United States Department of Labor
Employees' Compensation Appeals Board

S.F., Appellant	)	
	)	**Docket No. 07-164**
and	)	**Issued: November 7, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Troy, MI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On October 24, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated September 6, 2006 which denied her claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant sustained permanent impairment due to her February 3, 2000 injury.

FACTUAL HISTORY

On February 3, 2000 appellant, then a 55-year-old city carrier, injured her low back when she slipped on an icy sidewalk while delivering mail. The Office accepted her claim for

lumbosacral contusion, lumbosacral strain and exacerbation of herniated nucleus pulposus at L4-5. Appellant stopped work on February 3, 2000 and returned on February 4, 2000.[1]

Appellant came under the care of Dr. A.J. Brewer, a Board-certified orthopedic surgeon. In reports dated February 3 to March 24, 2000, Dr. Brewer indicated that appellant's medical history was significant for work-related back injuries in 1994, 1996 and 1999. He diagnosed L4-5 disc herniation by history, contusion lumbosacral spine with muscle strain and degenerative arthritis of the lumbosacral spine and pelvis. Dr. Brewer recommended physical therapy and returned appellant to work subject to restrictions. A February 3, 2000 lumbar spine x-ray revealed no acute bony abnormality and slight disc space at L4-5. A May 8, 2000 magnetic resonance imaging (MRI) scan of the lumbar spine revealed a large central nuclear extrusion at L4-5 with compression of cauda equina and a large nuclear extrusion, centrally and to the right of midline at L5-S1 level with obstruction of the nerve root canal entry zone, displacement of S1 root and compression of cauda equina.

Dr. Brewer referred appellant to Dr. Lisa B. Grant, a Board-certified physiatrist. In reports dated August 8 to November 21, 2000, Dr. Grant noted appellant's history, diagnosed right sacroiliitis and symptoms of right L5-S1 radiculopathy and recommended steroid injections. In reports dated January 29 to November 28, 2001, she diagnosed bilateral sacroiliitis, greater on the right, with some improvement of the right L5-S1 radiculopathy. Dr. Grant noted that appellant underwent epidural steroid and facet joint blocks and physical therapy without improvement. She opined that appellant's condition was chronic and recommended that he work six hours per day within restrictions.

In February 2002, the Office referred appellant to Dr. Andrew Haig, a Board-certified orthopedic surgeon, for an evaluation of permanent partial impairment in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (A.M.A., *Guides*). In a report dated February 11, 2002, Dr. Haig opined that appellant had not reached maximum medical improvement.

On February 8, 2003 appellant filed a claim for a schedule award. She submitted reports from Dr. Grant dated August 29, 2002 to February 10, 2003. Dr. Grant recommended that appellant continue working six hours per day subject to restrictions. In correspondence dated March 28, 2003, the Office advised appellant that the medical evidence indicated that she had not reached maximum medical improvement and, therefore, a schedule award for permanent impairment could not be considered.

In an April 10, 2003 report, Dr. Grant noted that appellant presented with complaints of pain radiating into both legs with numbness and tingling. She noted findings upon physical examination of cranial nerves were grossly intact, motor examination was normal for strength in

[1] Appellant has the following claims which were administratively consolidated into the present claim before the Board: a June 29, 1994 injury which was accepted for protrusion of L4-5 discs, File No. 09-0392696; a May 28, 1996 injury which was accepted for lumbosacral sprain, File No. 09-0416907; and a March 6, 1999 injury which was accepted for herniated nucleus pulposus, File No. 09-0454979.

[2] A.M.A., *Guides* (5th ed. 2001).

the bilateral upper extremities, intact sensation, reflexes were intact, negative Achilles tendon, normal range of motion of the hips and tenderness over the sacroiliac joints. Dr. Grant diagnosed bilateral sacroiliitis, history of chronic radiculopathy in the right lower extremity and right knee pain. She opined that appellant had reached maximum medical improvement. Dr. Grant referred appellant to a Dr. Hague for an impairment rating.

