United States Department of Labor
Employees' Compensation Appeals Board

J.W., Appellant	)	
and	)	**Docket No. 06-2147**
	)	**Issued: August 20, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 20, 2006 appellant filed a timely appeal of a September 13, 2006 decision of the Office of Workers' Compensation Programs which granted schedule awards for 16 percent impairment of the right and left lower extremities and denied a schedule award claim for erectile dysfunction. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the appeal.

ISSUES

The issues are: (1) whether appellant is entitled to more than 16 percent right lower extremity impairment and 16 percent left lower extremity impairment, for which he received schedule awards; and (2) whether appellant established that he sustained impairment of the penis causally related to his accepted employment injury. On appeal, appellant's attorney contends that the Office should have relied on Dr. George L. Rodriguez', a Board-certified physiatrist, impairment rating calculations in determining a schedule award for the lower extremities. He further argues that the Office should have sent appellant to an appropriate medical specialist for a schedule award determination regarding the urological condition.

FACTUAL HISTORY

This case has previously been before the Board. In a decision dated May 16, 2006, the Board set aside the Office's January 4, 2005 decision granting schedule awards for 16 percent permanent impairment of the right and left legs and remanded the case for further development.[1] The Board found that the December 9, 2004 report of the Office medical adviser, upon which the schedule award was based, required clarification. The Board noted that the Office medical adviser applied the July 9, 2004 impairment findings of Dr. Rodriguez, a Board-certified physiatrist, to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*) pertaining to impairments due to spinal nerve root impairments affecting the lower extremity. However, Dr. Rodriguez had calculated impairment based on spinal peripheral nerve impairment. The Board requested that the Office medical adviser explain why Dr. Rodriguez' impairment rating based on spinal peripheral impairment was not utilized. The Board also requested that the Office medical adviser explain why a Grade 4 or a 25 percent sensory deficit under Table 15-16 of the A.M.A., *Guides* was used when Dr. Rodriguez had classified appellant's dysesthesia of the femoral nerve as a Grade 1 sensory deficit or an 85 percent sensory deficit under Table 16-10 of the A.M.A., *Guides.* The Board noted that, while Dr. Rodriguez found 10 percent impairment of appellant's penis due to work-related erectile dysfunction, the Office had not issued a final decision on that matter. The findings of fact and conclusions of law as set forth in the Board's prior decision are hereby incorporated by reference.

The relevant facts indicate that the Office accepted appellant's claim for an acute lumbar strain with radiculopathy and approved surgical procedures of August 13, 1991, March 29, 1994, May 29, 1996, September 9, 1999 and May 2, 2001. In his December 9, 2004 report, the Office medical adviser noted that Dr. Robert F. Draper, a Board-certified orthopedic surgeon and Office referral physician, found no motor or sensory deficits in his May 10, 2004 report but that Dr. Rodriguez had found such deficits in his July 9, 2004 report. Based on Dr. Rodriguez' findings, the Office medical adviser recommended that appellant be awarded a schedule award for 16 percent permanent impairment to his right leg and 16 percent permanent impairment to his left leg. Under Table 15-18, page 424, the Office medical adviser found that the maximum loss for an impairment to the L5 nerve root was 5 percent sensory or pain loss and 37 percent motor loss and the maximum loss for an impairment to the S1 nerve root was 5 percent sensory or pain loss and 20 percent motor loss. Under Table 15-15 on page 424, a Grade 4 sensory loss of 25 percent multiplied by the 5 percent maximum sensory loss of the L5 nerve root resulted in 1.25 sensory loss for L5 nerve root. A Grade 4 sensory loss of 25 percent multiplied by the 5 percent maximum sensory loss of the S1 nerve root resulted in 1.24 sensory loss for the S1 nerve root. Under Table 15-16 on page 424, a Grade 4 motor loss equated to 25 percent motor deficit which, when multiplied by an L5 maximum motor impairment of 37 percent, yielded 8.25 percent impairment for the L5 nerve root. A Grade 4 motor loss of 25 percent multiplied by a S1 maximum motor loss impairment of 20 percent yielded 5 percent impairment for the S1 nerve root. The medical adviser determined that the L5 sensory impairment of 1.25 percent plus the L5

