United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
	)	**Docket No. 07-2234**
and	)	**Issued: July 11, 2008**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Brick, NJ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 4, 2007 appellant filed a timely appeal from a March 26, 2007 decision of the Office of Workers' Compensation Programs, adjudicating his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a two percent permanent impairment of his right lower extremity for which he has received a schedule award and whether he has any left lower extremity permanent impairment.

FACTUAL HISTORY

This is the second appeal in this case.[1] By decision dated June 21, 2004, the Board set aside a June 16, 2003 Office decision and remanded the case for further development of the medical evidence. The Board found an unresolved conflict on the issue of appellant's impairment of his lower extremities and directed the Office to refer him to a new impartial medical specialist. The law and the facts of the previous Board decision are incorporated herein by reference.

On September 20, 2004 the Office referred appellant, together with a statement of accepted facts and a list of questions and the case file, to Dr. George P. Glenn, Jr., a Board-certified orthopedic surgeon and an impartial medical specialist, to resolve the conflict in the medical opinion evidence. It advised Dr. Glenn that he must use the statement of accepted facts as the frame of reference for his report.[2]

In a report dated September 28, 2004, Dr. Glenn reviewed appellant's medical history and provided findings on physical examination. He stated:

> "Circulation involving the left lower extremity appeared to be somewhat impaired. The leg from the knee distal to … the foot on the left was mottled and somewhat cyanotic. I could not detect any dorsalis pedis or posterior tibial pulses on the left. They were easily palpable on the right…. Capillary return was poor bilaterally…. There was a normal range of motion involving the feet and ankles. [Appellant] had about a 20 [degree] flexion contracture involving the left knee…. There was no evidence of knee joint effusion…. Ligamentous stability was preserved…. Medial and lateral stability was likewise preserved…. Hip motion was normal in terms of range bilaterally."
>
> * * *
>
> "The reflex response was physiologic, [appellant] demonstrating ... active and symmetrical patellar and Achilles' reflexes in both extremities. There were no pathological reflexes, no areas of muscle fasciculation, and no apparent areas of muscle atrophy. Calf circumferences were … equal bilaterally…. The right thigh measured 47 cm [centimeters], 52 cm and 59 cm respectively. The left thigh measured 47 cm, 52 cm and 58 cm respectively…. There obviously was no evidence of atrophy.
>
> "Motor strength was tested carefully in both upper and lower extremities and was normal throughout all muscle groups. Great toe extensor strength on the right was difficult to assess because of the painful right toe, however, all other dorsi flexor

[1] *See* Docket No. 04-183 (issued June 21, 2004). On October 19, 1987 appellant, then a 28-year-old letter carrier, sustained a herniated disc and spondylolisthesis at L5-S1. On June 28, 2001 he filed a claim for a schedule award. By decision dated July 25, 2002, the Office denied his schedule award claim.

[2] The statement of accepted facts states that the Office accepted the conditions of a herniated disc and spondylolisthesis at L5 to S1 as arising out of the October 19, 1987 employment injury.

strength involving the remaining toes and ankle, as well as plantar flexor strength, eversion and inversion, knee flexor and extensor strength, and all quadrants of hip strength measurements were normal….

"[Appellant] felt the vibrating tuning fork in the right patella, but not on the left and from that area distal through the tibia into the ankle and foot [he] denied any ability to distinguish a vibrating tuning fork from one which was not vibrating. He also reported complete inability to distinguish his toe positions in space (absence of position sense). He, however, shows no evidence of ankle or patellar clonus, nor was there any evidence of a Babinski. The position and vibratory sense deficit would suggest some involvement of [appellant's] posterior spinal column elements."

* * *

"[Appellant] reports a diminished ability to feel pinprick involving both lower extremities from the knee distal in a stocking type distribution, however, [he] reports a discernibly greater loss to involve the distal right ankle into the third and fourth toes. The stocking hypesthesia of course has no basis in organic pathology. One could argue that the outer ankle and foot involvement actually represents a sensory deficit. Whatever it is it is quite minimal and certainly i[n] no way associated with any motor weakness. Two point discrimination is preserved in both upper extremities and absent in both lower extremities (toes)."

