United States Department of Labor
Employees' Compensation Appeals Board

VANESSA YOUNG, Appellant	)	
and	)	**Docket No. 04-562**
	)	**Issued: June 22, 2004**
DEPARTMENT OF HEALTH & HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION, New York, NY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member
A. PETER KANJORSKI, Alternate Member

JURISDICTION

On December 23, 2003 appellant, through her attorney, filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated March 5, 2003, granting a schedule award for a 29 percent impairment of her right lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award in this case.

ISSUE

The issue is whether appellant has more than 29 percent permanent impairment of her right lower extremity, for which she received a schedule award.

FACTUAL HISTORY

On January 10, 1997 appellant, then a 42-year-old service representative, filed a traumatic injury claim alleging that she slipped and fell while in the performance of duty on January 7, 1997. The Office accepted appellant's claim for subluxation of the coccyx on

March 21, 1997. Appellant returned to work on January 27, 1997. Appellant received a third-party recovery as a result of her employment injury.

Appellant requested a schedule award on March 25, 2002. In support of her claim, she submitted a narrative report from Dr. Nicholas Diamond, an osteopath, dated December 20, 2001 finding that she had 40 percent impairment of her right lower extremity. The Office medical adviser reviewed this report on May 4, 2002 and found that appellant had 29 percent impairment of her right lower extremity. By decision dated May 8, 2002, the Office granted appellant a schedule award for 29 percent permanent impairment of her right lower extremity to run from December 20, 2001 to July 27, 2003.[1]

Appellant, through her attorney, requested an oral hearing on May 21, 2002. Appellant testified at the oral hearing on December 9, 2002. By decision dated March 5, 2003, the hearing representative affirmed the May 8, 2002 decision finding that appellant had no more than 29 percent permanent impairment of her right lower extremity.[2]

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[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, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[5]

ANALYSIS

The Office accepted appellant's claim for subluxation of her coccyx, the caudal extremity of the vertebral column.[6] A schedule award is not payable for a member, function or organ of the body not specified in the Act or in the implementing regulations. As neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the

[1] The Office noted that appellant retained a surplus of her third-party settlement and was not entitled to further monetary disbursements from the Office until the surplus had been absorbed.

[2] On appeal to the Board, appellant submitted additional new evidence. As the Office did not consider this evidence in reaching a final decision, the Board may not review the evidence for the first time on appeal. 20 C.F.R. § 501.2(c).

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] *See id.*

[6] *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* (30th ed. 2003).

back or spine, no claimant is entitled to such an award.[7] However, as the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of the impairment originates in the spine.[8]

Appellant submitted a report dated December 20, 2001 from Dr. Diamond, an osteopath, who noted appellant's history of injury and medical treatment as well as performing a physical examination and providing his findings. He noted appellant's physical findings as loss of range of motion in her right hip, decreased motor strength in her quadriceps and right hip extensor, as well as decreased sensory perception on the L5 and S1 dermatomes. Dr. Diamond noted that appellant experienced ilioinguinal tenderness as well as right lower extremity pain. He concluded that appellant's loss of adduction of her right hip was a five percent impairment.[9] Dr. Diamond also found that appellant had right lower extremity pain with decreased sensory examination to pinprick and light touch involving the L5 and S1 dermatomes of the right lower extremity. He found a 4 percent impairment of both the right L5 nerve root and right S1 nerve root.[10] He further found that appellant had 4/5 motor strength weakness in her right knee extension, a 12 percent impairment[11] and 4/5 motor strength weakness in her right hip extension, a 17 percent impairment.[12] Dr. Diamond combined these impairment ratings to total 37 percent impairment, and then determined that appellant had an additional 3 percent impairment due to pain[13] for a total right lower extremity impairment rating of 40 percent.

The Office medical adviser reviewed Dr. Diamond's report on May 4, 2002. He properly noted that appellant's right leg condition was due to her neurogenic impairments as a result of the accepted subluxation of the coccyx. The Office medical adviser concluded that any loss of range of motion of appellant's right lower extremity should not be considered in determining appellant's permanent impairment as the deficit to the right leg was neurogenic and not mechanical. In the discussion of impairments due to injury of the spine, the A.M.A., *Guides* do not provide for loss of range of motion of the lower extremities including only sensory and muscle deficit impairments.[14] In the chapter evaluating the lower extremities, the A.M.A.,

[7] *George E. Williams*, 44 ECAB 530, 533 (1993).

[8] *Id.*

[9] A.M.A., *Guides*, 537, Table 17-9.

[10] *Id.* at 424, Table 15-18; Table 15-15.

[11] *Id.* at 531, Table 17-7; 532, Table 17-8.

[12] *Id.*

[13] Dr. Diamond incorrectly relied on Figure 18-1 of the A.M.A., *Guides* in reaching his impairment rating due to pain.

[14] A.M.A., *Guides*, 398-411, Section 15.8 Range-of-Motion Method; 423, Section 15.12, Nerve Root and/or Spinal Cord.

