United States Department of Labor
Employees' Compensation Appeals Board

R.D., Appellant	)	
and	)	**Docket No. 20-1052**
	)	**Issued: January 5, 2022**
U.S. POSTAL SERVICE, WARREN POST OFFICE, Warren, MI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On April 20, 2020 appellant filed a timely appeal from a February 28, 2020 merit decision 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.[2]

ISSUE

The issue is whether appellant has met his burden of proof to establish permanent impairment of his right lower extremity, warranting a schedule award.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the February 28, 2020 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

FACTUAL HISTORY

On July 9, 2014 appellant, then a 57-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained injury to the right hip, knee, and lower back due to factors of his federal employment including carrying, casing, tying, and delivering mail, picking up trays and tubs of mail, pushing a hamper, and walking. On August 13, 2014 OWCP accepted his claim for right hip enthesopathy and displacement of the lumbar intervertebral disc without myelopathy. It paid appellant intermittent wage-loss compensation on the supplemental rolls from August 19, 2014 to May 15, 2015.

On June 4, 2015 appellant filed a claim for a schedule award (Form CA-7).

In an April 23, 2015 report, Dr. Peter E. Metropoulos, Board-certified in occupational medicine, provided a permanent impairment evaluation and rating. On physical examination, he observed lumbar spine tenderness, right ankle dorsiflexion asymmetry, and sensory decrease across dermatomes. Dr. Metropoulos noted a magnetic resonance imaging (MRI) scan dated November 5, 2014 of mild broad-based subligamentous protrusion at L4-5 and facet ligamentous hypertrophy leading to bilateral recess narrowing, predominantly facet degenerative findings at L5-S1, and L3-4 facet ligamentous hypertrophy. He further noted electromyogram (EMG) evidence of right L3 and L4 radiculopathy, fibrillation in the vastus medialis, and sural nerve neuropathy. An MRI scan of the right hip dated November 5, 2014 demonstrated hip osteoarthrosis with subchondral marrow signal alteration, diffuse articular cartilage thinning, and a bilateral superior acetabular nondisplaced labral tear. Dr. Metropoulos noted accepted conditions of right hip enthesopathy and lumbar disc displacement.

Referencing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] and *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment Using The Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Dr. Metropoulos opined that appellant reached maximum medical improvement (MMI) as of April 23, 2015. He stated that the involved nerve root was the right L4 lumbar nerve root. Dr. Metropoulos utilized Table 2, page 6 of *The Guides Newsletter* for the L4 spinal nerve level. He assigned mild sensory and motor deficits, which were rated as Class 1 class of diagnosis (CDX). Dr. Metropoulos referenced the appropriate supplemental tables for grade modifiers applicable to the impairment rating including Table 16-5, page 515; Table 16-6, page 516; Table 16-7, page 517, and Table 16-8, page 519. Application of the grade modifiers for the sensory component rendered a sum of zero, and as such, Dr. Metropoulos found that rating remained in the default Grade C position for a one percent permanent impairment for the L4 sensory component deficit. The calculation of the grade modifiers for the motor component also rendered a sum of zero, and thus, the motor impairment also remained at the default position of Grade C for five percent permanent impairment for the L4 motor deficit. Utilizing Table 2, page 5 of *The Guides Newsletter*, Dr. Metropoulos conducted similar calculations for the L3 spinal nerve level, finding mild sensory and motor deficits, sensory and motor grade modifiers that rendered sums of zero. He found one percent permanent impairment for the L3 sensory deficit and three percent permanent impairment for the L3 motor deficit. Dr. Metropoulos then rated appellant's S1 and S2

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

nerve roots for mild sensory and motor deficits and concluded that appellant had a lower extremity impairment of 1 percent for S1 sensory loss, and three percent permanent impairment for S1 motor loss. He similarly rated the S2 nerve root for mild sensory and motor loss and found a one percent permanent impairment for mild sensory loss and three percent permanent impairment for mild motor loss. Dr. Metropoulos then rated appellant's right hip acetabular labral tear under Table 16-4, page 513 of the A.M.A., *Guides*. He placed this diagnosis in CDX 1 and related that the grade modifier for functional history (GMFH) was 1, the grade modifier for physical examination (GMPE) was 1, and that clinical studies were not available for review therefore the total of the modifiers left the rating in the default Grade C positon and resulted in a permanent impairment rating of two percent. Dr. Metropoulos then referenced the Combined Values Chart on pages 604 to 605, Appendix A, and rendered a final lower extremity impairment rating of 20 percent.

