United States Department of Labor
Employees' Compensation Appeals Board

G.C., Appellant	)	
and	)	**Docket No. 08-1935**
	)	**Issued: February 12, 2009**
DEPARTMENT OF VETERANS AFFAIRS, LYONS VETERANS HOSPITAL, Lyons, 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 3, 2008 appellant, through his attorney, filed a timely appeal from an April 10, 2008 merit decision of the Office of Workers' Compensation Programs granting him a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award decision.

ISSUE

The issue is whether appellant has more than a 12 percent permanent impairment of the right lower extremity.

FACTUAL HISTORY

This case is before the Board for the second time. On May 11, 2005 the Board affirmed a December 8, 2004 decision finding that appellant was not entitled to a schedule award for either lower extremity due to his April 16, 2002 employment injury.[1] The Board determined that appellant had not submitted sufficient medical evidence to show that he sustained a permanent impairment to his right or left lower extremity. The findings of fact and conclusions of the law from the prior decision are hereby incorporated by reference.

On January 10, 2006 appellant, through his attorney, requested reconsideration. He submitted a November 22, 2005 impairment evaluation from Dr. David Weiss, an osteopath, who is Board-certified in family practice, cited to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), to find that appellant had a 30 percent total impairment of the right lower extremity. This was based on a motor strength deficit of the right quadriceps and gastrocnemius and a sensory deficit at L4, L5 and S1. On May 31, 2006 an Office medical adviser reviewed Dr. Weiss' report and noted that the Office had accepted a herniated disc at L5-S1, which would produce radiculopathy only at L5. He concluded that appellant had 10 percent impairment due to sensory and motor deficits at L5.

On June 5, 2006 the Office determined that a conflict existed between Dr. Weiss and the Office medical adviser regarding the extent of appellant's permanent impairment. On July 14, 2006 it referred him to Dr. Thomas D. DiBenedetto, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated July 24, 2006, Dr. DiBenedetto utilized the tables of the A.M.A., *Guides* relevant to determining impairments of the spine in finding that appellant had a 10 to 13 percent whole person impairment. He further determined that he had 31 percent impairment due to muscle weakness of the lower extremity. Dr. DiBenedetto indicated that appellant's "motor strength testing was nonphysiologic and I could not ascertain whether he was putting forth maximal effort."

On September 4, 2006 an Office medical adviser asserted that Dr. DiBenedetto did not properly apply the A.M.A., *Guides*. He reiterated that appellant had 10 percent right lower extremity impairment.

By decision dated November 30, 2006, the Office granted appellant a schedule award for a 10 percent impairment of the right lower extremity. The period of the award ran for 28.80 weeks from November 22, 2005 to July 11, 2006. On December 6, 2006 appellant, through his attorney, requested an oral hearing. Following a preliminary review of the record, on February 2, 2007 a hearing representative set aside the November 30, 2006 schedule award decision. She instructed the Office to obtain clarification from Dr. DiBenedetto regarding the extent of appellant's permanent impairment.

In response to the Office's request for clarification, on February 23, 2007 Dr. DiBenedetto reviewed and discussed the findings from his prior report. On March 31, 2007

[1] Docket No. 05-497 (issued December 8, 2004). The Office accepted that on October 16, 2002 appellant, then a 55-year-old corrective therapist, sustained a herniated disc at L5-S1 in the performance of duty. Appellant returned to light-duty work on August 18, 2003 and subsequently resumed his usual employment.

an Office medical adviser concluded that Dr. DiBenedetto did "not give a final recommended percentage except to say that his 31 percent calculation, which does not have any back-up by using tables, would not be valid because of the nonphysiologic aspects that he notes above." The Office medical adviser again opined that appellant had 10 percent right lower extremity impairment.

By decision dated April 3, 2007, the Office denied appellant's claim for an increased schedule award after finding that the evidence established that he had no more than a 10 percent impairment of the right lower extremity. On April 5, 2007 appellant requested an oral hearing. By decision dated June 5, 2007, a hearing representative set aside the June 5, 2007 decision and remanded the case for the Office to refer appellant for another impartial medical examination. He noted that Dr. DiBenedetto did not sufficiently respond to the Office's request for clarification and his opinion was insufficient to resolve the conflict in medical opinion.

On July 11, 2007 the Office referred appellant to Dr. Jason Rudolph, a Board-certified orthopedic surgeon, for an impartial medical examination. In a report dated August 21, 2007, Dr. Rudolph diagnosed chronic lumbosacral strain with right L5 radiculopathy. He found that appellant had five percent whole person impairment due to a documented spinal injury and five percent whole person impairment due to loss of lumbar range of motion. Dr. Rudolph further related:

> "Finally, determining impairment based on nerve root radiculopathy, I refer to Tables 15-15, 15-16, 15-17 and 15-18 on page 424. This is an L5 nerve impairment with a motor deficit measuring Level 4. This would correspond to .25 [times a] factor of 3.7 which equals a maximal percent due to motor dysfunction of 9.25, rounded down to 9 percent. Maximal sensory deficit corresponds to .05 percent [times] 8 percent due to the classification of Grade 2 sensory loss, decreased superficial cutaneous pain, intactile sensibility with abnormal sensations or moderate pain that may prevent some activity. This corresponds to a maximal percentage due to sensory deficit of 4 percent."

