United States Department of Labor
Employees' Compensation Appeals Board

M.P., Appellant	)	
and	)	**Docket No. 08-2483**
	)	**Issued: June 3, 2009**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Miami, FL, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 17, 2008 appellant filed a timely appeal from Office of Workers' Compensation Programs' decisions dated June 18 and September 2, 2008. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant has sustained any permanent impairment to a scheduled member of his body causally related to his accepted lower back condition, thereby entitling him to a schedule award under 5 U.S.C. § 8107; and (2) whether the Office properly refused to reopen appellant's case for reconsideration of his claim under 5 U.S.C. § 8128.

FACTUAL HISTORY

On June 6, 2001 appellant, then a 53-year-old mechanic, strained his lower back while pulling and pushing an ice machine. He filed a claim for benefits on June 11, 2001, which the Office accepted for displacement of lumbar intervertebral disc at L2-3 without myelopathy.

On January 5, 2006 appellant filed a Form CA-7 claim for a schedule award based on a partial loss of use of his left and right lower extremities.

In a report dated November 26, 2007, Dr. Joseph DeVeau, a specialist in family practice, found that appellant had an eight percent whole person permanent impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (fifth edition) (the A.M.A., *Guides*). He stated that appellant related complaints of intermittent pain and numbness radiating to the stomach which dissipated when he stood up. Dr. DeVeau advised that appellant's symptoms were aggravated by walking up stairs, bending, stooping and reaching too high. He noted that a July 25, 2001 magnetic resonance imaging (MRI) scan administered by Dr. Miguel A. Tabaro, Board-certified in physical and rehabilitative medicine and the attending physician, revealed disc herniation on the left at L2-3 which was compressing the thecal sac, possibly involving the emerging left L2 nerve root, with diffuse bones and facet disease at L4-5 and L5-S1, and a questionable annular tear at L2-3. Dr. DeVeau stated that a May 9, 2002 MRI scan indicated degenerative disc disease, diffuse bones with facet disease at L4-5 and L5-S1, and diffuse bones with questionable annular tear at L2-3.

On examination, appellant demonstrated "dull" pain in his back and a posture within normal limits. Dr. DeVeau advised that slump test increased his low back pain in the left leg, with no radiating symptoms. He rated appellant normal on his instability and deep knee bend tests. Dr. DeVeau provided a lumbar diagnosis-related estimated (DRE) impairment of category II, which indicated that appellant's clinical history and examination findings were compatible with a specific injury. These findings included: significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, and complaints of radicular pain without objective findings; and no alteration of the structural integrity and no significant radiculopathy. If appellant did previously have clinically significant radiculopathy with an imaging study showing a herniated disc, then he would no longer have radiculopathy following conservative treatment. If appellant had fractures, it would show: (1) less than 25 percent compression of one vertebral body: (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; or (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does no disrupt the spinal canal.

Dr. DeVeau found that appellant had reached maximum medical improvement. He stated that appellant had residual function with limitations on daily living activities, and reiterated that he rated appellant at DRE lumbar category II, which yielded a total lumbar whole person impairment of eight percent pursuant to Table 15-3 of the A.M.A., *Guides*.

In order to determine whether appellant had any ratable impairment from his accepted lumbar condition pursuant to the A.M.A., *Guides*, the Office referred him for a second opinion examination with Dr. Alexander N. Doman, Board-certified in orthopedic surgery. In a report dated March 25, 2008, Dr. Doman stated:

> "On examination, ... [appellant] subjectively does have a mild limp on the left side. He does not smoke. On further examination, this gentleman has [subjective] complaints of decreased sensation to sharp touch involving the lateral aspect of his left side and leg. [Appellant] also has voluntary giving way weakness when strength testing the quadriceps, hamstrings and extensor hallux longus as well as the tibial anterior muscles on the left side. He has a negative

straight leg raising test in the sitting position. There are no signs of muscular atrophy. Deep tendon reflexes are symmetric.

"X-rays of the lumbar spine are performed showing mild decrease in disc height at L2-L3. There is evidence of mild facet joint sclerosis with degenerative changes at L5-S1.

"Diagnostic studies are performed including nerve conduction velocity studies of the left lower extremities. These studies of the left leg shows findings suggestive of a mild left sided L5 radiculopathy. However, these findings could also represent a proximal neuropathy, sciatic neuropathy or a lumbosacral plexopathy. None of these findings can possibly be related to a herniated lumbar disc at the L2-L3 level. This gentleman also had a diagnostic test consistent of an MRI scan of the lumbar spine performed on March 31, 2008. This MRI scan performed minor loss of disc height L2-L3. There is no evidence of a herniated lumbar disc. There is no evidence of nerve root compression or any involvement of any exiting nerve root at this level. The MRI scan also confirmed degenerative facet joint arthropathy at the L5-SI level without a herniated disc. There is no evidence of spinal stenosis."

