United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	**Docket No. 10-1903**
	)	**Issued: May 20, 2011**
DEPARTMENT OF JUSTICE, U.S. MARSHALL SERVICE, Covington, KY, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 13, 2010 appellant filed a timely appeal from a June 1, 2010 merit decision of the Office of Workers' Compensation Programs which affirmed the denial of his claim for a schedule award. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decision.

ISSUE

The issue is whether appellant sustained permanent impairment to a scheduled member.

FACTUAL HISTORY

On February 25, 2008 appellant, then a 31-year-old U.S. Marshall, filed a traumatic injury claim alleging that on February 22, 2008 his herniated lumbar disc was aggravated after standing for six hours on a protection detail assignment. The Office accepted the claim for an

[1] 5 U.S.C. §§ 8101-8193.

aggravation of lumbar intervertebral displacement and disc herniation at L5-S1 with myelopathy. Appellant missed work intermittently and received wage-loss compensation.[2]

Appellant came under the care of Dr. Jonathan Borden, a Board-certified neurologist, on March 7, 2008, for refractory back pain and bilateral leg pain which worsened on February 22, 2008 after standing for an extended period of time. Dr. Borden diagnosed L5-S1 herniated disc and degenerative disc disease and recommended surgery.[3] On June 25, 2008 appellant was treated by Dr. Onassis Caneris, a Board-certified neurologist, who performed a epidurogram and diagnosed lumbar radiculopathy and lumbar spondylosis. In a November 6, 2008 report, Dr. Caneris opined that a magnetic resonance imaging scan of the lumbar spine revealed disc desiccation at L5-Sl with herniated disc at the L5-S1 that was likely due to a prior June 5, 2007 work injury. He noted that appellant had a second incident in February 2008 which likely exacerbated his initial injury.

In a January 19, 2009 report, Dr. Ronald D. Fudala, a Board-certified orthopedic surgeon, who diagnosed lumbar disc displacement status post surgery. Dr. Fudala noted normal range of motion of the hips, no weakness in either leg, normal patella and Achilles reflexes, intact L2 to S1 dermatomes with no sensory deficit and no evidence of acute nerve root irritation on the right side. He found that appellant was neurologically intact with good functional movement and opined that the posterolateral gluteal pain was most likely myofascial.

In a February 2, 2009 report, Dr. Allan R. Kohlhaas, a Board-certified orthopedic surgeon, reviewed the records provided and examined appellant.[4] On examination, he noted a minimal right hip pain, a well-healed nontender scar on the lower back, flexion of 85 degrees without difficulty, extension was 10 degrees, right and left lateral bending was 45 degrees without pain or discomfort, straight leg raises to 90 degrees without difficulty, thigh and calf muscles were symmetrical, sensation was intact and no numbness or tingling in the lower extremities. Dr. Kohlhaas diagnosed a herniated disc at L5-S1 causally related to the June 5, 2007 lifting incident. He opined that the February 22, 2008 work incident materially aggravated the preexisting condition; however, the aggravation ceased after surgery on November 6, 2008.

On April 27, 2009 appellant filed a claim for a schedule award. On May 4, 2009 the Office requested that he submit a detailed report from a treating physician with an impairment evaluation pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment, (*A.M.A., *Guides*).[5]

[2] Appellant filed another claim for a traumatic back injury on June 5, 2007 which was accepted by the Office for subluxation complex L1 to L5, claim number xxxxxx384. This claim was doubled with the current claim before the Board.

[3] Dr. Borden performed a posterior lumbar arthrodesis on November 6, 2008.

[4] The Office referred appellant to Dr. Kohlhaas to resolve medical conflict regarding the nature of appellant's accepted condition.

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

In a June 2, 2009 report, Dr. Martin Fritzhand, Board-certified in occupational health, reviewed appellant's history and medical treatment. He reported findings upon examination of difficulty forward bending, normal range of motion, normal muscle strength with no evidence of atrophy with diminished pinprick and light touch over the lateral aspect of both feet revealing evidence of nerve root damage. Dr. Fritzhand stated that maximum medical improvement was reached in May 2009. He opined that appellant sustained three percent impairment to each leg pursuant to the A.M.A., *Guides*. Dr. Fritzhand referenced Figure 16-4, sciatic nerve impairment and noted a severity of one pursuant to Table 16-11, for mild sciatic nerve impairment. He further noted "Table 16-6, FHA GMO (A), Table 16-8, CSA, GM3(D)."

In a June 23, 2009 decision, the Office denied appellant's claim for a schedule award.

Appellant requested an oral hearing.

In a decision dated August 24, 2009, the hearing representative vacated the June 23, 2009 decision and remanded the case for further medical development.

In a September 2, 2009 report, an Office medical adviser advised that there was no basis for rating impairment due to appellant's accepted conditions. He referenced Dr. Kohlhaas' February 2, 2009 report and Dr. Fudala's January 19, 2009 report which showed no neurological impairment. The medical adviser noted that, while Dr. Fritzhand's report noted diminished pin prick and light touch over the lateral aspect of both feet, this finding was inconsistent with the other medical evidence. He noted that sensory loss from a nerve root compression usually followed a dermatomal pattern, pursuant to Figure 16-3, page 537 of the A.M.A., *Guides*. The medical adviser noted that the sensory loss alleged was completely separate from a motor loss which was inconsistent with nerve root loss which was a combination of motor and sensory loss. He opined that the best and most objective assessment of appellant's status was from Dr. Kohlhaas. The medical adviser further noted that the Office guidelines and methodology considered only impairments that affect the extremities and, in the absence of objective evidence of extremity impairment, there was no impairment.