[1] Docket No. 06-240 (issued May 16, 2006). Appellant's claim was accepted for an acute lumbar strain with radiculopathy. He underwent lumbar discectomy at L4-5 with facetectomy at L5-S1, discectomy at L5-S1 and lumbar decompressive surgeries.

motor impairment of 8.25 percent yielded a total L5 sensory/motor impairment of 10 percent. The S1 sensory impairment of 1.25 percent plus the S1 nerve motor impairment of 5 percent yielded a total S1 sensory/motor impairment of 6 percent. The Office medical adviser then combined the 10 percent L5 impairment with the 6 percent S1 impairment and found that appellant had 16 percent impairment for each leg.

Pursuant to the Board's decision, the Office requested that the Office medical adviser reevaluate the medical record and explain why Dr. Rodriguez' impairment rating based on spinal peripheral nerve impairment was not utilized and why a Grade 4 or 25 percent sensory deficit under Table 15-15 of the A.M.A., *Guides* was assigned. It additionally requested that the Office medical adviser address Dr. Rodriguez' 10 percent impairment rating for erectile dysfunction, which he had opined was employment related.

In an August 30, 2006 report, the Office medical adviser noted the recommendations in his prior report and explained that appellant's diagnoses of herniated nucleus pulposus at L3-4, L4-5 and L5-S1 and radiculopathy bilaterally L3-5 referenced nerve roots, not nerves. He advised that Dr. Draper had evaluated appellant's nerve roots and found no motor or sensory deficits on both sides, no abnormality of light touch sensation of S1, L5, L4, L3, L2 and L1 nerve roots, and normal straight leg and motor testing. The Office medical adviser stated that Dr. Draper carried out appropriate testing on the nerve roots while Dr. Rodriguez incorrectly referenced actual nerves, such as the femoral and sciatic nerve roots. He explained that it was inappropriate to conduct testing on the actual nerves, since the nerves constitute a combination of multiple nerve roots and the accepted conditions reference nerve roots, not nerves. Thus, the medical adviser opined that, since Dr. Rodriguez referenced nerves, as opposed to nerve roots, his impairment rating was rejected as it did not conform to the methodologies of the A.M.A., *Guides*. He used a Grade 4 involvement of the sensory and motor nerve roots identified at Tables 15-16 and 15-18, page 424 as a compromise between Dr. Rodriguez' finding that the motor and sensory nerves were abnormal and Dr. Draper's finding that such nerves were normal. The medical adviser reiterated his previous calculations and opined that appellant had 16 percent impairment of each leg.

The Office medical adviser also rejected Dr. Rodriguez' recommendation of a 10 percent erectile dysfunction impairment on the basis that Dr. Draper's examination, which he found to be more detailed and highly credible, did not note neurologic abnormalities. As there were no neurologic abnormalities, he opined that it would be highly unlikely that appellant would have an erectile dysfunction as a result of his work-related injury. Furthermore, the medical adviser noted that a request for erectile dysfunction due to low back conditions, in the presence of a normal examination by an Office referral physician, would require an urologist. However, based on the neurologic examination and the lack of causal relationship, he did not see any justification for such a referral.

By decision dated September 13, 2006, the Office found that appellant was entitled to no more than the 16 percent impairment for each lower extremity impairment, for which he previously received an award. The Office further denied appellant's claim for 10 percent permanent impairment due to erectile dysfunction.

