U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BILLY R. STONE and U.S. POSTAL SERVICE,
POST OFFICE, Fort Worth, Tex.

Docket No. 97-1003; Submitted on the Record;
Issued December 15, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
A. PETER KANJORSKI

The issues are: (1) whether the Office of Workers' Compensation Programs properly determined on December 2, 1996 that the position of limited-duty city carrier fairly and reasonably represented appellant's wage-earning capacity; and (2) whether appellant has established that he is entitled to an additional schedule award greater than the 21 percent award that he received for his left lower extremity.

On June 1, 1995 appellant, then a 41-year-old city carrier, filed a notice of traumatic injury, alleging that he injured his lower left back and experienced pain in his left buttock and leg on May 22, 1995 when he pulled a tray in the course of his federal employment. Appellant stopped working on May 31, 1995. On September 11, 1995 the Office accepted the claim for a "subluxation/dislocation lumbar."

On June 6, 1995 Dr. Ernest Khoury, appellant's treating physician, diagnosed a herniated disc at L4-5 level with left radiculitis. Dr. Khoury is a specialist in anesthesiology and emergency medicine. Dr. Terry James, an anesthesiologist, treated appellant with an epidural steroid injection on June 22, 1995 and pursuant to his instructions appellant began a limited-duty assignment on September 18, 1995.

On November 8, 1995 Dr. Leighton B. Parker, a Board-certified neurological surgeon, treated appellant for "… increasing low back pain, radiating pain into his left hip, his left anterolateral thigh and occasionally into his calf and left foot." Dr. Parker indicated that appellant denied any right leg pain. Dr. Parker stated that appellant had symptoms and signs consistent with left L5 radiculopathy secondary to left posterolateral disc herniation at the L4-5 level.

On November 22, 1995 Dr. Khoury indicated that appellant continued to suffer leg pain. He requested a discectomy to remove the herniation and a laminectomy to relieve pressure on the nerve root.

On January 11, 1996 the Office medical adviser indicated that a herniated nucleus pulposus, L4-5, Left, was supported by the history, physical examination and tests. He noted that appellant's May 22, 1995 injury resulted in low back pain and left sciatica and that the physical examination revealed decreased sensation in the L5 dermatome and weak dorsiflexion on the left side. The medical adviser agreed that an L4-5 discectomy was reasonable and necessary.

On January 19, 1996 the Office approved an L4-5 discectomy.

On February 15, 1996 Dr. Parker recorded that appellant still had intermittent radicular pain down his left leg to his foot. He stated that his examination revealed a mild to moderate foot drop on the left side with numbness in the left L5 dermatome, particularly over the left big toe dorsal aspect. On February 21, 1996 Dr. Parker reviewed appellant's symptoms of pain in his lower back radiating down his left leg and noted that appellant denied any right leg pain. He diagnosed a herniated lumbar disc. On February 21, 1996 Dr. Parker performed a left L4 discectomy. Appellant subsequently received compensation for total temporary disability.

On March 6, 1996 Dr. Parker stated that appellant developed some recurrent back and left leg pain.

On March 16, 1996 Dr. Khoury indicated that appellant had a left post lateral disc herniation, L4-5 level, impinging on the thecal sac and nerve root. He diagnosed an L4-5 discectomy and indicated appellant was disabled from work.

On April 17, 1996 Dr. Parker indicated that appellant had experienced an amelioration of the radicular pain down his left leg. On May 28, 1996 Dr. Parker stated that appellant was doing well after surgery, but that he continued to have some back aches and had numbness down his left leg. On July 9, 1996 Dr. Parker noted that appellant continued to have numbness in his leg.

On July 24, 1996 Dr. Khoury diagnosed lumbar disc herniation resulting in leg pain, numbness, and loss of strength based on positive magnetic resonance imagings, positive electromyography findings, functional capacity tests and a positive myelogram. Dr. Khoury indicated that the conditions were related to appellant's employment injury. He further stated that appellant was evaluated for permanent impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, and that appellant had a 33 percent loss of function of the left lower leg and an 11 percent loss of function of the right lower leg.

On July 24, 1996 Dr. Arthur Michael Gray, a chiropractor, noted that appellant had experienced a loss of strength and sensation in one leg.

