United States Department of Labor
Employees' Compensation Appeals Board

R.N., Appellant	)	
and	)	
U.S. POSTAL SERVICE, POST OFFICE, Tulsa, OK, Employer	)	**Docket No. 12-1465** **Issued: February 11, 2013**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 27, 2012 appellant, through his attorney, filed a timely appeal from an April 6, 2012 decision of the Office of Workers' Compensation Programs (OWCP) regarding a 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 this case.

ISSUE

The issue is whether appellant sustained more than a three percent impairment of the right leg or a zero percent impairment of the left leg.

On appeal, counsel contends that OWCP's April 6, 2012 decision is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before December 1, 2000 appellant, then a 42-year-old letter carrier, sustained a displacement of a lumbar intervertebral disc without myelopathy. He had a prior claim accepted under File No. xxxxxx688 for a November 28, 1997 left ankle sprain with osteomyelitis and synovitis.

A September 15, 2003 magnetic resonance imaging (MRI) scan showed an L4-5 disc bulge and L5-S1 disc protrusion indenting the thecal sac. A January 25, 2005 MRI scan showed a broad posterior L5-S1 central spondylosis/protrusion with an osteophyte and a moderate right-sided L4-5 protrusion with indentation of the thecal sac and intrathecal nerve root displacement. Based on this study, Dr. Allan Fielding, an attending Board-certified neurosurgeon, opined on January 26, 2005 that appellant's pain was due to degenerated L4-5 and L5-S1 discs. On August 18, 2005 Dr. Christopher Boxell, an attending Board-certified neurosurgeon, performed a lumbar discogram at L3-4, L4-5 and L5-S1. It revealed internal disc derangement syndrome with midline disc protrusions at L4-5 and L5-S1 and a left-sided paracentral protrusion at L5-S1. Lumbar x-rays of October 24, 2005 showed focal disc degeneration with slight disc space narrowing at L5-S1.[2]

On August 13, 2008 OWCP issued a schedule award under File No. xxxxxx688 for 35 percent permanent impairment of the left leg due to weakness and restricted motion of the left ankle and foot, ligamentous instability of the left ankle and a rocker bottom left foot.

February 20, 2009 nerve conduction velocity (NCV) studies showed chronic left L5 radiculopathy and mild right L5 radiculopathy. A June 26, 2009 MRI scan showed degenerative disc disease and central annular disc bulges indenting the thecal sac at L4-5 and L5-S1.

On April 4, 2010 appellant claimed an additional schedule award. In a March 26, 2010 impairment rating from, Dr. M. Stephen Wilson, an attending orthopedic surgeon, referenced the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). He found a class 1 diagnosis-based impairment (CDX) for sensory deficit of the L5 nerve, with a default value of 3 percent, a class 1 motor deficit of the L5 nerve, with a default value of 13 percent, based on appellant's history of injury, chronic neuropathy and moderate weakness as documented on current and prior examinations. Dr. Wilson assessed a grade 1 modifier for Functional History (GMFH) secondary to an American Association of Orthopedic Surgeons (AAOS) scale score of 2, according to Table 16-6.[3] He found a grade 2 modifier for Clinical Studies (GMCS) according to Table 16-8.[4]

[2] From December 2005 to August 2009, appellant was followed by Dr. David Fell, a Board-certified neurosurgeon, Dr. Wohong Min, a Board-certified neurosurgeon, Dr. Jospeh Blough, a Board-certified family practitioner, Dr. Richard D. Thomas, a Board-certified orthopedist, and Dr. C. Anthony Scott, an osteopathic physician Board-certified in orthopedics.. Each physician diagnosed L4-5 and L5-S1 disc degeneration with bilateral L5 radiculopathy. These physicians did not provide an impairment rating.

[3] Table 16-6, page 516 of the sixth edition of the A.M.A., *Guides* is entitled "Functional History Adjustment -- Lower Extremities."

[4] Table 16-8, page 519 of the sixth edition of the A.M.A., *Guides* is entitled "Clinical History Adjustment -- Lower Extremities."