In a report dated June 12, 2015, Dr. Metropoulos opined that appellant had reached MMI as of that date. He noted that appellant had radiation to the right lower extremity of pain and paresthesia along multiple dermatomal nerve root distributions and noted asymmetry to right ankle dorsiflexion, as well as right hip pain.

On April 12, 2016 OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and the medical record to Dr. Eric M. Orenstein, a Board-certified orthopedic surgeon acting as district medical adviser (DMA) in order to determine whether he had permanent impairment due to his accepted conditions. In a May 7, 2016 report, Dr. Orenstein reviewed appellant's history of injury, including the SOAF and the reports of Dr. Metropoulos dated April 23 and June 12, 2015. He related that he did not have sufficient information to perform an impairment rating for the right hip, as Dr. Metropoulos had not provided a history of appellant's right hip functional impairments and no findings on physical examination. With regard to appellant's claimed right lower extremity impairment due to spinal nerve root involvement, Dr. Orenstein referred to *The Guides Newsletter*. He related that, while an EMG had revealed right L3-4 radiculopathy with fibrillation in the vastus medialis muscle, there was no mention of any muscular weakness related to this nerve root involvement in the report of June 12, 2015. Therefore, Dr. Orenstein rated appellant for mild sensory deficit of one percent at L3 and one percent at L4, without a motor deficit at these levels. He further stated that he rated appellant for a mild sensory deficit of one percent at S1 for EMG evidence of sural nerve involvement, without any rating for motor deficit. For L5, Dr. Orenstein stated that he rated appellant for mild motor deficit of five percent permanent impairment. He noted that all of these classes would be CDX 1. In terms of grade modifier for GMFH, Dr. Orenstein assigned Grade 0 because appellant had a normal gait, for GMPE, he assigned Grade 1 due to range of motion (ROM) asymmetry of the right ankle; and he related that the grade modifier for clinical studies (GMCS) was inapplicable. Noting that the net adjustment would be 1 to the left, he stated that for L3, the final percentage of permanent impairment was zero, for L4, it would remain at 1 percent, for L5, the final impairment would be four percent, one percent for sensory deficit and three percent for motor deficits, for S1, it would be zero percent, and as such, the final percentage of permanent impairment for the right lower extremity would be five percent using the Combined Values Chart on page 604 of the A.M.A., *Guides*. Dr. Orenstein disagreed with Dr. Metropoulos' calculation for GMFH and GMPE for the right hip, noting no documentation of history or physical examination of the hip. He disagreed with Dr. Metropoulos' calculations for the spinal nerve roots in that he included a motor deficit for the sural nerve, a nerve that is sensory only, and did not appropriately assign

adjustments for functional history and physical examination. Dr. Orenstein opined that the date of MMI was June 12, 2015.

In a letter dated October 7, 2016, Dr. Metropolous responded to the DMA's May 7, 2016 report. He noted that it was questionable whether the DMA had reviewed the April 23, 2015 report because that report contained the results of an examination of the right hip. Dr. Metropolous noted that the date of MMI was April 23, 2015. He stated that, while the DMA opined that no impairment calculation should be provided for the motor components of the lumbar nerve roots previously calculated except for the L5 nerve root, this would not be supported based on the evidence given that the innervation of the muscles contributing to the right dorsiflexion impairment would be inclusive of multiple lumbar levels. Dr. Metropolous stated that the presence of an impairment was supported, as EMG findings corresponded to physical examination.

