United States Department of Labor
Employees' Compensation Appeals Board

J.S., Appellant	)	
and	)	**Docket No. 09-1338**
	)	**Issued: March 23, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 27, 2009 appellant filed a timely appeal from an April 15, 2009 schedule award decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(e), the Board has jurisdiction over the merits of the schedule award claim.

ISSUE

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

FACTUAL HISTORY

On May 2, 2007 appellant, then a 60-year-old rehabilitation letter carrier, filed a claim for a back condition which he attributed to sitting in a high chair, on about April 30, 2007, that put pressure on his back and caused pain. He did not stop work. The Office accepted the claim for acute lumbosacral sprain and later accepted an aggravation of preexisting degenerative disc disease. The evidence indicates that appellant had a prior history of lumbar disc herniation and

degenerative disc disease at L4-5 and L5-S1 and was placed on permanent light duty as a result of those conditions. Diagnostic studies of November 19, 2008 reflected that he had degenerative joint disease of the right and left hip and mild chondromalacia patella of the right and left knees.

In a March 31, 2008 report, Dr. George A. Nelson, an internist, noted treating appellant for chronic lumbosacral sprain. An electromyogram (EMG) and nerve conduction study done on December 5, 2007 revealed a postacute bilateral lumbosacral radiculopathy affecting L4 to L5/S1 nerve roots. A July 18, 2007 magnetic resonance imaging (MRI) scan study revealed degenerative disc disease in the lumbar spine with a disc bulge at L5/S1. There was also disc space and moderate foraminal narrowing at L5/S1. Dr. Nelson indicated that, while appellant was working light duty, he would stand for a significant period of time and would repeatedly climb stairs. He stated that appellant's March 13, 2008 evaluation was remarkable for tenderness to palpation of the lumbar paraspinal muscles with spasms of the paraspinal musculature and decreased lumbar range of motion. The neurological examination was without focality. Dr. Nelson provided an impression of chronic lumbosacral sprain with radiculopathy superimposed upon lumbar degenerative disc disease and a disc bulge at L5/S1 with disc space and moderate foraminal narrowing at L5/S2. He recommended continued physical therapy, isokinetic strengthening to stabilize appellant's spine, aquatic exercises and epidural steroid injections.

In a July 23, 2008 report, Dr. Bong S. Lee, a Board-certified orthopedic surgeon, to whom the Office referred appellant regarding the extent of his work-related condition, noted the history of injury and his significant past history of low back injuries on the job since 1991. He indicated that appellant had partially disabling preexisting degenerative discogenic disease of the lumbar spine with disc bulging at L4-5 and L5-S1, from which he had been on light-duty status since 1991. On physical examination, Dr. Lee found that appellant had normal spinal examination with a complaint of pain with 30 degrees flexion, no extension and 10 degree lateral bending. Straight leg raising test was attempted, but appellant resisted with complaints of pain of 10 to 20 degrees elevation of both lower extremities. The sitting root test was negative. The sensory examination of both lower extremities was reported as normal, with no weakness or atrophy of the intrinsics of the feet, normal skin colors and temperatures and no evidence of instability of the vasomotor function. Knee reflexes revealed an absence on the left and a positive one on the right. Dr. Lee diagnosed chronic degenerative discogenic disease of the lumbosacral spine and opined this condition was an aggravation of his preexisting longstanding degenerative discogenic disease. He opined that appellant needed continued physical therapy and could remain on light-duty status. Dr. Lee indicated that appellant would continue to have ongoing symptomatology of his low back because of his preexisting advancing degenerative discogenic disease.

On January 12, 2009 appellant filed a claim for a schedule award. In a November 13, 2008 report, Dr. Daisy A. Rodriguez, a Board-certified internist, noted the history of injury and that he was on permanent light duty secondary to his low back condition. She reported the strength evaluation of the right leg was full but three out of five for the left leg extremity. Reduced sensory of both lower extremities was noted with dysesthesias present in the left knee. Range of motion of the hip was also noted as limited. Dr. Rodriguez diagnosed the following conditions secondary to the April 30, 2007 work injury: lumbosacral strain/sprain; lumbar

degenerative disc disease; lumbar radiculopathy at L4, L5 and S1; degenerative joint disease of left hip; degenerative joint disease left knee; and chronic pain.

