United States Department of Labor
Employees' Compensation Appeals Board

D.S., Appellant	)	
and	)	**Docket No. 13-2011**
	)	**Issued: February 18, 2014**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Detroit, MI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 3, 2013 appellant, through counsel, timely appealed the April 8, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 claim.[2]

ISSUE

The issue is whether appellant has a ratable impairment of the lower extremities due to his employment-related lumbar condition.

[1] 5 U.S.C. §§ 8101-8193 (2006).

[2] The record on appeal contains evidence received after OWCP issued its April 8, 2013 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1) (2012).

FACTUAL HISTORY

Appellant, a 52-year-old custodian, injured his lower back on May 4, 2009 lifting a bucket of water which he emptied into a sink. OWCP accepted the claim for sciatica and lumbar radiculopathy. In September 2010, it provided appellant with information regarding possible entitlement to a schedule award.[3] OWCP requested an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2008). In light of his accepted lumbar condition, it provided appellant specific guidance on rating spinal nerve impairment under the A.M.A., *Guides* (6th ed. 2008).

On September 16, 2010 appellant filed a claim (Form CA-7) for a schedule award. In a September 15, 2010 report, Dr. William N. Grant, a Board-certified internist, noted appellant's complaint of constant low back pain radiating down the backs of both legs and associated paresthesias. Appellant also complained of lower extremity instability. He felt as if his legs were giving out and he was going to collapse. Appellant's pain was 4 on a scale of 0 to 10. On physical examination, Dr. Grant noted diminished normal curvature of the lumbar spine. He also reported tenderness to palpation of the lumbosacral spine area. There was limited range of motion of the lumbar spine and appellant had a positive heel/toe test and positive straight leg raising tests. Dr. Grant also noted diminished deep tendon reflexes, bilaterally. He diagnosed sciatica and found that appellant had reached maximum medical improvement. Dr. Grant rated 25 percent bilateral lower extremity impairment due to peripheral nerve impairment under Table 16-12, A.M.A., *Guides* 534-35 (6th ed. 2008). His rating was based on a diagnosis of sciatica with a moderate motor deficit.

OWCP referred appellant for a second opinion evaluation to Dr. Nathan A. Fogt, a Board-certified orthopedic surgeon. In a January 4, 2011 report, Dr. Fogt noted a history of injury on May 4, 2009 while lifting a bucket of water. He summarized various treatment records, including a May 21, 2009 lumbar magnetic resonance imaging (MRI) scan and a July 20, 2009 electromyography and nerve conduction study (EMG/NCV). The MRI scan revealed degenerative disc changes at L4-5 and L5-S1.[4] Appellant's EMG/NCV results were abnormal and indicative of a recent mild left lumbar radiculopathy and a distal pure sensory axonal peripheral polyneuropathy in the feet. Dr. Fogt also reviewed Dr. Grant's September 15, 2010 report. Appellant reported working as a custodian and was not involved in any type of active treatment or pain management. Dr. Fogt also noted that prior epidural injections had provided no relief.

Appellant's current complaints included constant low back pain and some bilateral radicular symptoms, right greater than left. The pain distribution pattern involved the posterior and lateral aspects of appellant's leg, his calf and down to the bottom of the foot. Appellant also reported difficulty with stairs and prolonged weight bearing. Dr. Fogt noted that there were no

[3] Appellant previously filed a claim for a schedule award which OWCP denied on January 25, 2010 because he had not yet reached maximum medical improvement.

[4] Noted disc protrusions at L4-5 and L5-S1 touched, but did not displace the traversing bilateral L5 and S1 nerves in the central canal. The MRI scan also revealed mild bilateral L4-5 and L5-S1 foraminal narrowing, degenerative facet changes at L4-5 and an annular fissure of the disc at L5-S1.

bowel or bladder complaints. Neurological examination revealed no clonus present and a negative Babinski. Appellant was unable to perform a heel or toe walk. Dr. Fogt also noted that there was no identifiable dermatomal pattern or deficit to light touch. Lower extremity strength testing was grade 5/5 in all major muscle groups. Appellant had an absent Achilles reflex bilaterally and a +1 patellar reflex. Physical examination of the lower extremities revealed that appellant was nontender to palpation of the hips, knees and ankles. Appellant reported that there was adequate range of motion in all joints and all planes and no joint effusion. Physical examination of the lumbar spine revealed mild tenderness to paraspinal palpation at L3-4, right somewhat worse than left. There was no significant paravertebral spasm identified. Dr. Fogt noted that appellant was slightly tender to palpitation over the sciatic notch on the right and there was equivocal piriformis stretch on the right. Straight leg raising test revealed increasing pain at 20 degrees on the left and approximately 25 degrees on the right. Appellant had a negative Faber test. Dr. Fogt also reported forward flexion to 80 degrees, bilateral rotation to 30 degrees and extension to 15 degrees.