In a September 4, 2009 decision, the Office denied appellant's claim for a schedule award.

Appellant requested a review of the written record.

On June 1, 2010 the hearing representative affirmed the September 4, 2009 decision.

LEGAL PRECEDENT

The schedule award provision of the Act[6] and its implementing regulations[7] 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

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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 Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[8] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[9]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[10] Neither the Act nor the implementing federal regulations provide for the payment of a schedule award for the permanent loss of use of the back, the spine or the body as a whole; a claimant is not entitled to such a schedule award.[11] The Board notes that section 8101(19) specifically excludes the back from the definition of "organ."[12] A claimant may receive a schedule award for any permanent impairment to the upper or lower extremities even though the cause of the impairment originated in the spine.[13]

ANALYSIS

On appeal appellant contends that he is entitled to a schedule award. The Office accepted his claim for an aggravation of lumbar intervertebral displacement and an aggravation of disc herniation at L5-S1 with myelopathy, for which he underwent surgery. The Act does not provide for a schedule award based on impairment to the back or spine. Appellant may only receive a schedule award for impairment to the upper or lower extremities if such impairment is established as being due to his accepted back condition.

The Board has carefully reviewed Dr. Fritzhand's report of June 2, 2009, and notes that he did not adequately explain how his rating was reached in accordance with the relevant standards of the A.M.A., *Guides*.[14] Dr. Fritzhand found appellant had three percent impairment of each leg pursuant to the A.M.A., *Guides*. He noted findings that included normal muscle strength with no evidence of atrophy, and diminished pinprick and light touch over the lateral aspect of both feet revealing evidence of nerve root damage. Dr. Fritzhand opined that for mild sciatic nerve impairment appellant qualified for a severity one pursuant to Table 16-11 pursuant to the A.M.A., *Guides*. He further noted "Table 16-6, FHA GMO (A), Table 16-8, CSA, GM3(D);" however, it is unclear how Dr. Fritzhand determined that appellant qualified as

[8] 20 C.F.R. § 10.404. For impairment ratings calculated on and after May 1, 2009, the Office should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.a (January 2010).

[9] *See id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[10] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[11] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[12] 5 U.S.C. § 8101(19).

[13] *Thomas J. Engelhart*, *supra* note 10.

[14] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

severity one, sciatic nerve impairment, as he did not explain how this impairment value was appropriate under Table 16-11. For the clinical studies adjustment, it is unclear how Dr. Fritzhand assigned a grade 3 modifier[15] pursuant to the A.M.A., *Guides.* He noted pinprick and light touch was diminished over the lateral aspect of both feet revealing evidence of nerve root damage but he failed to provide an explanation as to how these findings constituted a grade 3 modifier for clinical studies adjustment nor did he explain how he calculated the specific impairment values using Table 16-6 and Table 16-8 of the A.M.A., *Guides*.[16] Therefore the Board finds that Dr. Fritzhand did not properly follow the A.M.A., *Guides.* The Board has held that an attending physician's report is of diminished probative value where the A.M.A., *Guides* were not properly followed.[17]

In a September 2, 2009 report, an Office medical adviser reviewed Dr. Fritzhand's report and advised that certain findings on examination were inconsistent with other medical evidence in the record. The February 2, 2009 report from Dr. Kohlhaas and the January 19, 2009 report from appellant's treating physician, Dr. Fudala, showed no neurological impairment. The medical adviser noted that sensory loss from a nerve root compression usually follows a dermatomal pattern, as noted at Figure 16-3, page 537 of the A.M.A., *Guides*. He advised that the sensory loss found by Dr. Fritzhand was separate from a motor loss and inconsistent with nerve root loss which generally is a combination of motor and sensory loss. The medical adviser opined that the most objective assessment was from Dr. Kohlhaas. He further noted that the Office guidelines consider only those impairments that affect the extremities and, in the absence of objective evidence of extremity impairment, there was no impairment. The Board finds that the Office medical adviser provided sound reasoning for his finding that Dr. Fritzhand's report was inadequate to support an impairment rating and that the other medical evidence of record also offered no basis for rating impairment in appellant's legs.

The Board finds that the Office properly found that appellant had no permanent impairment to a scheduled member of the body pursuant to the A.M.A., *Guides*. There are no medical reports of record, in conformance with the A.M.A., *Guides*, which support that appellant has a ratable impairment to a scheduled member of the body.[18]

CONCLUSION

The Board finds that the Office properly denied appellant's claim for a schedule award.

[15] A.M.A., *Guides*, 518, Table 16-8.

[16] *See id*., at 28 (provides that a discussion of how the *Guides* criteria were applied to the medical information that generated the specific rating is required for an impairment evaluation to be consistent with the *Guides*).

[17] *See Paul R. Evans, Jr.,* 44 ECAB 646 (1993); *John Constantin,* 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[18] Appellant may submit additional evidence, together with a formal written request for reconsideration, to the Office within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(d).

ORDER

IT IS HEREBY ORDERED THAT the June 1, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 20, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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