In a November 29, 2008 report, Dr. Rodriguez indicated that appellant had significant low back pain, which radiated down the left buttock and hip into the thigh and knee with paresthesias, as well as the giving out of the left knee and dysfunction. She opined that appellant reached maximum medical improvement on August 31, 2008. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[1] Dr. Rodriguez opined that appellant had 43 percent right leg impairment, based on motor and sensory deficits at L4, L5 and S1 nerve roots and 63 percent left leg impairment, based on 46 percent impairment due to motor and sensory deficits at L4, L5 and S1 nerve roots, 30 percent impairment for lost range of motion of the left hip and 3 percent chronic pain of left knee. In determining the lower extremity impairments due to motor and sensory deficits of the L4, L5 and S1 nerve roots, Dr. Rodriguez utilized Table 15-15, Table 15-16 and Table 15-18 of the A.M.A., *Guides*. Under Table 15-18 of the A.M.A., *Guides*, she noted that the maximum impairment for a lower extremity due to loss of function due to pain was 5 percent for each of the L4, L5 and S1 nerve roots and maximum percent loss of function due to strength was 34 percent for L4 nerve root, 37 percent for L5 nerve root and 20 percent for S1 nerve root. Under Table 15-15 of the A.M.A., *Guides*, Dr. Rodriguez determined the grades of appellant's sensory and motor deficits for the nerve roots. For the right leg, she identified the L4, L5 and S1 nerve roots had a Grade 4 or 25 percent sensory deficit which resulted in 1 percent impairment for each nerve root when multiplied by the 5 percent maximum percent loss of function due to pain. Dr. Rodriguez determined that the L4, L5 and S1 nerve roots had a Grade 3 or 50 percent motor deficit. This resulted in 17 percent impairment for the L4 nerve root, 19 percent impairment for the L5 nerve root and 10 percent impairment for the S1 nerve root when multiplied by the respective maximum percentage of loss for each nerve root. For the left lower extremity, Dr. Rodriguez determined that the L4, L5 and S1 nerve roots had a Grade 3 or 60 percent sensory deficit, which resulted in 3 percent impairment for each nerve root when multiplied by the 5 percent maximum percent loss of function due to pain. She determined that the L4, L5 and S1 nerve roots also had a Grade 3 or 50 percent motor deficit. This resulted in 17 percent impairment for the L4 nerve root, 19 percent impairment for the L5 nerve root and 10 percent impairment for S1 nerve root when multiplied by the respective maximum percentage of loss for each nerve root. Dr. Rodriguez combined the impairment values for each nerve root to find a 43 percent right leg impairment and 46 percent left leg impairment due to sensory loss and motor deficits. For left hip range of motion, she utilized Table 17-9, page 537, of the A.M.A., *Guides*. Dr. Rodriguez found no impairment for 0 degrees extension; 5 percent impairment for 90 degrees flexion; 5 percent impairment for 20 degrees internal rotation; 10 percent impairment for 15 degrees external rotation; 5 percent impairment for 5 degrees adduction; and 5 percent impairment for 20 degrees abduction. She added the hip range of motion impairments to total 30 percent. Dr. Rodriguez also found that appellant had three percent impairment due to chronic left knee pain pursuant to section 18.3d(c), page 573, of the A.M.A., *Guides*. She combined these findings to arrive at total left leg impairment of 63 percent.

[1] A.M.A., *Guides* (5th ed. 2001).

In a February 23, 2009 report, an Office medical adviser reviewed the medical evidence and opined that there was no evidence of motor deficit in either leg. He noted that the July 24, 2008 report from Dr. Lee, an Office referral physician, reported a normal sensory examination of both lower extremities. The Office medical adviser noted Dr. Lee's findings were in direct contrast to Dr. Rodriguez, who found multiple abnormalities. He also noted that Dr. Lee found a negative sitting root test, which suggested no evidence of radiculopathy. The Office medical adviser stated Dr. Lee diagnosed recurrent sprain superimposed on degenerative disc disease and found no change in his preexisting condition. He also noted that Dr. Nelson's report indicated that appellant had a normal neurologic examination with chronic lumbar strain and radiculopathy superimposed on degenerative disc disease with disc bulge at L5-S1 and disc space narrowing at L5-S1. The Office medical adviser noted that both physicians found that a December 5, 2007 EMG showed bilateral lumbosacral radiculopathy L4 to S1 and a July 18, 2007 MRI scan indicated degenerative lumbar changes, especially at L5-S1, with disc space narrowing and moderate foraminal narrowing. He concluded that both Drs. Nelson and Lee found no neurologic abnormality or weakness of either lower extremity and no nerve root compression was noted on MRI scan studies or clinically. In view of the EMG studies and appellant's intermittent radicular symptoms, the Office medical adviser opined that appellant reached maximum medical improvement on November 13, 2008 and had four percent impairment of right lower extremity and four percent impairment left lower extremity based on sensory deficit or pain of the L4, L5 and S1 nerve roots. Under Table 15-18 of the A.M.A., *Guides*, he found the maximum percent loss of function due to pain was five percent for each of the L4, L5 and S1 nerve roots. Under Table 15-15 of the A.M.A., *Guides*, the Office medical adviser determined that appellant had Grade 4 or 25 percent deficit due to pain. He multiplied the 25 percent by the 5 percent impairment due to loss of function for pain for the L4, L5 and S1 nerve roots to find a total of 3.75 percent or 4 percent impairment for each leg. The Office medical adviser noted that, while Dr. Rodriguez indicated a left knee impairment, that was not an accepted condition.

