United States Department of Labor
Employees' Compensation Appeals Board

DONALD J. MORETON, Appellant	)	
and	)	**Docket No. 04-1948**
	)	**Issued: January 27, 2005**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Brockton, MA, Employer	)	

Appearances:
Donald J. Moreton, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On August 2, 2004 appellant filed a timely appeal from the July 19, 2004 merit decision of the Office of Workers' Compensation Programs, granting a schedule award for a two percent impairment of the left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this schedule award case.

ISSUE

The issue is whether appellant has more than a two percent permanent impairment of the left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On June 6, 2001 appellant, then a 57-year-old tractor trailer operator, filed a traumatic injury claim alleging that on that date he experienced pain in his lower back while bending to

pick up a chock block.[1] By letter dated August 15, 2001, the Office accepted appellant's claim for a lumbar strain.

On June 6, 2003 appellant filed a claim for a schedule award. By letter dated July 17, 2003, the Office advised Dr. Robert P. Naparstek, a treating physician who is Board-certified in internal and occupational medicine, that appellant's work-related lower back condition may be impairing one or both of his lower extremities. The Office noted that a schedule award may not be paid for impairment to the back but could be awarded for impairment to the lower extremities. The Office requested that Dr. Naparstek determine the extent of any impairment to appellant's lower extremities utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th edition 2001) (A.M.A., *Guides*) and state whether he had reached maximum medical improvement.

In an October 10, 2003 letter, Dr. Naparstek responded that appellant had reached maximum medical improvement as of June 26, 2002. He diagnosed severe spinal canal stenosis and a right sacroiliac sprain. Dr. Naparstek noted appellant's limitations which included, working no more than 4 hours a day, occasional lifting of no more than 15 pounds and use of anti-fatigue mats and footstools for prolonged standing. He stated that he did not do impairment ratings and suggested that another physician perform this task based on the medical record and/or his own examination of appellant.

By letter dated March 8, 2004, the Office advised appellant that a physician's opinion establishing permanent impairment and that he had reached maximum medical improvement was necessary to take further action on his claim. In an accompanying letter of the same date, the Office authorized appellant to obtain an examination to determine the extent of impairment of his lower extremities pursuant to the A.M.A., *Guides*.

Dr. Richard R. Renaud, appellant's treating Board-certified orthopedic surgeon, submitted an April 6, 2004 report. He provided a history of appellant's June 6, 2001 employment injury and medical treatment. He noted appellant's complaints of daily pain, difficulty with walking more than half an hour and down hills, and pain radiating into both legs on occasion; predominantly into the left thigh around the lateral aspect of his leg and into the sole of his foot. Dr. Renaud reviewed an August 4, 2001 MRI scan which showed small spinal stenosis, a generally small spinal canal with concomitant facet arthritis and ligamentum flavum hypertrophy, posterior L5-S1 disc protrusion and left paramedian disc protrusion. On physical examination, Dr. Renaud found that forward flexion was to the junction of the middle and distal thirds of the thigh, extension was 10 degrees and lateral bend was 15 degrees. He noted that appellant had mild tenderness of the paraspinus musculature, decreased sensation to light touch at the lateral aspect of the left thigh and in the sole of his left foot. Extensor hallucis longus was 4/5 and hip flexion, knee flexion and extension were 5/5 bilaterally. Straight leg raising was negative in both sitting and lying positions, the Faber's test was unremarkable, hip range of motion was slightly decreased on the left side with the lack of internal rotation, deep tendon reflexes were zero to one in the left knee jerk and one in the right and two plus in the ankle jerk.

[1] Appellant retired from the employing establishment on July 1, 2003. An August 4, 2001 magnetic resonance imaging (MRI) scan was reported as showing a congenitally borderline small diameter of the lumbar canal with superimposed facet degeneration and spinal stenosis.

Dr. Renaud diagnosed spinal stenosis with concomitant radiculitis to the left leg. He evaluated appellant's impairment based on muscle strength, finding that he had no greater than a Grade IV weakness based on his muscle examination. Dr. Renaud stated that, while appellant's radicular findings were somewhat greater on the left than on the right, the differences in strength were subtle. He determined that appellant had a 22 percent impairment of each lower extremity utilizing the combined values for the Grade IV weaknesses of the plantar flexion, dorsiflexion, ankle, knee and the extensor hallucis longus. He converted this rating into a 9 percent impairment of the whole person for each lower extremity, and using the Combined Values Chart he determined that appellant had a 17 percent impairment of the whole person. Dr. Renaud agreed with the diagnosis of spinal stenosis with radicular components. He stated that appellant had reached maximum medical improvement. He opined that the medical records suggested that appellant's clinical condition was caused by a combination of a congenitally narrow canal, degenerative arthritis and degenerative disc disease of the lumbar spine with secondary disc protrusions that impacted the nerve roots, more on the left than on the right. Dr. Renaud concluded that the June 6, 2001 employment injury represented a "likely aggravating factor in [appellant's] clinical condition and may, in fact, be a predominant cause of his clinical symptoms, but is not the predominant cause of the anatomic pathology noted on these diagnostic studies."