LEGAL PRECEDENT -- ISSUE 1

Under section 8107 of the Federal Employees' Compensation Act[2] and section 10.404 of the implementing federal regulation,[3] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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*[4] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[5]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[6] As neither the Act nor its regulations provide for the payment of a schedule award for the permanent loss of use of the back or the body as a whole, no claimant is entitled to such a schedule award.[7] The Board notes that section 8109(19) specifically excludes the back from the definition of organ.[8] However, a claimant may be entitled to a schedule award for permanent impairment to an upper or lower extremity even though the cause of the impairment originated in the neck, shoulders or spine.[9]

Office procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from a physician is obtained.[10]

ANALYSIS -- ISSUE 1

The Office based appellant's schedule award of 16 percent permanent impairment to the right lower extremity and 16 percent permanent impairment to the left lower extremity on the December 9, 2004 and August 30, 2006 reports of its Office medical adviser. In a December 9, 2004 report, the Office medical adviser compared the findings of Dr. Draper, the Office referral physician, to that of Dr. Rodriguez and indicated that, based on the findings contained in Dr. Rodriguez' report, that appellant had both sensory and motor impairments stemming from

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[5] *See Joseph Lawrence, Jr., supra* note 4; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989).

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

[7] 5 U.S.C. § 8107; *see also Phyllis F. Cundiff*, 52 ECAB 439 (2001); *Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[8] 5 U.S.C. § 8109(c).

[9] *Thomas J. Engelhart, supra* note 6.

[10] *See Thomas J. Fragale*, 55 ECAB 619 (2004). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Evaluation of Schedule Awards*, Chapter 2.808.6(d) (August 2002).

his accepted work-related conditions. The Office medical adviser then applied Dr. Rodriguez' findings with the provisions of the A.M.A., *Guides* pertaining to impairments due to spinal nerve root impairments affecting the lower extremity under Tables 15-15 and 15-18 and opined that appellant had 16 percent right lower extremity impairment and 16 percent left lower extremity impairment.[11] Based on the Board's remand instructions, in his August 30, 2006 report, the Office medical adviser stated that, although Dr. Rodriguez had calculated an impairment rating based on spinal peripheral nerve impairment, an impairment rating based on actual nerves was inappropriate in this case. He explained that nerves consist of a combination of multiple nerve roots and the accepted conditions refer to nerve roots, not nerves. As appellant's accepted conditions pertain to various nerve roots, the Office medical adviser's rationale for not using Dr. Rodriguez' impairment rating based on spinal peripheral nerve impairment is supported by the record. Additionally, the Office medical adviser explained that he calculated a Grade 4 involvement of the sensory and motor nerve roots based on a consideration of both Dr. Rodriguez' finding that the motor and sensory nerves were abnormal and Dr. Draper's finding that such nerves were normal. The Board finds that the Office medical adviser presented a well-rationalized explanation of the manner in which the impairment evaluation was calculated.

The Office medical adviser's December 9, 2004 report found that, based on Dr. Rodriguez' findings and the A.M.A., *Guides*, appellant had 16 percent permanent impairment to the right lower extremity and 16 percent permanent impairment to the left lower extremity. He found a Grade 4 (25 percent) sensory and motor deficit in accordance with Table 15-15, A.M.A., *Guides* 424.[12] According to the A.M.A., *Guides*, Table 15-18, page 424, an L5 nerve root impairment affecting the lower extremity represents a maximum 5 percent loss due to sensory deficit or pain and a 37 percent motor loss. Under the same table, an S1 nerve root impairment affecting the lower extremity represents a maximum 5 percent loss due to sensory deficit or pain and a 20 percent motor loss. To determine the lower extremity impairment one multiplies appellant's Grade 4 classification (25 percent) by the maximum percentage loss due to sensory deficit or pain or due to motor loss. Applying this formula, appellant had 1.25 percent impairment for sensory deficit (25 percent times 5 percent) which is rounded to 1 percent[13] and 9.25 percent impairment for motor loss (25 percent times 37 percent) which is rounded to 9 percent in each lower extremity with respect to the L5 nerve root. Appellant had 1.25 percent impairment for sensory deficit (25 percent times 5) which is rounded to 1 percent and 5 percent impairment rating for motor loss (25 percent times 20 percent) in each lower extremity with respect to the S1 nerve root. When the L5 sensory bilateral impairment of 1 percent is added to the L5 motor bilateral impairment of 9 percent, a total of 10 percent impairment involving the L5 bilateral nerve results. When the S1 sensory bilateral impairment of one percent is added to the

[11] A.M.A., *Guides* (5th ed.), Table 15-15, Determining Impairment Due to Sensory Loss, and Table 15-18, Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity, page 424.