Dr. Fogt diagnosed lumbar sprain/strain and radicular back pain which he attributed to appellant's accepted injury. He advised that appellant was able to perform his custodian duties. Dr. Fogt found that appellant was at maximum medical impairment. Based on the results of his examination, he found that appellant had no impairment of the lower extremities under the A.M.A., *Guides* (6th ed. 2008).

On February 3, 2011 the medical adviser reviewed Dr. Fogt's findings on examination of no identifiable dermatomal sensory deficit and normal muscle power. He also noted normal range of motion in both lower extremities and no evidence of effusion. Additionally, appellant was reportedly nontender and there was no reported muscle spasm. Based on the January 4, 2011 examination, Dr. Fogt found no (zero percent) impairment of the lower extremities.

On March 18, 2011 OWCP denied appellant's claim for a schedule award. However, the decision was set aside by the Branch of Hearings and Review on September 28, 2011. The hearing representative remanded the case so that Dr. Fogt could comment on the significance of appellant's July 20, 2009 EMG/NCV results in evaluating impairment to the lower extremities due to sensory deficit.[5]

On February 13, 2012 Dr. Fogt stated that, at the time of his January 2011 examination, there was no indication of any sensory deficit as related to an EMG that would warrant a permanent partial impairment. He referenced the January 4, 2011 neurological examination findings, which revealed no identifiable dermatomal patterns or deficits and lower extremity strength testing of 5/5. Based on the objective findings, Dr. Fogt stated that there were no clinically relevant sensory deficits related to appellant's accepted work injury. Accordingly, he found no evidence to support any change of his January 4, 2011 opinion.

By decision dated February 23, 2012, OWCP denied appellant's claim for a schedule award. In an August 9, 2012 decision, a hearing representative found that OWCP neglected to forward the relevant medical evidence to its medical adviser for review. Additionally, appellant

[5] The hearing representative accepted Dr. Fogt's findings with respect to the absence of any lower extremity motor deficits.

submitted recent electrodiagnostic studies. A June 5, 2012 EMG/NCV revealed normal lower extremity nerve conduction studies. However, the needle EMG demonstrated mild chronic bilateral L5 radiculopathies without ongoing denervation. This latest study when compared to appellant's 2009 study reportedly revealed an interval improvement in that there was no active denervation. A follow-up study on June 12, 2012 reportedly showed mild distal axonal sensory polyneuropathy.

In a report dated September 1, 2012, Dr. Brian M. Tonne, a medical adviser, found no bilateral lower extremity impairment under the A.M.A., *Guides* (6th ed. 2008).[6] He explained that Dr. Grant's September 15, 2010 findings were unacceptable for rating impairment because he did not document any motor function deficits on physical examination. Dr. Tonne also noted that appellant's latest EMG/NCV revealed mild chronic bilateral L5 radiculopathy with interval improvement since a 2009 examination. With respect to Dr. Fogt's findings, he noted that the examination revealed no motor or sensory deficits. Dr. Tonne explained that where there is no objective motor or sensory deficit, designation as "[c]lass 0" impairment is appropriate regardless of the EMG/NCV results.[7] Therefore, he concurred with Dr. Fogt's finding that appellant had no (zero percent) lower extremity impairment.

By decision dated November 1, 2012, OWCP denied appellant's schedule award claim. He subsequently requested an oral hearing which was held on February 19, 2013.

OWCP received additional medical evidence, which included physical therapy treatment records and reports from Dr. William S. Gonte, a Board-certified internist,[8] who first examined appellant on May 31, 2011 and diagnosed lumbar radiculopathy.[9] Dr. Gonte advised appellant to stop work and recommended additional physical therapy, which commenced on June 14, 2011.

In February 2012, Dr. Gonte diagnosed cervical radiculitis in addition to appellant's ongoing lumbar radiculopathy/radiculitis. He treated appellant for both conditions through February 2013. Dr. Gonte's February 13, 2013 physical examination revealed a full range of motion in the extremities, no edema, no atrophy or deformity, no focal deficits and grade 5/5 muscle strength. He also noted that appellant's reflexes were bilaterally symmetric and his gait was good. Additionally, appellant's cerebellar, sensory, proprioception and vibratory senses were grossly intact. Examination of his back revealed full range of motion and no spasm was noted.

Dr. Gonte did not provide a lower extremity impairment rating.

[6] Dr. Tonne specializes in orthopedic surgery.

[7] Dr. Tonne referenced Proposed Table 2, *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the sixth edition (July/August 2009).