Using the net adjustment formula of (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) or (1-1) + (2-1) resulted in a total modifier of +1, raising the default rating of C to D, equaling a 4 percent or moderate sensory deficit and a 13 percent or moderate motor deficit. Referring to the Combined Values Chart at page 604, Dr. Wilson found a 16 percent impairment of the right lower extremity due to L5 nerve deficits. He also found a 12 percent impairment of the right leg due to sensory and motor deficits in the S1 dermatome. Dr. Wilson assessed a class 1 impairment for moderate sensory deficit of the S1 nerve with a default value of eight percent, based on a history and current findings of neuropathy and weakness. He applied a grade 1 GMFH for an AAOS score of 2 according to Table 16-6 and a GMCS of 2 according to Table 16-8. Using the net adjustment formula of (1-1) + (2-1), Dr. Wilson found a +1 modifier, raising the rating from C to D, equaling a three percent moderate sensory deficit and a nine percent moderate motor deficit. Using the Combined Values Chart, he calculated a 12 percent impairment of the right leg. Dr. Wilson combined the L5 and S1 nerve deficits to total a 28 percent impairment of the right leg above any prior rating.

Regarding the left lower extremity, Dr. Wilson found a class 1 CDX for moderate sensory deficits in the L5 nerve distribution, with a default value of three percent and mild motor deficits in the L5 dermatome, with a default value of five percent, due a documented history of pain and weakness. He assigned a GMFH of 1 for an AAOS score of 2 according to Table 16-6 and a GMCS of 2 according to Table 16-8. Using the net adjustment formula of (1-1) + (2-1) resulted in a +1 modifier, raising the impairment rating for C to D, equaling a four percent moderate sensory deficit and seven percent mild motor deficit. Referring to the Combined Values Chart, Dr. Wilson found an 11 percent impairment of the left leg. He also assessed a class 1 impairment for S1 nerve root deficits, with a default value of two percent and class 1 mild motor deficits with a default value of three percent based on neuropathy and weakness on current and prior examinations. Dr. Wilson assigned a GMFH of 1 for an AAOS score of 2 according to Table 16-6 and a GMCS of 2 according to Table 16-8. Using the net adjustment formula of (1-1) + (2-1) resulted in a total grade modifier of +1, raising the rating for C to D, equaling a three percent moderate sensory deficit and a four percent mild motor deficit. Referring to the Combined Values Chart, Dr. Wilson found a seven percent impairment of the left lower extremity due to S1 nerve impairment. He combined all the impairments to equal 18 percent "over and above any prior injury."

On May 26, 2010 Dr. Michael M. Katz, an OWCP medical adviser, reviewed Dr. Wilson's March 26, 2010 report. He stated that there were insufficient objective findings of nerve root compression to support Dr. Wilson's impairment rating.

On August 23, 2010 OWCP obtained a second opinion from Dr. Timothy Pettingell, a Board-certified physiatrist, regarding the issue of permanent impairment. Dr. Pettingell found that appellant had reached maximum medical improvement. He diagnosed bilateral L5 radiculopathy and chronic lumbar pain due to degenerated L4-5 and L5-S1 discs. Dr. Pettingell noted that the L5-S1 disc protrusion with bilateral neuroforaminal encroachment and right L4-5 narrowing visible on the June 6, 2009 MRI scan adequately correlated appellant's bilateral L5 radiculopathy; therefore, the impairment rating should be based on bilateral L5 radiculopathy,

using the peripheral nerve model. According to Table 16-12 of the A.M.A., *Guides*,[5] common peroneal nerve impairment for the right lower extremity equaled a class 1, default grade C or three percent impairment of the leg. As appellant had atrophy of the extensor digitorum brevis of the left foot, Dr. Pettingell assigned a class 2, default grade C or 16 percent lower extremity impairment. He found a GMFH of zero and GMCS of zero. Dr. Pettingell therefore found a two percent impairment of the left lower extremity and a 14 percent impairment of the right lower extremity.

In an October 5, 2010 report, Dr. H. Mobley, an OWCP medical adviser, reviewed Dr. Pettingell's report and disagreed with the impairment ratings. Regarding the left leg, he referenced Table 16-11[6] and Table 16-12 to assess 16 percent impairment due to class 2, grade C moderate motor impairment of the common peroneal nerve. Dr. Mobley noted a GMCS and GMFH of zero. Applying the net adjustment formula of (0-1) + (0-1), he found a net adjustment of -2, lowering the default grade C to A, equaling a 14 percent impairment of the left lower extremity. However, Dr. Mobley noted that as appellant had already received a schedule award for a 35 percent impairment of the left leg under File No. xxxxxx688, he was not entitled to an additional award. Regarding the right leg, he found a grade C, mild sensory impairment of the common peroneal nerve. Using the same calculation as for the left lower extremity, he found a modifier of -2, lowering the default grade of C to A, equaling a one percent impairment of the right lower extremity.