On October 25, 2016 OWCP requested clarification from Dr. Orenstein and submission of an addendum report addressing Dr. Metropoulos' responses. In an addendum report dated November 19, 2016, Dr. Orenstein noted that the examination of appellant's hip on June 12, 2015 demonstrated diffuse tenderness about the right hip without point tenderness with overall stable joints, no crepitus, locking, or popping, and motor and neurological function grossly intact. He opined that there had not been any information provided to support a change in the permanent impairment rating for the right lower extremity with regard to lumbosacral radiculopathy, stating that an EMG finding in itself was not sufficient to calculate permanent impairment for a motor deficit, and that one could not calculate a permanent impairment rating for a motor deficit of the sural nerve as it was a purely sensory nerve. Dr. Orenstein opined that appellant's final rating of permanent impairment for the right lower extremity based on nerve root deficits was five percent. With regard to appellant's right hip, he referenced the A.M.A., *Guides* Table 16-4, Hip Regional Grid, with a key factor of hip arthritis. This was Class 1 with a default Grade C rating of seven percent based on a three-millimeter cartilage interval. The GMFH was a Grade 0 modifier, as there was no mention of ambulatory difficulty. The GMPE was a Grade 1 modifier for minimal palpatory findings, while the GMCS was inapplicable. The net adjustment was one to the left for a final rating of permanent impairment of the right hip of six percent. As such, the final combined rating of permanent impairment for the right lower extremity was 11 percent. Dr. Orenstein opined that the date of MMI was June 12, 2016.

In a letter addressed to Dr. Metropoulos dated March 23, 2018, OWCP requested that he review and provide commentary on Dr. Orenstein's addendum report of November 21, 2016.

In a letter dated April 2, 2018, Dr. Metropoulos replied to OWCP's March 23, 2018 request. He stated that the DMA, despite reviewing the initial evaluation with impairment calculations, claimed that there was no documentation related to the hip, prohibiting the calculation of an impairment. Contrary to that assertion, Dr. Metropoulos noted that there was information regarding appellant's right hip pain and an objective examination of the hip, along with MRI scan findings. He noted that the DMA did not include the motor component for the L3 and L4 lumbosacral nerves on the basis that there was no documentation through manual muscle testing weakness of any lower extremity muscle groups, but that contrariwise, Dr. Metropoulos had provided the results of testing demonstrating the presence of a notation of right ankle dorsiflexion asymmetry. Dr. Metropoulos further opined that the correct date of MMI was April 23, 2015.

On June 27, 2018 OWCP referred appellant's claim, along with a SOAF and the medical record, to Dr. Louis Radden, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether he had permanent impairment due to his accepted conditions.

On July 25, 2018 OWCP requested clarification from Dr. Orenstein and submission of an addendum report addressing Dr. Metropoulos' responses dated September 8, 2016 and April 2, 2018. In an addendum report dated July 29, 2018, Dr. Orenstein stated that he had reviewed these responses and that they did not alter his previously-stated opinions. He noted that Dr. Metropoulos' ankle/foot examination was imprecise with no documentation of actual ROM measurements and no documentation of strength measurements using a scale of one to five. Dr. Orenstein stated that this lack of precision precluded him from using strength measurements in his assessment of a GMPE, and furthermore, precluded him from using the ROM method as an alternative method of calculating the percentage of permanent impairment, as no ROM measurements were recorded for either hip. As such, he maintained his initial assertions regarding appellant's percentage of permanent impairment.

