

In a June 29, 2006 decision, the Office found that appellant was not totally disabled due to the accepted condition for claimed periods beginning July 12, 2005, she had no continuing work-related disability and she could perform the duties of her date-of-injury position. By decisions dated December 11, 2006 and June 11, 2007, it denied appellant's request for authorization of an L5-S1 discectomy and L5 fragment removal for the reason that the need for the surgery was not causally related to the May 14, 2005 work injury.

On September 1, 2008 appellant filed a claim for a schedule award. In an April 11, 2008 report, Dr. Glenn M. Amundson, a Board-certified orthopedic surgeon, opined that appellant reached maximum medical improvement in terms of her back condition.

In a November 5, 2008 letter, the Office reviewed the medical evidence appellant submitted and informed her that, to support a schedule award claim, she must submit medical evidence which shows the impairment has reached maximum medical improvement, a detailed description of the permanent impairment and any permanent impairment of the same member or function which preexisted the work injury, and an estimate of the permanent impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).¹ It noted that it had not accepted a radiculopathy condition affecting the left lower extremity and that it had denied her request for lumbar surgery associated with a left-sided radiculopathy in its December 11, 2006 decision.

Dr. Amundson continued to submit progress reports. No impairment estimate was provided.

In a February 23, 2009 report, Dr. William O. Hopkins, a Board-certified orthopedic surgeon and second opinion physician, reviewed the statement of accepted facts, medical record, history of injury and reported his examination findings. He indicated that appellant had numbness in the right foot medially and bilaterally, numbness in the anterior right calf of the right posterior thigh and in the left posterior thigh. Dr. Hopkins noted that he agreed with Dr. Amundson that appellant reached maximum medical improvement on April 11, 2008. He stated that appellant had a change in her reflexes at the right Achilles tendon with minimal reduction in size of the right thigh as compared to the left. Dr. Hopkins advised, however, that this would not be associated with an L4-5 or a L5-S1 disc herniation. He opined that appellant's disability factors were related to a mild sensory deficit in the right leg as well as pain. Dr. Hopkins indicated strength was excellent and was not included as a disability factor. Range of motion of the lumbar spine was also not included as a disability factor. For pain, Dr. Hopkins reported using Table 18-4 of the A.M.A., *Guides*. He indicated that appellant's total pain severity score was 14, her mean activity limitation score was 5, and her total pain impairment attributed to mood state was 25 with a mean score of 6 (25 divided by 4). Dr. Hopkins stated that he added an additional score of 10 as he felt her reactions and estimates were appropriate for her problem. He advised that he did not see any evidence of exaggerations of pain responses during her physical examination or interview. Dr. Hopkins advised that appellant's total score was 45, which put her into a moderate pain category under Table 18-7. He stated that her total extremity disability would be 45 for pain and 5 for her sensory loss. In a March 3, 2009 report, Dr. Hopkins noted that appellant had a mild sensory loss at both the L5 and S1 root distributions. He clarified that, using Tables 15-15 and 15-16 of the A.M.A., *Guides*, appellant had five

¹ A.M.A., *Guides* (5th ed. 2001).

percent leg impairment at both levels. Dr. Hopkins advised that, under Tables 15-16, 15-17 and 15-18 of the A.M.A., *Guides*, this would give an additional one percent impairment for her sensory loss.

In a March 20, 2009 report, an Office medical adviser reviewed the medical evidence and opined that appellant had one percent right lower extremity impairment. Based on Dr. Hopkins' reports, he indicated that appellant reached maximum medical improvement on April 11, 2008. The Office medical adviser indicated that Dr. Hopkins erroneously cited Tables 15-16, 15-17 and 15-18 of the A.M.A., *Guides* to offer one percent disability for sensory loss for the right lower extremity. He advised that the correct tables for rating pain and/or sensory change in the lower extremity should be Tables 15-15 and 15-18. The Office medical adviser noted that Dr. Hopkins indicated on sensory assessment that appellant had numbness in the right foot both medially and laterally, numbness in the anterior right calf of the right posterior thigh, and numbness in the left posterior thigh. Based on appellant's history, he stated that left leg numbness in the upper thigh was a referred numbness and not a radicular numbness from the accepted lumbar condition. To offer one percent impairment rating of the right lower extremity under Table 15-15, the Office medical adviser advised it would be appropriate to offer a grade of 20 percent and multiply the 20 percent by the maximum five percent loss due to pain for the nerve root, which would yield one percent impairment. The Office medical adviser further advised that Dr. Hopkins did not properly assess impairment under Chapter 18. He noted that under Chapter 18 only a three percent impairment rating could be processed taking all the factors into consideration, which Dr. Hopkins did not do. The Office medical adviser further indicated that Dr. Hopkins' information did not conform to the requirements of Chapter 18 such that his pain rating was not proper.