On June 13, 2004 Dr. David I. Krohn, an Office medical adviser, reviewed appellant's medical records including, Dr. Renaud's medical report. He stated that, since left lower extremity weakness, paresthesias and a diminished left knee reflex were first noted on August 15, 2001, nearly 10 weeks after the injury in question, the findings of weakness and diminished sensation other than over the lateral left thigh were likely unrelated to the injury in question. He further stated that the underlying condition of spinal stenosis at two levels caused him to suspect that these symptoms which were new at the time, may well likely have resulted from the natural progression of this condition. He opined:

> "[I]n the absence of medical records prior to the injury in question demonstrating diminished sensation over the proximal lateral left thigh, this [sic] symptoms likely resulted from the injury in question. The distribution of this symptom corresponds to that area served by the lateral femoral cutaneous nerve on the left. The *Guides to the Evaluation of Permanent Impairment*, fifth edition, A.M.A., page 552 Table 17-37 provides a maximum two percent impairment of the left lower extremity for diminished sensation. This is the schedule award I assign for the injury in question.
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> "Date of maximum medical improvement occurred by March 14, 2002 by Robert P. Naparstek, MD (Orthopedics) as indicated by his office note of that date."

By decision dated July 19, 2004, the Office granted appellant a schedule award for a two percent impairment of the left lower extremity for the period July 1 through August 10, 2003.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulation[3] sets forth the number of weeks of compensation to be paid for permanent loss, or loss of use, of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[4] However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.[5]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from appellant's physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This 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.[6]

ANALYSIS

Dr. Renaud found that appellant reached maximum medical improvement as of April 6, 2004. On physical examination, he found that appellant's forward flexion was to the junction of the middle and distal thirds of the thigh, extension was 10 degrees and lateral bend was 15 degrees. He noted that appellant had mild tenderness of the paraspinus musculature and decreased sensation to light touch at the lateral aspect of the left thigh and in the sole of his left foot. Extensor hallucis longus was 4/5 and hip flexion, knee flexion and extension were 5/5 bilaterally. Straight leg raising was negative in both sitting and lying positions, the Faber's test was unremarkable, hip range of motion was slightly decreased on the left side with the lack of internal rotation, deep tendon reflexes were zero to one in the left knee jerk and one in the right and two plus in the ankle jerk. Dr. Renaud diagnosed spinal stenosis with concomitant radiculitis to the left leg. He evaluated appellant's impairment based on muscle strength, finding that appellant had no greater than a Grade IV weakness based on his muscle examination. Dr. Renaud concluded that the June 6, 2001 employment injury represented a "likely aggravating factor in [appellant's] clinical condition and may, in fact, be a predominant cause of his clinical

[2] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[3] 20 C.F.R. § 10.404 (1999).

[4] 5 U.S.C. § 8107(c)(19).

[5] 20 C.F.R. § 10.404 (1999); *Donald E. Stockstad*, 53 ECAB __ (Docket No. 01-1570, issued January 23, 2002); *petition for recon. granted* (*modifying prior decision*), Docket 01-1570 (issued August 13, 2002).

[6] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

symptoms, but is not the predominant cause of the anatomic pathology noted on these diagnostic studies."

Dr. Renaud improperly used the A.M.A., *Guides* 532, Table 17-8 in finding that appellant had a 22 percent impairment of each lower extremity. He calculated appellant's impairment rating by using "whole person" impairment ratings rather than the impairment ratings for appellant's lower extremities. Further, Dr. Renaud was equivocal as to whether appellant's June 6, 2001 employment injury aggravated his left lower extremity condition and how much of the impairment was due to appellant's underlying preexisting conditions.[7]

Dr. Krohn, the Office medical adviser, opined that appellant reached maximum medical improvement on March 14, 2002. Applying the appropriate edition of the A.M.A., *Guides* to Dr. Renaud's findings, the Office medical adviser determined that appellant had a two percent impairment of the left lower extremity. Table 17-37, page 552, provides for a maximum rating of two percent impairment of the lower extremity for dysfunction of the lateral femoral cutaneous nerve. Dr. Krohn allowed the maximum impairment provided under Table 17-37 for the sensory deficit, or pain, extending into appellant's left lower extremity.

The Office medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. Renaud's April 6, 2004 report and determined that appellant had two percent permanent impairment of the left lower extremity. This evaluation conforms with the A.M.A., *Guides* and establishes that appellant has no more than a two percent permanent impairment of the left lower extremity.

CONCLUSION

The Board finds that appellant has failed to establish that he has more than a two percent permanent impairment of the left lower extremity for which he received a schedule award.

[7] The Board has held that medical opinions based upon an incomplete history or which are speculative or equivocal in character have little probative value. *See Vaheh Mokhtarians*, 51 ECAB 190 (1999).

ORDER

IT IS HEREBY ORDERED THAT the July 19, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 27, 2005
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member