In an April 15, 2009 decision, the Office granted appellant a schedule award for four percent right lower extremity impairment and four percent left lower extremity impairment. The award covered the period November 13, 2008 to April 23, 2009 for a total of 161.28 days of compensation.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] 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. The Act, however, 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

[2] 5 U.S.C. §§ 8101-8193.

[3] 20 C.F.R. § 10.404.

uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[4]

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 back, no claimant is entitled to such an award.[5] 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 an extremity even though the cause of the impairment originated in the spine.[6]

It is well established that, in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[7]

ANALYSIS

The Office accepted that appellant sustained an acute lumbosacral sprain and an aggravation of preexisting degenerative disc disease due to his accepted employment injury. It granted him a schedule award for four percent impairment of each leg.

The Board finds that the case is not in posture for decision. Appellant submitted a November 29, 2008 report from Dr. Rodriguez, which found that appellant had 43 percent impairment of the right lower extremity and 63 percent impairment of the left lower extremity pursuant to the A.M.A., *Guides*. In calculating appellant's impairment rating for the lower extremity, Dr. Rodriguez found that appellant had both sensory and motor impairments of the L4, L5 and S1 nerve roots which resulted in a 43 percent right lower extremity impairment and 46 percent left lower extremity impairment, a left hip impairment and a left knee impairment. She properly applied Table 15-15 and Table 15-18 of the A.M.A., *Guides* to determine that appellant had one percent impairment for each of the L4, L5 and S1 nerve roots of the right lower extremity and three percent impairment for each of the L4, L5 and S1 nerve roots of the left lower extremity due to sensory loss. Dr. Rodriguez also properly applied Table 15-16 and Table 15-18 of the A.M.A., *Guides* to determine that appellant had 17 percent impairment of the L4 nerve root, 19 percent impairment of the L5 nerve root and 10 percent impairment of the S1 nerve root of both the right and left lower extremities due to motor loss.

The Office medical adviser reviewed the medical evidence and gave reasons he relied upon the findings of Drs. Lee and Nelson instead of those of Dr. Rodriguez. Based on his review of the medical evidence and in light of appellant's reported intermittent radicular symptoms, the Office medical adviser concluded that appellant only had a sensory deficit of the L4, L5 and S1 nerve roots. He explained how he applied Table 15-15 and Table 15-18 in determining that

[4] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[6] *Id.*

[7] *Michael C. Milner*, 53 ECAB 446, 450 (2002).

appellant had four percent impairment of each lower extremity due to sensory loss or pain stemming from the L4, L5 and S1 nerve roots.

As the opinions of Dr. Rodriguez and the Office medical adviser differ regarding the extent of appellant's permanent impairment to each lower extremity, this creates a conflict in the medical evidence necessitating referral to an impartial medical specialist. 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.[8] Consequently, the case must be remanded for appellant's referral to an appropriate Board-certified impartial medical specialist to determine the extent of his permanent impairment of his lower extremities.

The Board notes that Dr. Rodriguez additionally provided impairment ratings for hip range of motion and left knee impairment. The Office medical adviser excluded from his impairment recommendation left hip impairment with no explanation and excluded left knee impairment as it was not an accepted condition. While appellant's attorney properly contends that appellant's preexisting impairments should be included in the schedule award determination, it is not clear from the medical evidence whether his bilateral knee and hip conditions preexisted his accepted employment injury. As such, in updating the statement of accepted facts for the impartial medical specialist, the Office should review the evidence and determine which, if any, leg and hip conditions preexisted the April 30, 2007 work injury. After this and such further development as the Office deems necessary, the Office should issue an appropriate decision concerning permanent impairment of appellant's lower extremities, including any preexisting condition.

CONCLUSION

The Board finds that the case is not in posture for decision as a conflict in medical opinion exists regarding the extent of appellant's permanent impairment.

[8] 5 U.S.C § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002).

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2009 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: March 23, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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