United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 08-2171**
	)	**Issued: February 20, 2009**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 4, 2008 appellant filed a timely appeal from an Office of Workers' Compensation Programs' schedule award decision dated June 5, 2008. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 13 percent permanent impairment to his right lower extremity and 13 percent impairment for the left lower extremity.

FACTUAL HISTORY

On October 3, 2000 appellant, a 40-year-old letter carrier, filed a Form CA-2 claim for benefits, alleging that he developed two herniated discs in his lower back due to factors of his employment. The Office accepted his claim for aggravation of degenerative disc disease.

On August 8, 2001 Dr. Marc Levin, Board-certified in neurosurgery and appellant's treating physician, performed surgery to correct lumbar stenosis and lumbar disc herniation at

L3. He performed the procedures consisting of bilateral L3-4 and L4-5 laminectomies, foraminectomies and excision of an L3 disc herniation.

On March 10, 2004 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of his right and left lower extremities.

In a report dated May 2, 2004, Dr. Levin stated:

> "[Appellant] was evaluated in my office on April 12, 2004. He has basically reached maximum medical improvement. On examination, he had diminution of range of motion of the lumbosacral spine, flexion to 35 degrees, hyperextension 10 degrees, lateral bending 10 degrees. Reflexes were diminished in both lower extremities at the knee and ankle. [Appellant] has constant pain of what he states is 5 to 6 out of 10, and occasional pain as high as 8 out of 10. Bilateral leg pain is on the right greater than the left.
>
> "[Appellant] has reached maximum medical improvement. Restrictions placed on him are permanent. His permanent partial impairment rating, according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (fifth edition) [A.M.A., *Guides*], is 25 percent of the person as a whole. This is based on the A.M.A., *Guides*, according to the DRE [diagnosis-related estimate] Category V."

In a memorandum/impairment evaluation dated September 20, 2004, an Office medical adviser reviewed Dr. Levin's findings and determined that appellant had a five percent impairment of the right lower extremity and a five percent impairment of the left lower extremity. He noted that appellant had complaints of pain in the buttocks on the right, radiating into the right leg, which worsened with increased activity. The Office medical adviser advised that there were no significant left lower extremity symptoms. He stated that Dr. Levin's May 2, 2004 report noted diminution of lumbar spine range of motion on physical examination. The Office medical adviser stated:

> "The only lower extremity impairment which could be derived from current medical narratives is the residual L4 and L5 radicular pain in each leg. Table 15-17 at page 424 [of the A.M.A., *Guides*], combined with Table 16-10, page 482 of the A.M.A., *Guides*, allows five percent for Grade 3 radicular pain in the distribution of the L4 and L5 nerve roots. Date of maximum medical improvement is estimated to have occurred one year postoperatively, August 8, 2002."[1]

By decision dated November 9, 2004, the Office granted appellant a schedule award for a five percent permanent impairment of the right lower extremity and a five percent permanent

[1] The Office medical adviser incorrectly stated in this report that appellant had a 55 percent left lower extremity impairment. He amended this typographical error in an October 25, 2004 supplemental report, in which he advised that the proper amount of left lower extremity impairment was five percent.

impairment of the left lower extremity for the period August 8, 2002 to February 25, 2003, for a total of 28.8 weeks of compensation.

In an April 18, 2005 report, Dr. Levin stated that he had reexamined appellant and determined that he had some mild weakness, rating a 4.5 out of 5, in the left and right quadriceps.

On October 21, 2005 appellant filed a Form CA-7 claim for an additional schedule award based on a partial loss of use of his right and left lower extremities.

In a report dated November 14, 2005, the Office medical adviser found that appellant had an additional eight percent bilateral lower extremity permanent impairment based on Dr. Levin's findings of a Grade 4 out of 5 strength in the distribution of the L4 and L5 nerve roots bilaterally according to Tables 15-15 and 15-18 at page 424 of the A.M.A., *Guides*. This amounted to a total 13 percent impairment for the right and left lower extremities.

By decision dated December 27, 2005, the Office granted appellant an additional eight percent schedule award for his right and left lower extremities for the period February 26, 2003 to January 14, 2004, for a total of 46.8 weeks of compensation.

On August 25, 2006 appellant underwent a magnetic resonance imaging (MRI) scan of the lumbar spine at the behest of Dr. Kevin G. Waldron, a specialist in neurosurgery. The results of the MRI scan indicated mild to moderate central canal stenosis at L2-3, secondary to disc bulge and facet/ligamentum flavum hypertrophy; postlaminectomy changes at L3-4 and L4-5; mild central canal stenosis at these levels with slight neural foraminal narrowing, with no large recurrent disc protrusion; and moderate to severe bilateral neural foraminal narrowing at L5-S1, secondary to disc bulge and facet hypertrophy.

