United States Department of Labor
Employees' Compensation Appeals Board

F.B., Appellant	)	
and	)	**Docket No. 12-379**
	)	**Issued: July 17, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Catoosa, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 9, 2011 appellant filed a timely appeal from an October 14, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) that denied her claim for an additional schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 established that she has more than a 10 percent impairment of the right lower extremity for which she received a schedule award.

FACTUAL HISTORY

On October 22, 2004 appellant, then a 45-year-old postmaster, filed an occupational disease claim, asserting that bending, twisting and lifting at work caused degenerative disc

[1] 5 U.S.C. §§ 8101-8193.

disease. OWCP accepted L4-5 radiculopathy, lumbar spondylosis and thoracic/lumbosacral neuritis. On September 14, 2005 appellant was granted a schedule award for a 10 percent impairment of the right lower extremity. On June 2, 2006 Dr. Donnie L. Hawkins, Board-certified in orthopedic surgery, performed decompressive surgery at L4-5. Appellant resigned, effective July 8, 2006.[2]

By decision dated July 25, 2007, OWCP reduced appellant's compensation benefits based on her capacity to earn wages as a human resource administrator, which yielded a 37 percent wage-earning capacity. On November 7, 2007 appellant elected retirement benefits from the Office of Personnel Management.

Appellant filed schedule award claims on August 27, 2009 and May 12, 2010. In an April 13, 2010 report, Dr. David A. Traub, an internist, who practices pain management, advised that, under Table 17-4 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] she had a 22 percent whole person impairment. On June 5, 2010 OWCP's medical adviser reviewed the medical record including Dr. Traub's April 13, 2010 report. The medical adviser noted that an award for a spinal impairment was not allowed under FECA and recommended a second opinion evaluation and impairment evaluation in accordance with the sixth edition of the A.M.A., *Guides*.

In August 2010, OWCP referred appellant to Dr. Christopher Jordan, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a September 11, 2010 report, Dr. Jordan reviewed the medical record and performed a physical examination. In an attached permanent impairment worksheet, he advised that, under proposed Table 2, Spinal Nerve Impairment: Lower Extremity Impairments, appellant had class 1 impairments each for L5 and S1 radiculopathy on the right. Dr. Jordan found a grade 1 modifier for Functional History (GMFH) and concluded that she had a three percent lower extremity impairment for L5 radiculopathy and a three percent lower extremity impairment for S1 radiculopathy. He combined the impairments and concluded that appellant had a five percent right lower extremity impairment.

On October 14, 2010 OWCP's medical adviser reviewed the record, including Dr. Jordan's report and agreed with his conclusion that appellant had a five percent right leg impairment. On November 29, 2010 the medical adviser stated that, since appellant had previously received a schedule award for a 10 percent right lower extremity impairment, she was not entitled to an additional award.[4]

By decision dated December 8, 2010, OWCP found that appellant was not entitled to an increased schedule award.[5] On May 12, 2011 appellant requested reconsideration and submitted

[2] The resignation was part of a settlement agreement signed by appellant on July 27, 2006.

[3] A.M.A., *Guides* (6th ed. 2008).

[4] Dr. Andreas F. Revelis, an anesthesiologist who practices pain medicine, performed monthly lumbar epidural steroid injections beginning January 4, 2010. He did not perform an impairment evaluation.

[5] The December 8, 2010 decision misidentifies the extremity involved as the right upper extremity rather than the right lower extremity.

a March 1, 2011 report in which Dr. Traub noted his disagreement with Dr. Jordan's report and advised that she should have been graded as class 4 based on her history and severe symptoms.

OWCP determined that a conflict in medical evidence had been created regarding the degree of appellant's lower extremity impairment and on June 24, 2011 referred her to Dr. Andrew Olshen, a Board-certified physiatrist. In a July 27, 2011 report, Dr. Olshen noted his review of the medical evidence and appellant's complaints of constant chronic pain in her lower back radiating down into both legs, with numbness and weakness. On physical examination, he noted normal gait and station, full range of motion of the lower extremities, bilateral lower extremity strength of 5/5 and advised that she could perform 10 single leg calf raises bilaterally. Straight leg raise was negative bilaterally and there was no evidence of atrophy or ankylosis. Dr. Olshen found decreased sensation to pin prick, only on the right, normal on the left. He diagnosed chronic right L5 sensory radiculopathy, status post lumbar fusion surgery and advised that appellant had reached maximum medical improvement on July 26, 2007. Dr. Olshen indicated that she had no evidence of decreased strength, atrophy or ankylosis, with subjective complaints of pain and discomfort. He advised that, under Table 16-11 of the sixth edition of the A.M.A., *Guides* under Table 16-11, Sensory and Motor Severity, appellant had a severity 2, moderate severity sensory deficit. Dr. Olshen identified the common peroneal nerve and found a class 1 impairment under Table 16-12, Peripheral Nerve Injury, for a sensory deficit, which had a default grade of C for a three percent impairment. He found a grade 2 modifier for GMFH and no modifiers for Clinical Studies (GMCS) or Physical Examination (GMPE) because she had no electrodiagnostic testing and a GMPE modifier was not to be used. Dr. Olshen concluded that the default value of three percent should be increased by one percent based on the GMFH modifier, for a total four percent right lower extremity impairment.