The Office referred appellant for a second opinion to Dr. Charles F. Xeller, a Board-certified orthopedic surgeon. In a report dated August 8, 2003, Dr. Xeller reviewed the medical records and performed a physical examination. He noted the history of appellant's work-related back injury and diagnosed degenerative disc disease and spinal stenosis. Dr. Xeller listed findings upon physical examination of no spasm, negative straight leg raises, normal knee and ankle reflexes, pain radiating down the left leg, full range of motion of the hips, knees and ankles, Patrick, Trendelenburg and Waddells' test were negative, no instability, gait was fairly normal, thigh measurements were 21 inches bilaterally and calves were 16 inches bilaterally and there was no vascular changes. He advised that appellant had residuals of her back injury with disc protrusions and the slow development of spinal stenosis. Dr. Xeller indicated that appellant could work eight hours per day with a lifting restriction of 25 pounds. He opined that appellant had reached maximum medical improvement and noted that she was a "DRE 2" of the lumbar spine for a seven percent impairment.

On June 23 and August 14, 2003 Dr. Grant noted findings upon physical examination of intact cranial nerves, normal strength in the bilateral upper and lower extremities, intact sensation, intact reflexes in the upper extremity but not obtainable from the lower extremities, negative straight leg raises bilaterally with good, pain-free range of motion in both hip joints with tenderness over the sacroiliac joints. She diagnosed bilateral sacroiliitis, history of chronic radiculopathy in the right lower extremity and right knee pain.

In a letter dated August 22, 2003, the Office requested that Dr. Xeller clarify whether appellant had residuals of her work-related injury and to provide an impairment rating in accordance with the A.M.A., *Guides*. In a response dated September 8, 2003, Dr. Xeller noted that appellant had residuals of the work-related lumbar strain and contusion as well as degenerative disc disease and spinal stenosis. He opined that appellant reached maximum medical improvement within six months of her date of injury. According to the A.M.A., *Guides*, page 385, appellant was a "DRE II" for a seven percent rating.

In a report dated October 7, 2003, an Office medical adviser indicated that appellant reached maximum medical improvement on August 3, 2000. She opined that in accordance with the A.M.A., *Guides* appellant had no impairment of either lower extremity. The medical adviser referenced Dr. Grant's report of June 2003 which noted normal left leg strength for zero percent impairment.

On October 22, 2003 the Office requested that the medical adviser clarify her October 7, 2003 report. On October 22, 2003 the Office requested that Dr. Xeller address whether appellant had residuals of the accepted work-related condition and to provide specific work restrictions.

On October 8, 2003 Dr. Grant noted treating appellant for right lumbar radiculopathy. She noted that examination findings had not changed since August 14, 2003. Dr. Grant diagnosed bilateral sacroiliitis, history of chronic radiculopathy in the right lower extremity and right knee pain. An MRI scan of the lumbar spine dated November 5, 2003, revealed broad-based disc bulge with radial tear at L4-5 with bilateral lateral components and bilateral neural foraminal narrowing.

In a report dated November 9, 2003, the medical adviser noted that there was no loss of strength for the left leg based on Dr. Xeller's examination of August 8, 2003 and Dr. Haig's report of February 11, 2002. She noted that Dr. Xeller provided a seven percent whole person impairment rating which was based on lumbar range of motion and not impairment to an extremity. The medical adviser found that Dr. Xeller's examination noted no impairment to appellant's lower extremities.

In a December 11, 2003 report, Dr. Xeller noted appellant's increased symptoms since the February 3, 2000 work injury. He stated that appellant was at maximum medical improvement and did not require ongoing treatment but recommended anti-inflammatory medication. Dr. Xeller advised that appellant's complaints of increased dermatomal pain radiating down her leg were consistent with some degree of nerve root compression. He opined that appellant could work eight hours a day with lifting limited to 25 pounds.