By decision dated December 1, 2010, OWCP granted appellant a schedule award for one percent impairment of the right leg. The period of the award ran from August 30 to September 19, 2010.

On December 14, 2010 appellant, through counsel, requested a telephonic hearing, held on April 13, 2011. At the hearing, he described difficulty with activities of daily living but acknowledged that he was able to work full time as a letter carrier. Appellant used two to four days of leave a month due to back and lower extremity pain. Dr. Wilson testified that his impairment rating was supported by clinical findings. Following the hearing, appellant submitted a March 15, 2011 impairment rating by Dr. John W. Ellis, an attending Board-certified family practitioner, who opined that appellant had a combined 14 percent impairment of the right lower extremity according to Table 16-12, 8 percent for L5 nerve root impairment and 7 percent for S1 nerve root impairment. Regarding the left lower extremity, Dr. Ellis found three percent impairment for S1 nerve root impairment according to Table 16-12.

By decision dated July 5, 2011, an OWCP hearing representative vacated the December 1, 2010 schedule award and remanded the case for additional development. On July 15, 2011 Dr. Mobley reviewed the impairment rating of Dr. Ellis and found unexplained discrepancies between that report and Dr. Pettingell's opinion. The medical adviser recommended a new impairment rating from a physiatrist.

[5] Table 16-12, page 535 of the sixth edition of the A.M.A., *Guides* is entitled "Peripheral Nerve Impairment -- Lower Extremity Impairments."

[6] Table 16-11, page 533 of the sixth edition of the A.M.A., *Guides* is entitled "Sensory and Motor Severity."

OWCP referred appellant to Dr. Michael Shawn Smith, a Board-certified physiatrist, for an impairment evaluation. In an August 9, 2011 report, Dr. Smith reviewed the record and noted examination findings. He diagnosed L5 radiculopathy of the right lower extremity and no abnormality of the left lower extremity. Referring to an A.M.A., *Guides* newsletter for rating spinal nerve impairment of the extremities, proposed table two, he assessed a class 1, moderate sensory deficit in the right L5 dermatome, with a range of 2 to 5 percent impairment of the lower extremity. Dr. Smith found a GMFH of 1 due to chronic symptoms, a GMCS of 1 for consistent studies showing a right-sided L5-S1 disc bulge and a GMPE of zero. Using the net adjustment formula of (1-1) + (1-1), equaling zero, he found a default impairment level of C, equaling three percent impairment of the right lower extremity due to accepted lumbar disc disease. Dr. Smith explained that, while appellant had intermittent left leg symptoms, sensory examination of the left leg was not sufficiently changed to document any peripheral nerve injury.

On August 22, 2011 Dr. Ronald Blum, an OWCP medical adviser, concurred with Dr. Smith's rating of three percent impairment of the right lower extremity and no impairment of the left lower extremity.

By decisions dated September 1, 2011, OWCP awarded appellant an additional two percent impairment of the right lower extremity, for a total of three percent. It further found that he had no ratable impairment of the left lower extremity.

In a September 8, 2011 letter, appellant, through counsel, requested a telephonic hearing, held on February 8, 2012. At the hearing, counsel contended that OWCP should accord Dr. Wilson the weight of the medical evidence. He submitted additional medical evidence.

An August 11, 2011 electromyography (EMG) of both lower extremities was negative for sensory or motor loss, lumbar radiculopathy, peripheral polyneuropathy, sensory or motor axonal loss. Dr. Wilson provided reports from September 30, 2011 to February 7, 2012 diagnosing lumbar radiculopathy and delineating work restrictions.