Guides specifically exclude lower extremity impairment due to the underlying spine pathology.[15] As there is no provision in the A.M.A., *Guides* allowing for loss of range of motion in the extremities due to an underlying spine pathology, the Office medical adviser correctly determined that appellant was not entitled to the five percent impairment for loss of right hip adduction as allowed by Dr. Diamond.

The Office medical adviser also properly found that Dr. Diamond failed to provide sufficient medical rationale to support his conclusion that appellant had three percent impairment due to pain. Dr. Diamond did not identify the nerve root involved and did not provide any findings such that a determination of the grade of the impairment could be made in accordance with A.M.A., *Guides.*[16] Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[17] As the Board is unable to clearly visualize how Dr. Diamond reached his impairment rating regarding pain, this element of appellant's permanent impairment has not been established as indicated in his December 20, 2001 report.

However, the Office medical adviser improperly failed to consider appellant's sensory impairment when determining her impairment. He stated that the range of motion deficits should not be included and specifically excluded the impairment rating for pain; however, the Office medical adviser did not offer any explanation for failing to include appellant's sensory impairments in determining his schedule award. As noted above, Dr. Diamond determined that appellant had sensory impairment of both the L5 and S1 nerve roots due to decreased pinprick and light touch. Appellant is entitled to permanent impairment of her right lower extremity due to sensory impairment in accordance with the A.M.A., *Guides.*[18]

The Office medical adviser concluded that appellant had motor strength deficits as determined by Dr. Diamond and based her impairment rating solely on these deficits. The Board notes that the A.M.A., *Guides* provide that, if a lower extremity impairment is due to an underlying spine disorder, the lower extremity impairment would, in most cases, be accounted for in the spine impairment rating.[19] In this case, both Dr. Diamond and the Office medical

[15] A.M.A., *Guides*, 524. Furthermore, the A.M.A., *Guides* exclude a combination of impairments for loss of muscle strength and loss of range of motion in evaluating lower extremity impairments. A.M.A., *Guides*, 526, Table 17-2.

[16] *Id.* at 424, Table 15-18; Table 15-15.

[17] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[18] A.M.A., *Guides*, 424, Tables 15-15 and 15-18.

[19] A.M.A., *Guides*, 524.

adviser rated appellant's motor strength deficits as if these impairments were due to lower extremity muscle weakness secondary to a pathology that does not have a primary neurologic basis, such as direct muscle trauma.[20] However, as noted by the Office medical adviser, appellant's lower extremity injury was the result of a neurogenic injury and should be evaluated under the rating methods for a spinal injury affecting the lower extremity. This method requires identifying the motion involved, as well as the muscles performing the motion and the spinal nerves involved and grading the severity of the motor deficit of individual muscles according to the appropriate classification. The maximum impairment of the extremity due to motor deficit for each spinal nerve structure involved must be determined and then the severity of the motor deficit must be multiplied by the maximum impairment value to obtain the extremity impairment for each spinal nerve involved.[21] As the medical evidence in the record does not provide the description of appellant's impairment due to motor deficit in sufficient detail for a proper application of the A.M.A., *Guides,* the impairment rating due to this condition cannot be appropriately determined based on the evidence currently before the Board.[22]

Proceedings before the Office are not adversarial in nature and the Office is not a disinterested arbiter; in a case where the Office "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."[23] In this case, appellant submitted medical evidence establishing permanent impairment due to her accepted subluxation of the coccyx. The Office referred this medical evidence to the Office medical adviser, who reviewed the report and determined that appellant had permanent impairment due to muscle strength deficits. However, as noted previously, the Office medical adviser did not apply the appropriate provisions of the A.M.A., *Guides* to reach appellant's impairment due to muscle strength. As the medical evidence regarding these impairments is not sufficient for a lay person such as a claims examiner or others reviewing the file to be able to clearly visualize the impairment and apply the appropriate provision of the A.M.A., *Guides,* the Office must undertake additional development of the medical evidence to appropriately determine appellant's impairment rating for schedule award purposes.

On remand, the Office should refer appellant to an appropriate physician to determine the extent of her permanent impairment due to her accepted employment injury. The physician should consider any impairment due to pain, sensory loss, motor strength deficits and any other impairment rating appropriate under applicable provisions of the A.M.A., *Guides*.

CONCLUSION

The Board finds that the case is not in posture for decision. The record is not sufficiently detailed to establish appellant's impairment rating due to loss of strength, sensory deficits or pain

[20] *Id.* at 531; 532, Table 17-8.

[21] *Id*. at 424, Table 15-16.

[22] Both the Office medical adviser and Dr. Diamond found appellant's active movement against gravity with some resistance, A.M.A., *Guides*, 531, Table 17-7, in both hip extension and knee flexion. *Id.* at 532, Table 17-8.

[23] *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

in accordance with the applicable provisions of the A.M.A., *Guides* and must be remanded for additional development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the March 5, 2003 decision of the Office of Workers' Compensation Programs is set aside and remanded for additional development consistent with this decision of the Board.

Issued: June 22, 2004
Washington, DC

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member