, appellant, to Dr. Dennis for a supplemental report regarding whether appellant has additional permanent impairment of appellant's lower extremities due to his accepted spinal injury. If Dr. Dennis is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to a second impartial medical specialist for the purpose of obtaining his rationalized medical opinion on the issue.[27] After this and such other further development as deemed necessary, OWCP shall issue a *de novo* decision on this matter.

CONCLUSION

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

[24] *See L.L.*, Docket No. 18-0745 (issued February 6, 2019).

[25] *See* A.M.A., *Guides* 531-33 (6th ed. 2009); *see also S.C.*, Docket No. 17-0019 (issued January 11, 2019).

[26] *M.D.*, Docket No. 19-0510 (issued August 6, 2019); *Nancy Lackner* (*Jack D. Lackner*), 40 ECAB 232 (1988).

[27] *S.R.*, Docket No. 17-1118 (issued April 5, 2018); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

ORDER

IT IS HEREBY ORDERED THAT the March 4, 2019 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: November 3, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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