Following OWCP's medical adviser's recommendation, by letter dated September 13, 2011, OWCP asked Dr. Olshen to calculate appellant's lower extremity impairment using the method described in the July/August 2009 issue of "The Guides Newsletter."[6] In a September 19, 2011 report, Dr. Olshen advised that, based on proposed Table 2, for L5 radiculopathy appellant had a moderate sensory deficit with a default value of three percent and a grade 2 modifier for GMFH, for plus one. He again concluded that she had four percent right lower extremity impairment.

On October 6, 2011 OWCP's medical adviser reviewed the record including Dr. Olshen's July 27 and September 19, 2011 reports. The medical adviser advised that maximum medical improvement was reached on July 27, 2011. The medical adviser noted that modifiers for GMPE and GMCS were not applicable and agreed that appellant had a GMFH modifier of 2. The medical adviser agreed with Dr. Olshen that appellant had a 4 percent right lower extremity impairment and concluded that, since she had previously received a schedule award for 10 percent right lower extremity impairment, she was not entitled to an increased award.

In a merit decision dated October 14, 2011, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Olshen, who performed an impartial evaluation, and concluded that appellant was not entitled to an increased schedule award for her right leg.

[6] On September 19, 2011 OWCP informed appellant that she had been underpaid a fraction of a day in the schedule award previously granted. On October 12, 2011 an additional payment of $46.62 was made.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing federal regulations[8] 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, FECA 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, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is to be used.[10]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[11] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA 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.[12]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that The AMA *Guides* Newsletter "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[13]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH and if electrodiagnostic testing were done, GMCS.[14] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[15]

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

[10] FECA Bulletin No. 09-03 (issued March 15, 2009).

[11] *Pamela J. Darling*, 49 ECAB 286 (1998).

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

[13] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010). The Newsletter is included as Exhibit 4.

[14] A.M.A., *Guides* 533.

[15] *Id*. at 521.

Section 8123(a) of FECA 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.[16] When 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 on a proper factual background, must be given special weight.[17]

ANALYSIS

The Board finds that appellant has no more than 10 percent impairment of the right lower extremity. OWCP accepted that she sustained employment-related L4-5 radiculopathy, lumbar spondylosis and thoracic/lumbar neuritis. The Board finds that the weight of the medical evidence regarding appellant's right lower extremity impairment rests with the opinion of Dr. Olshen who provided an impartial evaluation.

In the July 27, 2011 report, Dr. Olshen noted his review of the medical evidence and appellant's complaints of constant chronic pain in her lower back radiating down into both legs, with numbness and weakness. He provided findings on physical examination, noting normal gait and station, full range of motion of the lower extremities, bilateral lower extremity strength of 5/5, no evidence of atrophy or ankylosis and negative straight leg raise examination bilaterally. Dr. Olshen found decreased sensation to pin prick, only on the right. He diagnosed chronic right L5 sensory radiculopathy, status post lumbar fusion surgery and indicated that appellant reached maximum medical improvement on July 26, 2007. Dr. Olshen advised that, under Table 16-11 of the sixth edition of the A.M.A., *Guides* under Table 16-11, Sensory and Motor Severity, she had a severity two, moderate severity sensory deficit. He identified the common peroneal nerve and found a class 1 impairment under Table 16-12, Peripheral Nerve Injury, for a sensory deficit, which had a default grade of C for a three percent impairment. Dr. Olshen found a grade 2 modifier for GMFH and appropriately found that no modifiers for GMCS or GMPE.[18] He concluded that the default value of three percent should be increased by one percent based on the GMFH modifier, for a total four percent right lower extremity impairment. When asked by OWCP to provide an impairment analysis in accordance with the July/August 2009 issue of "The Guides Newsletter," which has been incorporated into OWCP procedures,[19] Dr. Olshen incorporated his previous impairment analysis and advised on September 19, 2011 that based on proposed Table 2, for L5 radiculopathy appellant had a moderate sensory deficit with a default value of three percent and a grade 2 modifier for GMFH, for plus one. He again concluded that she had four percent right leg impairment. On October 6, 2011 OWCP's medical adviser agreed with Dr. Olshen's conclusion.

[16] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[17] *Manuel Gill*, 52 ECAB 282 (2001).

[18] Both section 16.4c of the A.M.A., *Guides* and section 3.700, Exhibit 4, of OWCP procedures provide that adjustments are to be made only for GMFH and GMCS, if appropriate testing is done. *Supra* note 14; Federal (FECA) Procedure Manual, *supra* note 13.

[19] *Supra* note 13.

As noted above, for peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that The AMA *Guides* Newsletter "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[20] Dr. Olshen provided examination findings and rationale for his opinion and incorporated the procedures described above in concluding that appellant had a right lower extremity impairment of four percent. His report is thus entitled to the special weight accorded to an impartial examiner and constitutes the weight of the medical evidence.[21] Appellant therefore did not establish that she has a right lower extremity impairment greater than 10 percent, for which she previously received a schedule award.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant did not establish that she has more than a 10 percent impairment of the right lower extremity.

[20] *Id.*

[21] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

ORDER

IT IS HEREBY ORDERED THAT the October 14, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 17, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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