Dr. Rudolph combined the motor and sensory deficits and found a 13 percent whole person impairment, which he combined with the back impairment to find 21 percent whole person impairment. He opined that appellant had reached maximum medical improvement.

On September 15, 2007 an Office medical adviser reviewed Dr. Rudolph's report and noted that the Federal Employees' Compensation Act did not provide for whole person impairments.[2] He concurred with the impartial medical examiner's finding of a 9 percent impairment due to a motor deficit at L5 with Grade 4 weakness. The Office medical adviser, however, disagreed with Dr. Ruldoph's finding of a Grade 2 sensory deficit. He found that appellant had a Grade 4, or 25 percent, sensory deficit for pain or abnormal sensation forgotten during activity. The Office medical adviser multiplied the 25 percent for graded pain by the maximum impairment of the L5 nerve root for loss of function due to sensory deficit of 5 percent to find a 1.25 impairment, which he rounded down to 1 percent. He combined the impairment findings and concluded that appellant had a 10 percent impairment of the right lower extremity.

[2] 5 U.S.C. § 8107.

By decision dated September 28, 2007, the Office denied appellant's claim for an additional schedule award. On October 1, 2007 appellant's attorney requested an oral hearing. Following a preliminary review, on November 29, 2007 a hearing representative set aside the September 28, 2007 decision and remanded the case for the Office to obtain clarification of the extent of any permanent impairment from Dr. Rudolph. He found that the Office erred in according the Office medical adviser's opinion the weight of the evidence given that the case had been referred to an impartial medical examiner for resolution of the conflict.

On December 4, 2007 the Office informed Dr. Rudolph that the Act did not consider whole person impairments. It requested that he explain how he graded sensory deficit according to Table 15-15 of the A.M.A., *Guides*. In a January 16, 2008 response, Dr. Rudolph related that appellant had a Grade 3 sensory loss by history and the findings on examination. He stated:

> "[Appellant] demonstrated decreased superficial tactile sensitivity to light touch during my examination, and he also complained of abnormal sensations which clearly affected his activities. Specifically, he reported to me that he had to modify his work duties to the point where he was unable to perform his job as a physical therapist and he was performing primarily home evaluations due to the severe pain radiating down the right leg. I, therefore, concluded that this qualified as abnormal sensations or slight pain that interfered with some activities. I conclude that[,] based on [T]able 15-15, [appellant] qualifies as a [G]rade 3 sensory loss due to distorted superficial tactile sensitivity as documented in my report, decreased sensation to light touch, and distribution of the L5 nerve root to the right leg and abnormal sensations or slight pain that interferes with his activities."

On March 4, 2008 the Office medical adviser noted that a designation of a Grade 3 sensory deficit required documentation of two-point discrimination. He again found a 10 percent right lower extremity impairment.

On March 17, 2008 the Office requested that Dr. Rudolph review and comment on the Office medical adviser's March 4, 2008 report and provide his recommendation of appellant's impairment rating of the right lower extremity. The Office informed the physician that appellant currently worked without restrictions.

On March 28, 2008 Dr. Rudolph again determined that appellant had a Grade 3 impairment for abnormal sensations of pain which interfered with some activities according to Table 15-15 on page 424 of the A.M.A., *Guides*. He explained that he did not forget his pain during activities. Dr. Rudolph multiplied the 60 percent for graded pain by 5 percent, the maximum percent allowed for loss of function due to sensory deficit at L5 to find 3 percent impairment. He combined the 9 percent impairment due to motor loss with the 3 percent impairment due to a sensory deficit due to find a 12 percent impairment of the right lower extremity.

By decision dated April 10, 2008 the Office granted appellant a schedule award for an additional 2 percent permanent impairment of the right lower extremity, for a total impairment of 12 percent. The period of the award ran for 5.76 weeks from June 12 to July 22, 2006.

LEGAL PRECEDENT

The schedule award provision of the Act[3] and its implementing federal regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, 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 for all claimants, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[6]

Section 15.12 of the fifth edition of the A.M.A., *Guides* describes the method to be used for evaluation of impairment due to sensory and motor loss of the extremities. The nerves involved are first identified. Then, under Tables 15-15 and 15-16, the extent of any sensory and/or motor loss due to nerve impairment is to be determined, to be followed by determination of maximum impairment due to nerve dysfunction in Table 15-17 for the upper extremity and Table 15-18 for the lower extremity. The severity of the sensory or motor deficit is to be multiplied by the maximum value of the relevant nerve.[7]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[8] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[9]

When there exist 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.[10]

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[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404.