By decision dated March 30, 2009, the Office granted appellant a schedule award for one percent right lower extremity impairment. The award covered the period April 11 to May 1, 2008 for a total of 2.88 weeks of compensation.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act² and its implementing regulations³ 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 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

² 5 U.S.C. §§ 8101-8193.

³ 20 C.F.R. § 10.404.

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

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

ANALYSIS

The Office accepted appellant's claim for permanent aggravation of herniated nucleus pulposus at L5-S1. Appellant claimed a schedule award for impairment to her lower extremities due to her accepted lumbar condition. In finding that she had one percent impairment to her right lower extremity, the Office based its decision on the opinion of its Office medical adviser. The Board finds, however, that the case is not in posture for decision as a clarifying opinion from the Office medical adviser is necessary.

Initially it is noted that since Dr. Amundson failed to provide any impairment rating, the Office referred appellant to Dr. Hopkins, the second opinion physician. Dr. Hopkins noted appellant had numbness in the right root both medially and laterally, numbness in the anterior right calf of the right posterior thigh and the left posterior thigh. He opined appellant reached maximum medical improvement April 11, 2008 and, under the A.M.A., *Guides*, she had a one percent impairment involving both L5 and S1 root distributions subsequent to her sensory loss and a pain impairment of 6. Dr. Hopkins' impairment rating, however, does not conform to the A.M.A., *Guides*. While he stated that he used Tables 15-15, 15-16, 15-17 and 15-18 in determining sensory loss to appellant's leg involving both L5 and S1 root distributions, the Board notes only Tables 15-15 and 15-18 would be applicable for processing a sensory impairment in the lower extremity. Additionally, he did not explain how he applied the Tables to arrive at his impairment rating.⁷ The Board notes that under Table 15-18 the maximum sensory deficit or pain arising from a L5 and S1 root distribution carries 5 percent impairment each. This impairment value would be multiplied by the grade or percentage of sensory deficit under Table 15-15. While Dr. Hopkins stated that appellant had a mild sensory loss, he provided no percentage for the sensory deficit or any explanation how such a mild sensory loss of two nerve roots would result in one percent total impairment to the lower extremity. He also rated pain under Chapter 18 of the A.M.A., *Guides*. Chapter 18 however may not be utilized to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.⁸ Dr. Hopkins did not explain why appellant's pain could not be rated under other chapters of the A.M.A., *Guides*.

The Office medical adviser reviewed Dr. Hopkins' reports. He properly noted that to offer one percent impairment of the right lower extremity under Table 15-15, it would be appropriate to offer a grade of 20 percent. The Office medical adviser then multiplied the 20 percent by 5 percent maximum loss due to sensory deficit or pain under Table 15-18 to arrive at one percent impairment rating. However, he did not explain which nerve root, either the L5 or

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

⁶ *Id.*

⁷ *See Tommy R. Martin*, 56 ECAB 273 (2005) (where the Board found that a physician's impairment calculation not sufficiently supported by the A.M.A., *Guides* is of diminished probative value).

⁸ *See Linda Beale*, 57 ECAB 429 (2006); *Frantz Ghassan*, 57 ECAB 349 (2006).

S1, he attributed the 5 percent maximum impairment or provide an explanation as to why only one nerve root was used in his calculation when Dr. Hopkins had advised both the L5 and S1 nerve root distributions contributed to appellant's mild sensory loss.⁹ As such, the case must be remanded so the Office may obtain a clarifying opinion from the Office medical adviser.

After conducting such further development as the Office deems necessary, the Office should issue an appropriate decision considering all applicable impairment of appellant's lower extremities.

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the March 30, 2009 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision of the Board.

Issued: April 8, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

⁹ The Board notes that with a 20 percent sensory deficit either the L5 or S1 nerve root at 5 percent maximum impairment due to sensory deficit or pain would yield one percent lower extremity impairment.