In a second opinion report dated July 18, 2018, Dr. Radden reviewed appellant's history of injury, including the SOAF, and the medical record, and related appellant's physical examination findings. On physical examination, he observed a positive straight leg raise on the right, reproduced pain in the groin with ROM, antalgic gait, tenderness of the midline and paraspinal muscle areas, and muscle spasm in the paraspinal muscle area. Dr. Radden diagnosed herniated disc at L4-5 and enthesopathy of the right hip. He opined that appellant reached MMI on June 12, 2015. Referring to Table 16-4, page 512, of the A.M.A., *Guides*, Dr. Radden used CDX 1 for moderate motion deficits and significant weakness in addition to radiographic findings. That placed the lower extremity of the right hip at the default Grade C equivalent to five percent permanent impairment. The GMFH, GMCS, and GMPE were 1, 1, and 2, respectively, for a net adjustment of 1. As such, the final lower extremity impairment for the right hip was six percent. With regard to the lumbar spine conditions, Dr. Radden referred to Table 17-4, page 570, for motion segment lesions. This placed the right hip at the default Grade C seven percent permanent impairment. The GMFH, and GMPE were 2 and 2, respectively, for a net adjustment of 2. As such, the final lower extremity impairment for the right hip related to the lumbar spine condition was nine percent. The total right lower extremity percentage of permanent impairment was thus 15 percent. Dr. Radden noted significant differences between the left and right hip ROM, and stated that, according to Table 16-24, page 549, flexion for the right hip was classified as severe at 20 percent right lower extremity impairment; extension was mild at 5 percent right lower extremity impairment; internal rotation was mild at 5 percent right lower extremity impairment, and external rotation was moderate at 10 percent right lower extremity impairment.

On March 13, 2019 OWCP requested clarification from Dr. Orenstein and submission of an addendum report addressing Dr. Radden's July 18, 2018 second opinion report. In an addendum report dated April 7, 2019, Dr. Orenstein reviewed the SOAF and medical records, including Dr. Radden's July 18, 2018 report. Referring to Table 16-24 of the A.M.A., *Guides*, using the ROM method, he found that appellant would have a total of 35 percent permanent impairment of the right lower extremity, based on 20 percent impairment for hip flexion of 40 degrees, 5 percent impairment of internal rotation of 20 degrees, and 10 percent impairment for external rotation of 15 degrees. However, Dr. Orenstein noted ROM measurement for abduction

and adduction were not recorded. Referring to Table 16-4, page 513, under the DBI method for a labral tear, appellant was Class 1 with a default Grade C rating of 2 percent. The GMFH was Grade 1 for antalgic gait, Grade 3 for GMPE for severe motion deficits, and the GMCS was inapplicable. The net adjustment was two to the right for a final DBI permanent impairment rating of three percent. Dr. Orenstein noted that, as measurements were not provided for abduction and adduction of the right hip, he could not complete an impairment rating using the ROM method.

In a record of a telephone conversation dated June 4, 2019, an OWCP representative explained that it had attempted to obtain an addendum report from Dr. Radden, but that he was no longer in the QTC medical network and was thus unavailable.

On June 5, 2019 OWCP referred appellant, along with a SOAF and the medical record, to Dr. Emmanuel Obianwu, a Board-certified orthopedic surgeon, for a second opinion examination in order to determine whether he had permanent impairment due to his accepted conditions. In a report dated July 12, 2019, Dr. Obianwu reviewed appellant's history of injury, including the SOAF, and the medical record, and conducted a medical examination. On physical examination, he observed that deep tendon reflexes were present and equal bilaterally with diminished sensation over the lateral aspect of the right proximal thigh and the mid-portion of the lateral aspect of the right thigh. Dr. Obianwu observed no reflex changes in the lower extremities. He found negative foraminal closure and straight leg raising tests with no significant irritability of the hip joints. Dr. Obianwu observed no weakness in any of the muscle groups of the lower extremities. Abducting the right hip against resistance did not induce any significant pain and appellant did not have features of trochanteric bursitis. There was some tenderness in the midline of the lumbar spine at the lumbosacral junction and possibly at the level of the L4-5 disc. Dr. Obianwu observed no tightness of muscles in that area. Internal rotation of the hip joint did not induce any features over the lateral aspect of the right thigh. He found that a Deep Trendelenburg test was negative bilaterally. Dr. Obianwu stated that it was obvious from this finding that the hip joint itself was not contributing to appellant's symptomology, and the only reasonable culprit was lumbar disc disease.