In a decision dated December 11, 2003, the Office denied appellant's claim for a schedule award.[3]

On January 5, 2004 appellant requested reconsideration contending that she sustained permanently impairment due to her work-related injury and was entitled to a schedule award. On November 24, 2003 Dr. Grant treated appellant for pain radiating from her back down both lower extremities. She noted findings upon physical examination of intact cranial nerves, motor examination of normal strength in the bilateral arms and legs with intact sensation, intact reflexes in the upper extremity but not obtainable from the lower extremities, negative straight leg raises bilaterally with good, pain-free range of motion in both hip joints with tenderness over the sacroiliac joints. Dr. Grant diagnosed bilateral sacroiliitis, chronic and chronic bilateral radiculopathy and recommended a series of epidural steroid injections.

In a decision dated January 13, 2004, the Office denied reconsideration on the grounds that appellant's request neither raised substantive legal questions nor included new and relevant evidence and was therefore insufficient to warrant review of the prior decision.[4]

[3] The Office determined that there was a conflict in opinion between Dr. Grant, appellant's treating physician, and Dr. Xeller, the Office referral physician, regarding appellant's ability to work. Thereafter, in the course of developing the claim, the Office referred appellant to several impartial medical examiners. In a medical report dated June 13, 2005, Dr. Robert S. Levine, a Board-certified orthopedist, determined that appellant could return to a light-duty position eight hours per day.

[4] On June 30, 2004 appellant filed a claim for recurrence of disability, asserting that she had a recurrence of back pain on May 23, 2004. Medical evidence submitted in support of her recurrence claim did not specifically address whether she had an employment-related permanent impairment to a scheduled member of the body. The Office denied the recurrence claim on February 9, 2005.

On July 29, 2004 the Office authorized appellant to change her treating physician to Dr. David M. Montgomery, a Board-certified orthopedic surgeon, and to be seen in consultation with Dr. Dennis Dobritt, an osteopath.

In an August 6, 2004 report, Dr. Montgomery noted a history of injury and diagnosed lumbar disc disease and foraminal stenosis. He noted findings upon physical examination of no motor deficits in the quadriceps, tibialis anterior or gastrocnemium tendons, reflexes were symmetric and pedal pulses were a Grade 2. Dr. Dobritt noted a history of injury and diagnosed bilateral lumbosacral radiculopathy and degenerative disc disease at L4-5 and L5-S1 with disc protrusion at L4-5 and L5-S1. He noted findings upon physical examination of no pathological reflexes, sensation was intact in the lower extremities bilaterally, no autonomic dysfunction in the lower extremities, dorsal pedal pulses were palpable bilaterally, muscle strength was normal in the lower extremities bilaterally and straight leg raise was positive in the lower extremities bilaterally. Dr. Dobritt recommended a diagnostic bilateral L5-S1 transforaminal selective nerve root block and a percutaneous disc compression.

In a letter postmarked March 25, 2005 and in a letter dated May 30, 2005, appellant requested an oral hearing. In decisions dated May 13 and June 8, 2005, the Office denied appellant's request for an oral hearing.

In a letter dated June 25, 2005, appellant appealed her claim to the Board. On January 3, 2006 the Board issued an order remanding the case directing the Office to reconstruct the case record and to issue an appropriate decision to protect her appeal rights.[5]

In a decision dated September 6, 2006, the Office denied appellant's claim for a schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[6] and its implementing regulations[7] 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. However, the Act 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.[8]

[5] Docket No. 05-1457 (issued January 3, 2006).

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *See id*.; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the implementing regulations.[9] 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.[10] The Board notes that section 8101(19) specifically excludes the back from the definition of "organ."[11] 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.[12]

ANALYSIS

On appeal appellant contends that she is entitled to a schedule award for permanent impairment of her lower extremities and back. The Office accepted her claim for protrusion of L4-5 discs, lumbosacral sprain, herniated nucleus pulposus, lumbosacral contusion, lumbosacral strain and exacerbation of herniated nucleus pulposus at L4-5. However, as noted above, the Act does not permit a schedule award based on impairment to the back or spine. Appellant may receive a schedule award for impairment to the lower extremities if such impairment is established as being due to her accepted back condition.