* * *

"Dr. Weiss based his permanency impairment [rating] on a motor strength deficit involving the right hip flexors, the right calf atrophy and a sensory deficit of the right L4 and L5 nerve root. The examination today fails to demonstrate any evidence of motor impairment o[r] loss of motor strength in either lower extremity from the hip down to including the toe extensors and flexors, nor is there any evidence of extremity atrophy as determined by circumferential measurement. One could argue the sensory component of a peripheral nerve injury. One is permitted to combine this with a diagnosis based estimate (page 526[,] [T]able 17-2). One is not permitted to combine gait derangement, muscle atrophy or muscle strength (same table). The branches contributing to the sural nerve involvement as described on the right … would contribute to 2 [percent] of the lower extremity (page 552[,] [T]able 17-37). As stated there is no associated motor involvement to contribute to this figure. The vascular status on the left, the posterior column involvement and the peripheral neuropathy as described in the diagnostic studies … are not related…."

* * *

"I would agree with the other examiners that the spondylolisthesis as reported is a developmental situation and not traumatic. One could consider trauma

> superimposed upon the preexisting problem. I seriously doubt that [appellant] has an associated herniated disc…."

Dr. Glenn determined that appellant had a 5 to 8 percent whole person impairment, converted to an 18 percent impairment of the right lower extremity, based on Table 17-3 at page 527 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[3] He found no impairment of the left lower extremity.

On November 24, 2004 Dr. Henry Maglioto, an Office medical adviser, stated that appellant had a two percent impairment of the right lower extremity for sural nerve sensory loss based on Dr. Glenn's report and Table 17-37 (impairments due to nerve deficits) at page 552 of the A.M.A., *Guides*.[4] He noted that Dr. Glenn found no impairment of appellant's left lower extremity. Dr. Maglioto stated that Dr. Glenn erred in finding a whole person impairment, which is not permitted under the Federal Employees' Compensation Act.[5]

By decision dated December 30, 2004, the Office granted appellant a schedule award of 5.76 weeks,[6] from September 28 to November 7, 2004, based on a two percent impairment of his right upper extremity. It found no ratable impairment of his left lower extremity.

On January 6, 2005 appellant requested a hearing that was held on November 17, 2005. By decision dated February 16, 2006, the Office affirmed the December 30, 2004 decision.

Appellant requested reconsideration and submitted additional evidence. In a February 21, 2006 report, Dr. David Weiss, an orthopedic surgeon, stated that his June 6, 2001 report described appellant's radicular symptoms down his lower extremities and noted that Dr. Glenn also reported lower extremity radicular symptoms, worse on the right. He noted that Dr. Glenn found that two-point discrimination was absent in both lower extremities and there was diminished ability to feel pinprick. Dr. Weiss noted that Dr. Glenn reported pain in appellant's lower extremities. He stated his disagreement with Dr. Glenn regarding appellant's atrophy of his right and left calf. Dr. Weiss stated that his prior impairment rating, a 23 percent impairment of the right lower extremity and a 4 percent impairment of the left lower extremity, was unchanged.

Dr. Maglioto reviewed Dr. Weiss's report and stated that it did not produce objective physical data, only a verbal explanation of why he believed his prior report was accurate. He

---

[3] Dr. Glenn stated, "In actuality this table is used to convert lower extremity impairment to whole person impairment and I doubt is valid if utilized the other way around."

[4] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[5] *See infra* note 17.

[6] The Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by two percent equals 5.76 weeks of compensation.

stated that Dr. Weiss was unable to objectively refute Dr. Glenn's examination and opined that Dr. Glenn provided a more objective and detailed evaluation.

By decision dated March 26, 2007, the Office denied modification of the February 16, 2006 decision.

LEGAL PRECEDENT

Section 8107 of the Act[7] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[8]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[9] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[10] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[11] The functional method is used for conditions when anatomic changes are difficult to categorize, or when functional implications have been documented, and includes range of motion, gait derangement and muscle strength.[12] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[13] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[14] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[15]

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[9] A.M.A., *Guides*, 525.

[10] *Id.*

[11] *Id.*

[12] *Id*. at 525, Table 17-1.

[13] *Id.* at, 548, 555.

[14] *Id*. at 526.

[15] *Id*. at 527, 555.