Referring to the A.M.A., *Guides*, Dr. Obianwu noted that appellant had no motor deficits on the basis of his spinal nerve injury at the L4-5 level, but that there were sensory deficits in the right lower extremity. Considering that the only area of involvement was the lateral aspect of the right thigh, with reference to Figure 16-3 describing lower extremity innervation, he stated that the L3 nerve root was affected, but that there was overlap and that he would state with some degree of confidence that he still had L4 radiculopathy. As such, for the impairment rating, Dr. Obianwu used the L4 nerve root, which was the area of positive nerve impingement demonstrated by MRI scan. The involvement of the sensory nerves was mild-to-moderate. Referring to Table 2 of *The Guides Newsletter*, the moderate sensory deficit would be Grade C, equivalent to three percent impairment of the right lower extremity. Dr. Obianwu noted that there was no impairment of function, but persistent burning pain of the right thigh, and attributed a GMFH of 1. As physical examination revealed only the sensory impairment of diminished sensation of the lateral aspect of the right thigh, the GMPE was 1. As the diagnoses was supported by electrodiagnostic studies, the GMCS was 1. As such, the net adjustment was zero, and the final impairment of the right lower extremity caused by the L3-4 radiculopathy was three percent impairment of the right lower extremity. Dr. Obianwu observed that the spinal nerve involvement did not affect ROM of the

extremities and that ROM in the lumbar spine did not play a role in determining impairment under the A.M.A., *Guides* and *The Guides Newsletter*. He stated that the date of MMI was August 2015.

On July 31, 2019 OWCP forwarded Dr. Obianwu's July 12, 2019 report to Dr. Orenstein, the DMA, for review. In a report dated August 11, 2019, Dr. Orenstein noted that Dr. Obianwu had not addressed the hip pathology in his calculation as in his opinion, the labral tear was not causally related to appellant's symptoms, despite enthesopathy of the hip being an accepted condition. Using Dr. Radden's examination, as appellant had evidence of a labral tear of the right hip, under the DBI method and referencing Table 16-4, page 513 with a key factor of labral tear, appellant had a CDX 1 deficit with a default Grade C impairment rating of 2 percent. The GMFH would be Grade 1 for antalgic gait, while the GMPE would be Grade 3 for severe motion deficits. The GMCS would be inapplicable. The net adjustment would be two to the right with a final permanent impairment rating of three percent. Dr. Orenstein noted that according to Dr. Obianwu, appellant had a mild L4 sensory deficit of the right thigh in the L4 nerve root distribution. Referring to *The Guides Newsletter*, appellant would have a CDX 1 deficit for the L4 nerve root impairment with a default Grade C impairment rating of three percent. His gait was not described and the lower limb questionnaire was not completed, so a GMFH could not be performed. Appellant would have a Grade 1 modifier for GMPE for a half inch of right calf atrophy. The GMCS remained inapplicable. Dr. Orenstein stated that, because he lacked a gait description and did not have complete ROM measurements of the hip, he could not complete a permanent impairment rating for the right lower extremity based on ROM.

In a SOAF dated September 19, 2019, OWCP indicated that it had accepted right hip enthesopathy and a herniated lumbar disc. It explained how appellant's accepted conditions developed over the course of 28 years as a result of accepted duties of his federal employment as a letter carrier.