Appellant underwent an electromyogram (EMG) test on September 12, 2006, the results of which showed no electromyographic evidence of any lumbar radiculopathy.

On January 18, 2007 appellant filed a Form CA-7 claim for an additional schedule award based on a partial loss of use of his right and left lower extremities.

In a report dated May 24, 2007, Dr. John W. Ellis, a Board-certified family practitioner, found that appellant had a 25 percent impairment for the right lower extremity and a 25 percent impairment for the left lower extremity pursuant to Tables 15-15, 15-16 and 15-18 at page 424 of the A.M.A., *Guides*. He rated a 13.2 percent impairment based on pain in the right spinal nerve root at L4 for the right lower extremity. Dr. Ellis found that appellant had a Grade 3 sensory deficit at page 424, which yielded a 3.0 percent impairment derived from a 60 percent sensory deficit impairment (Table 15-15) times 5 percent (Table 15-18), and a Grade 3 motor deficit, which yielded a 10.2 percent impairment based on a 30 percent impairment (Table 15-16) times 34 percent (Table 15-18) for a 13.2 percent impairment. He then calculated a 14 percent impairment right lower extremity based on pain in the right spinal nerve root at L5. Dr. Ellis derived a 3.0 Grade 3 sensory deficit, derived from a 60 percent sensory deficit impairment (at Table 15-15) multiplied times 5 percent impairment (Table 15-18), and an 11.1 Grade 3 motor deficit impairment based on 30 percent motor deficit (at Table 15-16) times 37 percent impairment of function (at Table 15-18), for a 14.1 total added impairment of the right lower

extremity, for a combined 25 percent impairment for the right lower extremity. He then made similar calculations with regard to the left lower extremity to arrive at a 25 percent impairment for the left lower extremity.

In a report dated June 25, 2007, an Office medical adviser determined that appellant was not entitled to an award for an additional bilateral lower extremity impairment greater than the 13 percent already awarded. He opined that Dr. Ellis did not present sufficient objective evidence in his May 24, 2007 report to support any lower extremity impairment than that already awarded for weakness and residual radicular sensory loss in the L4 and L5 nerve roots. The Office medical adviser noted that appellant underwent an EMG test on September 12, 2006 which showed no evidence of any lumbar radiculopathy, and a lumbar MRI scan which only showed mild to moderate central canal stenosis at L2-5 with moderate to severe bilateral neural foraminal narrowing at L5-Sl. He also stated that the MRI scan noted no significant disc protrusion and that the rest of Dr. Ellis' physical examination was unremarkable.

By decision dated July 12, 2007, the Office denied appellant an additional schedule award.

On August 14, 2007 appellant requested reconsideration.

In a report dated September 18, 2006, received by the Office on August 17, 2007, Dr. Waldron found that appellant had a 48 percent whole person impairment which, when divided by .75, yielded a 64 percent impairment of the lumbar spine. He stated:

> "I had the pleasure of seeing [appellant] for a follow-up in the office following him obtaining a new lumbar spine MRI [scan] and EMG and nerve conduction velocity test. The lumbar spine MRI [scan] demonstrates mild to moderate L2-3 degenerative disc disease with mild spinal stenosis. There are post-laminectomy changes at L3-4 and L4-5 with mild canal stenosis and mild foraminal stenosis without disc protrusion. There is also moderate bilateral neural foramen narrowing at L5-Sl. No spondylolisthesis is noted. No ongoing severe canal stenosis noted. [Appellant's] EMG and nerve conduction velocity test fails to demonstrate any electromyographic evidence of lumbar radiculopathy. [His] subjective complaints have remained the same in symptomatology."

Dr. Waldron noted that appellant's physical examination was unchanged from his previous visits. He accorded 12 percent impairment of the whole person for a lumbar decompression at L3-4 plus 1 percent for L4-5, based on loss of range of motion; an additional 4 percent for loss of flexion and 5 percent for loss of extension plus 3 percent each for limited lateral bending; 3 percent for limited L3 function bilaterally and an additional 5 percent for limited L4 function bilaterally. Dr. Waldron added 1 percent each for approximately 26 percent loss of sensory deficit with ongoing pain which interfered with activities within the L3 and L4 nerve root distributions. This totaled 48 percent whole body impairment and a 64 percent lumbar spinal impairment when divided by .75.