By decision dated and finalized April 6, 2012, an OWCP hearing representative affirmed September 1, 2011 decisions. He found that Dr. Smith's report represented the weight of medical opinion. The hearing representative found that Dr. Wilson's reports were of diminished value as he did not base his impairment ratings on sufficient objective neurodiagnostic findings.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

all claimants. 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 FECA or in the regulations.[10] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[11] no claimant is entitled to such an award.[12] However, in 1966, amendments to FECA modified the schedule award provision 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. As the schedule award provision of FECA includes 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.[13]

ANALYSIS

OWCP accepted that appellant sustained displacement of the L4-5 intervertebral disc without myelopathy. He claimed a schedule award on April 4, 2010. Although FECA does not provide for a schedule award for the back or spine, impairment of the extremities due to a spinal injury may be compensable.[14]

Appellant submitted a March 26, 2010 impairment rating from Dr. Wilson, an attending orthopedic surgeon. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Wilson found a combined 28 percent impairment of the right lower extremity based on a 4 percent sensory and 13 percent motor impairment in the L5 dermatome and 12 percent for sensory and motor impairments in the S1 nerve distribution. Regarding the left lower extremity, he found a combined 18 percent impairment for L5 and S1 sensory and motor deficits. Dr. Wilson opined that these impairments were supported by physical examination findings, an August 18, 2005 discogram and February 20, 2009 NCV studies. Dr. Katz, an OWCP medical adviser, found that there were insufficient clinical studies to support Dr. Wilson's ratings.

OWCP then obtained a second opinion from Dr. Pettingell, a Board-certified physiatrist, who found a 14 percent impairment of the right leg and 2 percent impairment of the left leg based on common peroneal nerve impairment. Dr. Mobley, an OWCP medical adviser, agreed with Dr. Pettingell's rating method, but found a one percent impairment of the right leg and no impairment of the left leg. He stated that Dr. Pettingell misapplied the net adjustment formula. On December 1, 2010 OWCP granted appellant a schedule award for one percent impairment of

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

[10] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[11] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[12] *Thomas Martinez*, 54 ECAB 623 (2003).

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

[14] *See id*.

the right lower extremity, with no impairment of the left lower extremity, based on Dr. Pettingell's opinion as reviewed by the medical adviser.

Appellant submitted a March 15, 2011 impairment rating from Dr. Ellis, a Board-certified family practitioner, who found a 14 percent impairment of the right lower extremity due to L5 and S1 nerve root impairments and a 3 percent impairment of the left lower extremity due to S1 nerve root impairment.

On August 9, 2011 OWCP obtained a second opinion from Dr. Smith, a Board-certified physiatrist, who found three percent impairment of the right leg for moderate impairment in the L5 nerve distribution and no impairment of the left leg. Dr. Blum, an OWCP medical adviser, concurred with the ratings by Dr. Smith. OWCP issued September 1, 2011 decisions granting an additional two percent schedule award for the right lower extremity and finding that appellant had no additional ratable impairment of the left lower extremity.

Appellant disagreed and requested a second hearing. He submitted reports from Dr. Wilson diagnosing lumbar radiculopathy and an August 11, 2011 EMG study showing no lumbar radiculopathy or other spinal nerve impairment affecting either lower extremity. By an April 6, 2012 decision, OWCP affirmed its September 1, 2011 schedule award decisions.

The Board finds that Dr. Smith's report properly applied the applicable portions of the A.M.A., *Guides* to rate three percent impairment of the right leg and no impairment of the left leg. Dr. Smith based his opinion on the complete medical record and a statement of accepted facts. He correlated appellant's clinical findings with imaging and diagnostic studies of record, finding that radiographic studies documented L5 nerve root impingement competent to produce her subjective symptoms. Dr. Smith clearly explained the cause and extent of appellant's occupationally-related impairments. In contrast, Dr. Wilson based his impairment rating on S1 nerve root impingement, but did not support his rating by addressing the objective imaging or neurodiagnostic studies. Appellant did not provide adequate evidence of S1 nerve root impingement. The Board notes that the August 11, 2011 EMG study was negative for sensory or motor spinal nerve loss to either leg. OWCP properly accorded Dr. Smith's opinion the weight of the medical evidence. Its April 6, 2012 decision was proper under the facts and circumstances of this case.

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 has not established that he sustained more than a three percent impairment of the right lower extremity causally related to accepted lumbar conditions. The Board further finds that he has not established that he sustained a ratable impairment of the left lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 11, 2013
Washington, DC

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

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

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