On September 19, 2019 OWCP declared a conflict in the medical opinion evidence between Dr. Orenstein and Dr. Metropoulos over the applicable and interpretation of the A.M.A., *Guides* and impairment percentage and referred appellant for an impartial medical examination. In a November 11, 2019 report, Dr. Stanley S. Lee, a Board-certified orthopedic surgeon serving as impartial medical examiner (IME), discussed appellant's history of injury and reviewed his medical records. He recounted that appellant complained of pain in his back and right hip along the lateral aspect just proximal to the greater trochanteric region, shooting into the groin on the right side. On physical examination of the lower extremities, Dr. Lee observed full strength in hip abduction and adduction and full hip, knee, and ankle flexion and extension bilaterally. Appellant's patellar and Achilles reflexes were equal and symmetric bilaterally. Dr. Lee observed normal sensation to light touch in all dermatomes bilaterally and function range and extension of the spine to 70 degrees of flexion and ten degrees of extension. He noted negative straight leg raise tests bilaterally, no evidence of muscle atrophy on visual inspection, and normal gait. Examination of the bilateral hips demonstrated 90 degrees of flexion without flexion contracture with 30 degrees of abduction bilaterally, 10 degrees of adduction bilaterally, 20 degrees of internal rotation bilaterally, and 30 degrees of external rotation bilaterally. There was no pain with ROM to the terminal limits of ROM. Dr. Lee found that the records and physical examination were objectively negative for any ongoing impairment or pathology and noted that diagnostic test reports failed to document objective evidence of pathology. He noted that, while there were age-expected degenerative changes, they were not of clinical significance. Dr. Lee stated that he did

not believe that appellant sustained any work-related injury. He noted that he did not find any objective evidence of impairment to the right hip or lumbar spine.

On December 3, 2019 OWCP requested clarification and submission of an addendum report from Dr. Lee. It noted that it had accepted right hip enthesopathy and a herniated lumbar disc at L4-5 and requested a rationalized opinion as to whether the accepted work factors continued to contribute to appellant's present condition. OWCP further noted that, while Dr. Lee had opined that there were no objective findings to support permanent impairment, he did not cite to the A.M.A., *Guides* in support of his opinion, and requested that, if Dr. Lee opined that appellant continued to suffer from residuals of the accepted work-related conditions, to provide a calculation of permanent impairment with reference to the A.M.A., *Guides* and *The Guides Newsletter*. It stated that if Dr. Lee was of the opinion that appellant no longer suffered residuals of the accepted conditions to thoroughly explain whether there was any impairment to the right or left lower extremities with objective examination findings to support appellant's medical opinion.

In an addendum IME report dated January 16, 2020, Dr. Lee explained that right hip enthesopathy was a broad term referring to inflammation of the insertion of the tendon to the bone, also known as tendinitis. This diagnosis, he noted, did not carry any objective findings of injury or potential for long-term or permanent impairment. Similarly, Dr. Lee explained, a herniated lumbar disc, in the absence of neurological findings and neurological compression, was an incidental finding that would not carry any permanent impairment. Therefore, he opined that there was no impairment, as he did not find any objective evidence of any injury or impairment. Dr. Lee explained that, as he did not find any objective evidence of injury or impairment, the A.M.A., *Guides* would not apply. He noted that there was no evidence of spinal nerve damage and that in the absence of objective evidence of injury, a date of MMI would not be applicable. Dr. Lee stated that, as there was no evidence of impairment or injury, there was no diagnosis on which to base impairment. He further noted, "There is no diagnosis of injury." Dr. Lee noted that he did not find significant loss of ROM of appellant's spine or hip to support permanent impairment and did not find traumatically-induced injury to the hips to support a work-related condition.

By decision dated February 28, 2020, OWCP denied appellant's claim for a schedule award. It accorded the special weight of the medical evidence to IME Dr. Lee's November 11, 2019 and January 16, 2020 reports, wherein he found no objective evidence of injury or impairment.

LEGAL PRECEDENT

The schedule award provisions of FECA[4] and its implementing regulations[5] 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. FECA, however, 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

adoption.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

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.[8] Furthermore, the back is specifically excluded from the definition of organ under FECA.[9] 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 impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* is to be applied.[10]

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.[11] This is called an IME and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[12] 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.[13]

When OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence, and the IME's opinion requires clarification or elaboration, OWCP must secure a supplemental report from the examiner for the purpose of correcting the defect in the original

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

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id*. at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see B.M.*, Docket No. 19-1069 (issued November 21, 2019); *B.W.*, Docket No. 18-1415 (issued March 8, 2019); *J.M.*, Docket No. 18-0856 (issued November 27, 2018); *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[9] *See* 5 U.S.C. § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[10] *Supra* note 7 at Chapter 3.700. *The Guides Newsletter* is included as Exhibit 4.