On July 25, 1996 Dr. Khoury indicated that appellant reached maximum medical improvement on July 22, 1996 and that he evaluated appellant pursuant to the fourth edition of the A.M.A., *Guides*. Dr. Khoury noted that appellant had reduced ranges of lumbar motion in extension, flexion and right and left lateral bending. He noted weakness in the anterior left leg which effects his heel walk. Dr. Khoury found a permanent loss of sensation in the left leg below the knee and mild atrophy of the left calf. He found ongoing mild low back pain and

occasional radiating left leg pain. Dr. Khoury stated that these findings were permanent. He stated that there was a 33 percent impairment due to loss of use of appellant's left leg. In reaching this conclusion, Dr. Khoury found a 21 percent impairment due to loss of function of lower extremity due to loss of strength. This 21 percent impairment was due to a 15 percent impairment of the left deep peroneal nerve (60 percent loss of strength multiplied by 25 percent loss of function) and a 7 percent impairment of the left tibial nerve (20 percent loss of strength multiplied by 35 percent loss of function). Dr. Khoury further found an 11 percent loss of function of the left lower extremity due to sensory deficit from the posterior tibial nerve (75 percent multiplied by 15). He then combined the 21 percent impairment with the 11 percent impairment to find a 33 percent impairment due to loss of use of appellant's left leg. Finally, Dr. Khoury noted that there was an 11 percent impairment of appellant's right lower extremity due to loss of function of the lower right extremity due to sensory deficit from the posterior tibial nerve.

On August 1, 1996 Dr. Khoury provided appellant's permanent work restrictions. He stated that appellant could work eight hours per day, but that he could not walk a normal mail route or shoulder a mail pouch. Dr. Khoury stated that appellant could work a riding route two hours per day and that he could sit and stand intermittently fours hours per day. Finally, he stated that appellant could occasionally lift trays of mail weighing less than 20 pounds.

Appellant returned to work on August 6, 1996 at a salary of $694.90 per week.

On August 19, 1996 appellant filed a claim for a schedule award.

On August 29, 1996 the employing establishment offered appellant a permanent limited-duty position as a limited-duty city carrier at a salary of $694.90 per week. Appellant accepted this position on September 4, 1996 even though he began working on August 6, 1996.

By decision dated December 2, 1996, the Office noted that appellant was reemployed as a limited-duty city carrier on August 6, 1996 with wages of $694.90 per week. The Office found that this position fairly and reasonably represented his wage-earning capacity based on his previous salary of $684.69 and terminated compensation benefits.

On November 26, 1996 the Office medical adviser reviewed Dr. Khoury's impairment findings in order to determine the permanent impairment of appellant's lower extremity. The medical adviser utilized the fourth edition of the A.M.A., *Guides*. He noted that appellant had an accepted condition of a lumbar subluxation, which resulted in an L4-5 laminectomy and discectomy. Dr. Khoury stated that appellant had residual weakness and sensory deficit due to L5 radiculopathy. He stated that appellant reached maximum medical improvement on July 22, 1996. The Office medical adviser stated that Dr. Khoury described "impairment based on loss of function to peripheral nerves, which is not the case." He stated that impairment should be based on residual radiculopathy of L5. Based on the percentages of sensory and motor involvement Dr. Khoury ascribed to the peripheral nerves, the medical adviser utilized a Grade 3 motor deficit of 50 percent, Table 12, page 49 and a Grade 3 sensory deficit of 60 percent, Table 11, page 48. For the motor deficit L5, the medical adviser found an impairment of 19 percent by multiplying 50 percent for a Grade 3 motor deficit by 37 percent pursuant to Table 83, page 130. For the sensory deficit L5, the medical adviser found an impairment of 3 percent by multiplying

60 percent for a Grade 3 sensory deficit by 5 percent pursuant to Table 83, page 130. The medical adviser then used the Combined Values Chart on page 322 of the A.M.A., *Guides* to find a 21 percent impairment of the left lower extremity based on his impairment findings of 19 percent and 3 percent.

By decision dated December 6, 1996, the Office found that appellant had a 21 percent permanent impairment of the left leg.

Initially, the Board finds that the position of limited-duty city carrier to which appellant returned to on August 6, 1996 fairly and reasonably represented his present wage-earning capacity.