[12] With respect to sensory loss, a Grade 4 classification is characterized by distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or slight pain, that is forgotten during activity. This classification represents a 1 to 25 percent sensory deficit. A.M.A., *Guides* 424, Table 15-15.

[13] *See Marco A. Padilla*, 51 ECAB 202 (1999); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter, 3.700.3.b. (October 1990) (the policy of the Office is to round the calculated percentage of impairment to the nearest whole point).

S1 motor bilateral impairment of five percent, a six percent impairment involving the S1 bilateral nerve results. When the bilateral impairments involving the L5 and S1 nerve roots are properly combined (10 percent from the L5 nerve roots plus 6 percent from the S1 nerve roots), appellant's total impairment of each leg is 16 percent.[14]

The December 9, 2004 impairment rating provided by the Office medical adviser conforms to the A.M.A., *Guides*, and his finding constitutes the weight of the medical evidence.[15] Furthermore, the Office medical adviser provided a well-rationalized explanation as to why an impairment rating based on nerve roots, as opposed to nerves, was provided. Appellant has not submitted probative medical evidence to establish that he has greater than 16 percent impairment to either the left or the right lower extremities.

LEGAL PRECEDENT -- ISSUE 2

An employee seeking compensation under the Act has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence.[16]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[17] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[18] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[19]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that he is entitled to a schedule award for erectile dysfunction secondary to his accepted work-related injury. It is a claimant's burden

[14] *See* A.M.A., *Guides* 604, Combined Values Chart.

[15] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

[16] *Michael S. Mina*, 57 ECAB ___ (Docket No. 05-1763, issued February 7, 2006); *Gary J. Watling*, 52 ECAB 278 (2001).

[17] *Frankie A. Farinacci*, 56 ECAB ___ (Docket No. 05-1282, issued September 2, 2005); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[18] *Kathryn E. Demarsh*, 56 ECAB ___ (Docket No. 05-269, issued August 18, 2005); *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[19] *Daniel O. Vasquez*, 57 ECAB ___ (Docket No. 06-568, issued May 5, 2006); *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

to submit sufficient evidence to establish entitlement to a schedule award.[20] In this case, the Office has not accepted an erectile dysfunction as related to the employment-related back injury.[21]

The question of whether the work injury caused or affected appellant's erectile dysfunction and penile impairment was first raised in Dr. Rodriquez's July 9, 2004 report. Dr. Rodriquez did not explain how any impairment for loss of sexual function was due to the accepted back condition.[22] Dr. Rodriguez' report is insufficient to establish that appellant's erectile dysfunction is related to the accepted employment injury.

The Office medical adviser, in reviewing the medical record, found that Dr. Draper, the Office referral physician, had carried out appropriate testing on the nerve roots while Dr. Rodriguez, appellant's physician, incorrectly referenced actual nerves. On that basis, the Office medical adviser found Dr. Draper's report to be more detailed and credible than Dr. Rodriquez' report. As Dr. Draper found no neurologic abnormalities, the Office medical adviser opined that it would be highly unlikely that appellant would have an erectile dysfunction as a result of his work-related injury.

Dr. Rodriguez failed to provide medical reasoning to support his opinion that appellant had any condition affecting the penis causally related to the accepted employment injury. The Office properly relied on the Office medical adviser's opinion to find that appellant had no work-related condition of the penis. Appellant has not discharged his burden of proof on the issue of causal relationship and the Office properly denied his claim for a schedule award with regards to his erectile dysfunction.

CONCLUSION

The Board finds that appellant is not entitled to more than 16 percent right lower extremity impairment and 16 percent left lower extremity impairment, for which he received a schedule award. The Board also finds that appellant is not entitled to a schedule award based on erectile dysfunction and that a referral to an urologist is not appropriate in this case.

[20] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[21] Where an employee claims that a condition not accepted or approved by the Office was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury. *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[22] *See* 20 C.F.R. § 10.404(a) (provides for 205 weeks of compensation for 100 percent loss of use of the penis).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated September 13, 2006 is affirmed.

Issued: August 20, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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