The Office found that there was a conflict in the medical evidence between Dr. Ellis and Dr. Waldron regarding whether appellant was entitled to an additional award for a greater degree

of bilateral lower extremity impairment stemming from his accepted degenerative disc condition. The Office referred appellant to Dr. Charles W. Mercier, a Board-certified orthopedic surgeon, for a referee medical examination. In an April 15, 2008 report, Dr. Mercier found that appellant was not entitled to an award for bilateral lower extremity impairment greater than the 13 percent already awarded. He stated:

> "Given the accepted facts, the patient's pathology at L3-4 and L4-5 is work related. Based on the patient's postoperative MRI [scan], any preoperative pathology has been corrected. There is no residual pathology noted on the MRI [scan] that would cause radicular low back pain, continuing disability, or neurological loss in the lower extremities. This is supported by the patient's post-operative EMG nerve conduction velocity revealing only a peripheral neuropathy. This nonwork[-]related peripheral neuropathy could be confused with an L4 sensory dysfunction. In fact, no low back nerve root dysfunction was noted on the patient's electrodiagnostic testing. No motor dysfunction was coming from either the back or his peripheral nerves."

Dr. Mercier noted that the August 25, 2006 lumbar MRI scan showed postoperative changes at L3-4 and L4-5 with very mild spinal stenosis, with degenerative pathology at other levels causing various degrees of spinal stenosis. He noted no significant pathology at the operative levels that would cause neurological losses in the lower extremities. Dr. Mercier advised that appellant's subjective low back pain was increased with trunk rotation, and that he exhibited extensive subjective nonanatomical motor and sensory loss in both lower extremities. He also noted that appellant's straight leg testing was markedly contradictory and nonanatomical, bilaterally. Dr. Mercier opined that these findings represented "extensive false reporting" to clinical testing, which decreased the reliability of his clinical examination. He concluded:

> "Based on the information I have, the patient's prior permanent partial impairment rating was exceedingly generous. His exam[ination] today does not reveal any reliable objective findings to warrant any increase in what he had already been paid."

In a report dated May 26, 2008, the Office medical adviser found that appellant was not entitled to an additional schedule award. He noted that Dr. Mercier indicated that the August 25, 2006 MRI scan results showed that appellant did not have any residual pathology which would cause radicular low back pain, continuing disability, or neurological loss in the lower extremities, and that the September 12, 2006 EMG was negative for any lower lumbar nerve root dysfunction. The Office medical adviser also noted that Dr. Mercier believed that appellant's subjective complaints were unreliable, exaggerated and largely unsupported by objective, clinical findings.

By decision dated June 5, 2008, the Office found that appellant was not entitled to an additional schedule award for the left and right lower extremities.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] set 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 loss of use.[3] However, the Act does not specify the manner in which the percentage of loss of use of a member is to be determined. For consistent results and to ensure equal justice under the law to all claimants, the Office has adopted the A.M.A., *Guides* (fifth edition) as the standard to be used for evaluating schedule losses.[4]

ANALYSIS

In this case Dr. Mercier, the impartial specialist, found that appellant was not entitled to any additional impairment for the right and left lower extremities due to his accepted degenerative disc condition. The Office medical adviser relied on Dr. Mercier's opinion that any preoperative pathology stemming from appellant's accepted conditions had since been corrected. His opinion was based on the August 2006 MRI scan results which showed no residual pathology causing radicular low back pain, continuing disability, or neurological loss in the lower extremities and the September 5, 2006 EMG results which demonstrated only a peripheral neuropathy. Dr. Mercier noted no L4 sensory dysfunction, nerve root dysfunction, or motor dysfunction coming from either the back or his peripheral nerves. The Office medical adviser stated that the MRI scan results showed postoperative changes at L3-4 and L4-5 with very mild spinal stenosis, with degenerative pathology at other levels causing various degrees of spinal stenosis; there was no significant pathology at the operative levels that would cause neurological losses in the lower extremities. He also noted that Dr. Mercier believed appellant's subjective complaints of low back pain and lower extremity pain were not reliable, and constituted "extensive false reporting" to clinical testing; Dr. Mercier concluded that appellant's examination did not reveal any reliable objective findings to warrant any increase in his schedule award for a bilateral lower extremity impairment. The Board finds that the Office properly relied on the findings of the Office medical adviser, who found based on Dr. Mercier's referee opinion that appellant was not entitled to an award greater than that already awarded for a 13 percent bilateral lower extremity impairment.

As there is no other probative medical evidence establishing that appellant sustained any additional permanent impairment, the Office properly found that appellant was not entitled to more than a 13 percent impairment for the right lower extremity and a 13 percent impairment to the left lower extremity impairment.

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

[3] 5 U.S.C. § 8107(c)(19).

[4] 20 C.F.R. § 10.404.

CONCLUSION

The Board finds that appellant has no additional permanent impairment to his right and left lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the June 5, 2008 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: February 20, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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