In the present case, appellant had actual earning as a limited-duty city carrier with the employing establishment beginning August 6, 1996. It was proper for the Office, in its December 2, 1996 decision, to use appellant's actual earnings as the basis for his loss of wage-earning capacity, as there is no evidence that appellant's actual earnings did not fairly and reasonably represent his wage-earning capacity effective August 6, 1996. This determination is consistent with Board precedent which provides that, generally, wages actually earned are the best measure of a wage-earning capacity and that in the absence of evidence showing that they do not fairly and reasonably represent the injured employee's wage-earning capacity, they must be accepted as such measure.[1]

Moreover, the evidence does not show that the limited-duty city carrier position was an odd lot or makeshift position designed for appellant's particular needs. It was an actual position that appellant worked and he has submitted no evidence to show such a position was seasonal, part time or temporary, or to otherwise establish that it was not a suitable measure of his wage-earning capacity.

The Board further finds that appellant failed to establish entitlement to a schedule award in addition to the 21 percent he previously received for his left lower extremity.

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations,[3] set forth that schedule awards are payable for permanent impairment of specified body members, functions or organs. However, neither the Act nor the regulations specify the manner, in which the percentage of impairment is to be determined. For consistent results and to ensure equal justice for all claimant's, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment.[4]

In obtaining medical evidence for schedule award purposes, the Office must obtain an evaluation by an attending physician, which includes a detailed description of the impairment

[1] *Floyd A. Gervais*, 40 ECAB 1045 (1989).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.304.

[4] *Leisa D. Vassar*, 40 ECAB 1287 (1989).

including, where applicable, the loss in degrees of motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment. The description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[5] If the attending physician has provided a detailed description of the impairment, but has not properly evaluated the impairment pursuant to the A.M.A., *Guides*, the Office may request that an Office medical adviser review the case record and determine the degree of appellant's impairment rating utilizing the description provided by the attending physician and the A.M.A., *Guides*.[6]

In the instant case, appellant's treating physician, Dr. Khoury, a specialist in anesthesiology and emergency medicine, improperly based his impairment findings on damage to appellant's peripheral nerves rather than the spinal nerve root impairment affecting appellant's left lower extremity for which appellant's claim was accepted. Nevertheless, the Office medical adviser properly utilized Dr. Khoury's physical findings to determine that appellant had a 21 percent permanent impairment of the left lower extremity. In this regard, the medical adviser first relied on Dr. Khoury's physical findings of weakness in the anterior left leg effecting heel walk to determine that there was a Grade 3 impairment of the left lower extremity due to loss of power and motor deficit pursuant to Table 12, page 49 of the A.M.A., *Guides*. He then properly multiplied the maximum percentage of motor deficit for the Grade 3 classification, of 50 percent, by the maximum percentage loss of function due to loss of function due to strength deficit for L5 nerve root impairment found in Table 83, page 130, of 37 percent, to find that appellant suffered a 19 percent motor impairment of the left lower extremity. In addition, the medical adviser indicated that Dr. Khoury's description of a permanent loss of sensation in the left knee and occasional radiating left leg pain resulted in a Grade 3 classification of sensory deficit or pain pursuant to Table 11, page 44, of the *Guides*. The medical adviser then properly multiplied the maximum percentage of sensory deficit for this Grade 3 classification, of 60 percent, by the maximum percentage loss of function due to sensory deficit or pain for L5 nerve root impairment found in Table 83, page 130, of 5 percent, to find that appellant suffered a 3 percent sensory impairment of the left lower extremity. The medical adviser then properly combined the 19 percent motor deficit impairment with the 3 percent sensory deficit impairment pursuant to the Combine Loss Table of the A.M.A., *Guides*, page 322, to find that appellant had a 21 percent impairment of the left lower extremity.

As the Office medical adviser properly utilized the description of appellant's impairment provided by Dr. Khoury and the A.M.A., *Guides*, to evaluate appellant's impairment, and there is no other medical evidence of record that appellant has more than a 21 percent impairment of the left lower extremity, the Office properly found that appellant had a 21 percent impairment of the left lower extremity.

[5] *Joseph D. Lee*, 42 ECAB 172 (1990).

[6] *Paul E. Evans, Jr.*, 44 ECAB 646 (1993).

The decisions of the Office of Workers' Compensation Programs dated December 6 and 2, 1996 are affirmed.[7]

Dated, Washington, D.C.
December 15, 1998

Michael J. Walsh
Chairman

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

[7] On appeal, appellant argues that he is entitled to a schedule award for impairment to the right leg. As the Office has not issued a decision on this matter, it is not before the Board at this time.