[5] 20 C.F.R. § 10.404(a).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[7] A.M.A., *Guides* at 423; *see also B.C.*, 58 ECAB ___ (Docket No. 06-925, issued October 13, 2006).

[8] 5 U.S.C. § 8123(a).

[9] 20 C.F.R. § 10.321.

[10] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

ANALYSIS

The Office accepted that appellant sustained a herniated disc at L5-S1. In an impairment evaluation dated November 22, 2005, Dr. Weiss found that appellant had 30 percent right lower extremity impairment due to a motor strength deficit of the right quadriceps and gastrocnemius and a sensory deficit at L4, L5 and S1. An Office medical adviser determined that appellant had 10 percent impairment due to sensory and motor deficits at L5. The Office properly determined that a conflict in medical opinion existed between Dr. Weiss and the Office medical adviser and initially referred him to Dr. DiBenedetto for an impartial medical examination. On July 24, 2006 Dr. DiBenedetto advised that appellant had 10 to 13 percent whole person impairment or a 31 percent lower extremity impairment due to muscle weakness. He noted that he could not determine whether he provided maximum effort in his motor strength testing. Dr. DiBenedetto did not reference the specific tables of the A.M.A., *Guides* in calculating the lower extremity impairment. Further, the Act does not provide for impairment of the whole person.[11] The Office sought clarification from Dr. DiBenedetto regarding his opinion; however, on February 23, 2007 Dr. DiBenedetto reiterated his prior findings rather than clarifying his opinion. The Office properly referred appellant to Dr. Rudolph for a second impartial medical examination.[12]

On August 21, 2007 Dr. Rudolph determined that the maximum impairment provided for sensory deficits of the L5 nerve root was 5 percent, which he multiplied by a Grade 2 sensory loss of 80 percent to find 4 percent impairment.[13] He further found that appellant had a Grade 4 impairment due to a motor strength deficit, or 25 percent, which he multiplied by the maximum impairment of the L5 nerve for loss of motor strength, 37 percent, to find a 9.25 percent lower extremity impairment.[14] Dr. Rudolph concluded that appellant had a 13 percent whole person impairment of the lower extremity which he combined with the impairment of the back to find 21 percent whole person impairment. As noted, however, the Act does not provide for impairment of the whole person.[15] Further, the Act specifically excludes the back as an organ and, therefore, the back does not come under the provisions for payment of a schedule award.[16]

An Office medical adviser concurred with Dr. Rudolph's finding of nine percent impairment due to a Grade 4 motor strength deficits at L5. He found, however, that appellant had a Grade 2 sensory deficit for pain that was forgotten during activity rather than Grade 4

[11] *Tania R. Keka*, 55 ECAB 354 (2004).

[12] In situations where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original opinion. If the specialist is unwilling or unable to clarify and elaborate on his or her opinion, the case should be referred to another appropriate impartial medical specialist. *See Guiseppe Aversa*, 55 ECAB 164 (2003).

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

[14] *Id*. at 424, Tables 15-16, 15-18.

[15] *See D.J.*, 59 ECAB ___ (Docket No. 08-725, issued July 9, 2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[16] *See Patricia J. Horney*, 56 ECAB 256 (2005); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

impairment for pain that prevented some activities. On December 4, 2007 the Office requested that Dr. Rudolph explain his grading of appellant's sensory deficit under Table 15-15 on page 424 of the A.M.A., *Guides*. In a January 16, 2008 response, Dr. Rudolph concluded that appellant experienced decreased sensation to light touch and pain in the distribution of the L5 nerve root that interfered with activities, which constituted a Grade 3 sensory impairment.[17] An Office medical adviser reviewed his report and noted that Dr. Rudolph did not provide findings on two-point discrimination. On March 28, 2008 Dr. Rudolph again explained that he selected Grade 3 as the classification of his sensory deficit because he did not forgot the pain during activities. He multiplied the 60 percent for Grade 3 pain by 5 percent, the maximum impairment due to sensory loss provided to find 3 percent impairment.[18] Dr. Rudolph combined the 9 percent impairment due to motor loss which the 3 percent impairment due to sensory deficit to find a 12 percent impairment of the right lower extremity. The opinion of Dr. Rudolph, the impartial medical examiner, is entitled to special weight as his opinion is well rationalized and is in accordance with the A.M.A., *Guides.*[19] Consequently, the weight of the medical evidence establishes that appellant has no more than a 12 percent right lower extremity impairment for which he received schedule awards.

On appeal, appellant's attorney contends that Dr. Rudolph's opinion is insufficient to resolve the conflict in medical opinion. As noted, however, his opinion is reasoned and in accordance with the A.M.A., *Guides* and represents the weight of the medical evidence.

CONCLUSION

The Board finds that appellant has no more than a 12 percent permanent impairment of the right lower extremity.

[17] A.M.A., *Guides* at 424, Table 15-15.

[18] *Id*. at 424, Tables 15-15, 15-18.

[19] *See Phillip H. Conte*, 56 ECAB 213 (2004).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 10, 2008 is affirmed.

Issued: February 12, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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