Appellant submitted numerous reports from Dr. Grant. The Board has carefully reviewed Dr. Grant's opinion and notes that her findings do not support a schedule award for permanent partial impairment of the lower extremities. She noted findings upon physical examination of intact cranial nerves, motor examination was normal for strength, intact sensation, reflexes were intact, negative Achilles tendon, normal range of motion of the hips, tenderness over the sacroiliac joints. Although, Dr. Grant noted appellant's complaints of pain radiating into both legs with numbness and tingling she provided no objective clinical evidence of any neurological impairment.[13] Her reports offer no basis on which to rate impairment under the A.M.A., *Guides*.

The Office referred appellant to Dr. Xeller who stated that appellant had a seven percent whole person impairment of the spine. Dr. Xeller referenced Table 15-3 of the A.M.A., *Guides* which pertains to impairment for a lumbar spine injury.[14] As noted, however, neither the Act nor the implementing regulations provide for the payment of a schedule award for whole body impairment or for impairment of the back. Dr. Xeller did not otherwise address how any of his findings would reflect permanent impairment in a scheduled member of the body, such as the legs, under the A.M.A., *Guides*.

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

[10] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[11] 5 U.S.C. § 8101(19).

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

[13] Loss of sensation (pain) and loss of strength are rated according to guidelines set forth in the A.M.A., *Guides* at Chapter 17 for the lower extremities.

[14] A.M.A., *Guides* at 385, Table 15-3 (5th ed. 2001).

The Office medical adviser properly reviewed the medical record and found no basis on which to attribute permanent impairment to a scheduled member of the body.[15] The medical adviser referenced Dr. Grant's report of June 2003 which provided a measurement of normal lower extremity strength. In a report dated November 9, 2003, the medical adviser clarified that, as to the left lower extremity, there was no loss of strength based on Dr. Xeller's examination of August 8, 2003 and Dr. Haig's report of February 11, 2002. The medical adviser also noted that Dr. Xeller's finding of seven percent whole person impairment based on lumbar range of motion was not in reference to a scheduled member of the body. The medical adviser explained that for there to be impairment to the lower extremities there must be evidence of impingement or impairment of the exiting nerve roots in the lumbar spine which supply the lower extremities which was absent in appellant's case. The medical adviser properly concluded that appellant had no impairment to her lower extremities.

Additional reports from Dr. Grant noted symptoms of bilateral lumbar radiculopathy. She noted an essentially normal physical examination with intact cranial nerves, motor examination of normal strength in the bilateral upper and lower extremities, intact sensation, and negative straight leg raises bilaterally. However, Dr. Grant provided no objective clinical evidence of neurological impairment to the lower extremities. There was no other basis on which to attribute impairment under the A.M.A., *Guides*.

The reports of Drs. Montgomery and Dobritt do not support a schedule award for permanent partial impairment of the lower extremities. On August 6, 2004 Dr. Montgomery noted findings upon physical examination but did not specifically address permanent impairment of the extremities nor did he provide findings indicative of permanent impairment pursuant to the A.M.A., *Guides*. Dr. Dobritt noted findings on examination but did not specifically address permanent impairment of the extremities nor did he provide findings indicative of permanent impairment pursuant to the A.M.A., *Guides*. The physicians provided no basis on which to rate permanent impairment under the A.M.A., *Guides*. The Board finds that appellant has not established permanent impairment to a scheduled member of the body pursuant to the A.M.A., *Guides.*

CONCLUSION

The Board finds that the Office properly denied appellant's claim for a schedule award.

[15] The Board notes that it is appropriate for an Office medical adviser to review the clinical findings of the treating physician to determine the permanent impairment. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.5(c) (March 1994); *Richard R. LeMay*, 56 ECAB ___ (Docket No. 04-1652, issued February 16, 2005).

ORDER

IT IS HEREBY ORDERED THAT the September 6, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 7, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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