[11] 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).

[12] 20 C.F.R. § 10.321.

[13] *B.M., supra* note 8; *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

opinion.[14] If the referral physician fails to respond or does not provide an adequate response, OWCP should refer appellant for a new IME examination.[15]

ANALYSIS

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

The Board notes that OWCP properly identified a conflict in medical opinion between Dr. Metropoulos, appellant's treating physician, and Dr. Orenstein, the DMA, regarding appellant's permanent impairment. Dr. Metropoulos found that appellant's accepted right hip condition resulted in two percent permanent impairment, utilizing the DBI methodology, while Dr. Orenstein ultimately rated appellant's right hip permanent impairment as three percent permanent impairment. Drs. Metropoulos and Orenstein continued to disagree as to whether appellant had a ratable motor deficit of the L3, L4 and S1 nerve roots. Dr. Metropoulos continued to opine that appellant had motor deficit loss at these levels, while Dr. Orenstein continued to relate that the record did not indicate motor loss except at the L4 nerve root level. This conflict required referral to an IME pursuant to 5 U.S.C. § 8123.

In his November 11, 2019 report, Dr. Lee stated that he did not believe that appellant sustained any work-related injury. He noted that he did not find any objective evidence of impairment to the right hip or lumbar spine. In his addendum IME report dated January 21, 2020, Dr. Lee opined that there was no impairment, as he did not find any objective evidence of any injury or impairment. He explained that, as he did not find any objective evidence of injury or impairment, the A.M.A., *Guides* would not apply. Dr. Lee noted that there was no evidence of spinal nerve damage and that, in the absence of objective evidence of injury, a date of MMI would not be applicable. He stated that, as there was no evidence of impairment or injury, there was no diagnosis on which to base impairment.

The Board finds that Dr. Lee's opinion contradicts the SOAF, which makes clear that OWCP had accepted as employment related right hip enthesopathy and a herniated lumbar disc. OWCP procedures provide that, when a referee physician selected by OWCP renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[16] Dr. Lee disregarded the accepted conditions noted in the SOAF and opined that appellant stated that he did not believe that he sustained any work-related injury, stating in his January 21, 2020 addendum report, "There is no diagnosis of injury." OWCP, however, has accepted that appellant's work-related activities resulted in the accepted right hip enthesopathy and a herniated lumbar disc conditions. The Board has held that, if a referee physician does not base his or her opinion on the SOAF, the opinion lacks a proper factual background and, thus, is

[14] *W.H.*, Docket No. 16-0806 (issued December 15, 2016); *supra* note 7 at Chapter 2.810.11(e) (September 2010).

[15] *Id.*; *see also R.W.*, Docket No. 18-1457 (issued February 1, 2019).

[16] *Supra* note 7 at Chapter 2.810.11 (September 2010); *see R.T.*, Docket No. 20-0081 (issued June 24, 2020); *Roger W. Griffith*, 51 ECAB 491 (2000).

not rationalized.[17] As Dr. Lee's opinion is inconsistent with the SOAF, it is insufficient to resolve the existing conflict in medical opinion.[18]

Accordingly, there remains an unresolved conflict in medical evidence. On remand, OWCP shall refer appellant and a SOAF to another physician in the appropriate field of medicine to resolve the existing conflict as to the extent of permanent impairment, if any, due to the accepted right hip and lumbar conditions. After this and such other 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.

ORDER

IT IS HEREBY ORDERED THAT the February 28, 2020 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: January 5, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

[17] *T.M.*, Docket No. 20-1143 (issued December 14, 2020); *P.C.*, Docket No. 19-1468 (issued September 9, 2020); *D.M.*, Docket No. 17-1563 (issued January 15, 2019).

[18] *Id*.