No schedule award is payable for a member, function or organ of the body not specified under the Act or the implementing regulations.[16] Neither the Act not the regulations provide for a schedule award for loss of use of the back or to the body as a whole.[17] However, the schedule award provisions of the Act include the extremities and a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of such impairment originates in the spine.[18]

Section 8123(a) of the Act 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.[19] Where a case is referred to an impartial medical specialist 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.[20]

Board case precedent provides that, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report. Only when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is incomplete, vague, speculative or lacking in rationale, should the Office refer the claimant to a second impartial specialist.[21]

ANALYSIS

The Board finds that further development of the medical evidence is necessary to determine whether appellant has more than two percent right lower extremity impairment. The report of Dr. Glenn is not entitled to special weight due to several deficiencies.

Dr. Glenn did not accept the statement of accepted facts as a basis for his impairment rating. He stated that he seriously doubted that appellant had a herniated disc due to his employment injury. However, the statement of accepted facts provided to Dr. Glenn states that a herniated disc is an accepted condition in this case. The Office stated in its September 20, 2004 instructions to Dr. Glenn that he must use the statement of accepted facts as the frame of reference for his impairment rating but he failed to accept that appellant sustained a work-related herniated disc.

[16] *See J.Q.*, 59 ECAB __ (Docket No. 06-2152, issued March 5, 2008).

[17] *See Guiseppe Aversa*, 55 ECAB 164 (2003).

[18] *See J.Q.*, *supra* note 16; *Vanessa Young*, 55 ECAB 575 (2004).

[19] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan)*, 45 ECAB 207 (1993).

[20] *See Roger Dingess*, 47 ECAB 123 (1995); *Glenn C. Chasteen*, 42 ECAB 493 (1991).

[21] *See Nancy Keenan*, 56 ECAB 687 (2005).

The whole person impairment rating of five to eight percent found by Dr. Glenn is not consistent with the rating of impairment for a specific body member as listed under section 8107 of the Act. Dr. Glenn described impairment to appellant's right lower extremity due to residuals associated with his accepted back conditions. As noted, a schedule award is not payable for loss of use of the spine or for impairment of the whole person.[22] Therefore, appellant is not entitled to a schedule award for the whole body based on his accepted conditions. Dr. Glenn converted the 5 to 8 percent whole person impairment to 18 percent of the lower extremity using Table 17-3 at page 527 of the A.M.A., *Guides*. However, as he noted, Table 17-3 provides for the conversion of lower extremity impairment to whole person impairment, not the reverse. Dr. Glenn failed to determine the impairment of appellant's lower extremities by following the methods for determining impairment in Chapter 17 of the A.M.A., *Guides* which pertains to lower extremity impairment.

Dr. Glenn did not provide all of the range of motion measurements required in the A.M.A., *Guides* for determination of lower extremity impairment. He did not provide complete measurements for range of motion in appellant's lower extremities, including hip, knee, ankle, hindfoot and toe ranges of motion. Dr. Glenn stated that appellant had normal range of motion of the hips, feet and ankles but he provided no measurements to support his findings. He provided a flexion contracture (extension) measurement for appellant's left knee but no measurements for flexion, internal and external rotation and abduction and adduction of the hip; no flexion and varus and valgus measurements for the knee, no measurements for the ankle, hindfoot or toes of the left lower extremity or any measurements for the right lower extremity. The methods for determining impairment due to loss of range of motion for a lower extremity are explained at pages 533 to 538 of Chapter 17 of the A.M.A., *Guides*. Lacking range of motion measurements, Dr. Glenn's impairment assessment of appellant's lower extremity impairment is not complete.

Due to these deficiencies, Dr. Glenn's opinion regarding appellant's lower extremity impairment is not entitled to special weight. Therefore, the conflict in the medical evidence has not been resolved. In light of Dr. Glenn's lack of proficiency in applying the A.M.A., *Guides*, the Office may refer appellant to a new impartial medical specialist rather than request a supplemental report from Dr. Glenn.

CONCLUSION

The Board finds that this case is not in posture for a decision as to appellant's impairment of his lower extremities. After such further development as the Office deems necessary, it should issue an appropriate decision.

[22] *See Guiseppe Aversa, supra* note 17.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 26, 2007 is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: July 11, 2008
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board