[8] Dr. Gonte is also Board-certified in the subspecialties of geriatric medicine and sports medicine.

[9] Dr. Gonte's initial neurological examination revealed grade 5/5 muscle strength. Appellant's reflexes were bilaterally symmetric and his gait was good. Dr. Gonte also reported that appellant could heel/toe walk without difficulty. Straight leg raising test was equivocally positive. Lastly, he noted that cerebellar, sensory, proprioception and vibratory senses were grossly intact.

In an April 8, 2013 decision, the hearing representative affirmed OWCP's November 1, 2012 decision.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[10] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[11] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[12]

No schedule award is payable for a member, function or organ of the body that is not specified in FECA or in the implementing regulations.[13] The list of scheduled members includes the eye, arm, hand, fingers, leg, foot and toes.[14] Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[15] By authority granted under FECA, the Secretary of Labor expanded the list of scheduled members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina and skin.[16]

Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[17] A schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2008) provides a specific methodology for rating spinal nerve extremity impairment.[19] It was designed for situations where a particular

[10] For a total or 100 percent loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

[11] 20 C.F.R. § 10.404.

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[13] *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

[14] 5 U.S.C. § 8107(c).

[15] *Id.*

[16] 5 U.S.C. § 8107(c)(22); 20 C.F.R. § 10.404(b).

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[18] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a(3).

[19] The methodology and applicable tables were published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009).

jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the FECA Procedure Manual.[20]

ANALYSIS

In September 2010, OWCP advised appellant of the necessity of submitting an impairment rating in accordance with the A.M.A., *Guides* (6th ed. 2008). In light of appellant's accepted lumbar condition, he received information pertaining to rating extremity impairment due to spinal conditions. On appeal, counsel argued that OWCP's methodology amounts to "junk science." The Board notes, however, that the A.M.A., *Guides* have been adopted as the uniform standard applicable to all claimants for the determination of permanent impairment under FECA.[21]

Appellant's physician, Dr. Grant provided a lower extremity rating under Table 16-12, A.M.A., *Guides* 534-35 (6th ed. 2008) based on a diagnosis of sciatica with a moderate motor deficit. The Board notes that *The Guides Newsletter* (July/August 2009) provides the method for rating spinal nerve extremity impairment. Dr. Grant also failed to document specific results of sensory testing and/or motor assessment. According to the A.M.A., *Guides*, a moderate motor deficit is associated with grade 3/5 muscle strength on physical examination.[22] No such finding was addressed in Dr. Grant's September 15, 2010 report.[23] Thus, it is unclear how he concluded that appellant had a moderate motor deficit. Due to these deficiencies in Dr. Grant's report, OWCP properly referred appellant to Dr. Fogt for further evaluation.

Appellant's electrodiagnostic studies revealed evidence of lumbar radiculopathy and distal axonal sensory polyneuropathy. Notwithstanding these positive clinical studies, appellant's neurological examination findings define the impairment value assigned under the A.M.A., *Guides* (6th ed. 2008).[24] Dr. Fogt's January 4, 2011 neurological examination revealed no identifiable dermatomal pattern or deficit to light touch. He also advised that lower extremity strength testing was 5/5 in all major muscle groups. Without objective evidence of sensory and/or motor deficits on neurological examination, the appropriate impairment designation is "[c]lass 0" which corresponds to no ratable lower extremity impairment.[25] Appellant's functional history and clinical studies do not factor into the equation given the absence of objective evidence of sensory and/or motor deficits, which is the predominate factor in

[20] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4.

[21] *See J.C.*, Docket No. 11-241 (issued September 22, 2011); *M.R.*, Docket No. 11-84 (issued September 21, 2011).

[22] *See* Table 16-11, Sensory and Motor Severity, A.M.A., *Guides* 533 (6th ed. 2008).

[23] When appellant saw Dr. Fogt approximately four months later, lower extremity strength testing was grade 5/5, which is normal. *Id.*

[24] *See supra* note 19.

[25] *See* Proposed Table 2. *Id.*

determining spinal nerve extremity impairment. Dr. Tonne reviewed the rating process and he concurred with Dr. Fogt's determination of no bilateral lower extremity impairment.

Dr. Fogt's report is consistent with the A.M.A., *Guides* (6th ed. 2008). This opinion represents the weight of the medical evidence regarding the extent of appellant's lower extremity impairment. Accordingly, the Board finds that the record does not establish a ratable impairment of the lower extremities due to the accepted lumbar condition.

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

Appellant failed to establish that he has a ratable impairment of the lower extremities due to his May 4, 2009 employment-related lumbar injury.

ORDER

IT IS HEREBY ORDERED THAT the April 8, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 18, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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