Dr. Doman diagnosed mild degenerative disc disease of lumbar spine at L2-3 without evidence of nerve root compression or herniated disc. He stated:

"It is my firm and definite opinion that this gentleman's injury [which] was accepted in 2001 for a herniated lumbar disc at L2-L3, has resolved. There is no evidence of a herniated lumbar disc. He has no evidence of nerve root compression at this level. There is evidence on physical examination of symptom exaggeration where subjective findings outweigh objective findings."

Dr. Doman found that appellant reached maximum medical improvement on March 25, 2008. He noted that there were no nerve roots that were affected and opined that appellant had a permanent impairment of zero percent, with zero percent impairment due to loss of function from decreased strength, sensory deficit, pain or discomfort.

In an impairment evaluation dated June 12, 2008, an Office medical adviser reviewed Dr. Doman's findings. He determined that appellant had a zero percent impairment of the left upper extremity under the A.M.A., *Guides*. The Office medical adviser stated:

"The [second opinion] ... was carefully reviewed and there are no neurological findings of the [lower extremity] that correlate with the [accepted condition] to assign a [schedule award] for the bilateral [lower extremities]. There are no abnormal sensory or motor deficits of either [lower extremity] to support an impairment of the [lower extremity] based on radiculopathy or lumbar nerve root impingement/encroachment or myelopathy. There were no nerve roots or specific nerves of [lower extremity] affected. Therefore, the impairment [for the left lower extremity] equals zero percent. The impairment [for the right lower extremity] equals zero percent."

By decision dated June 18, 2008, the Office denied appellant's claim for a schedule award. It found that Dr. Doman's referral opinion, which established that appellant did not sustain any ratable impairment from his accepted lower back condition, represented the weight of the medical evidence.

On July 18, 2008 appellant requested reconsideration. In support of his request, he submitted a May 15, 2002 report from Dr. Tabaro, who noted the history of injury, reported that appellant had recurrent back pain radiating down his legs bilaterally to his feet, associated with numbness. Dr. Tabaro diagnosed acute lumbosacral strain and stated that appellant had complaints of severe lower back pain and loss of sensation at night in both legs. He outlined restrictions of no lifting exceeding 15 pounds, no reaching, no overhead activities, no flexing of the spine no twisting and no bending.

Appellant also submitted: a May 8, 2002 report from Dr. Tabaro which stated findings on examination and noted complaints of severe lower back pain; treatment notes from Dr. Tabaro dated October 2002 to June 2003; a February 21, 2006 report from Dr. Tabaro in which he noted that appellant had been treated for lumbar pain and indicated results of an MRI scan showed disc herniation on the left at L2-3 which was compressing the thecal sac, facet hypertrophy and bulging abutting the right L5 root at L5-S1; and a hospital admission slip dated May 2, 2008.

By decision dated September 2, 2008, the Office denied appellant's application for review on the grounds that it neither raised substantive legal questions nor included new and relevant evidence sufficient to require the Office to review its prior decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of the Federal Employees' Compensation Act[1] 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.[2] 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.[3]

ANALYSIS -- ISSUE 1

In the instant case, the Office medical adviser determined that appellant had no ratable permanent impairment under the A.M.A., *Guides* based on the March 25, 2008 report from Dr. Doman, who stated that appellant's accepted herniated disc at L2-3 had resolved and that appellant's examination showed no evidence of a herniated lumbar disc. He advised that there was no evidence of nerve root compression or any involvement of any existing nerve root at that

[1] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[2] *Id.* at § 8107(c)(19).

[3] 20 C.F.R. § 10.404.

level. While appellant showed findings suggestive of a mild left-sided L5 radiculopathy, Dr. Doman stated that these findings could also indicate a proximal neuropathy, sciatic neuropathy or a lumbosacral plexopathy. He opined that none of these findings could possibly be related to a herniated lumbar disc at the L2-3 level. Dr. Doman asserted that appellant demonstrated symptom exaggeration on examination and stated that his subjective findings outweighed his objective findings. He noted that the March 2008 lumbar MRI scan showed minor loss of disc height at L2-3 with no evidence of herniated lumbar disc, nerve root compression or spinal stenosis. Based on these findings, Dr. Doman concluded that appellant had a permanent impairment of zero percent, with zero percent impairment due to loss of function from decreased strength, sensory deficit, pain or discomfort.

The Office medical adviser adopted Dr. Doman's finding of a zero percent impairment rating for the lower extremities. He stated that appellant had no neurological findings which warranted a schedule award for the bilateral lower extremities; he noted that there were no abnormal sensory or motor deficits of either lower extremity and no findings of radiculopathy or lumbar nerve root impingement/encroachment or myelopathy sufficient to support an impairment of the lower extremities. In his November 26, 2007 report, Dr. DeVeau rated an eight percent whole person impairment based on appellant's clinical history and examination findings. However, as his report evaluated whole person impairment, it was of limited probative value.[4]

The Office medical adviser properly relied on Dr. Doman's findings to determine that appellant did not have a ratable permanent impairment under the A.M.A., *Guides*. As there is no other medical evidence establishing that appellant sustained any permanent impairment of a scheduled member, the Office properly found that appellant was not entitled to a schedule award due to his accepted lower back condition.

LEGAL PRECEDENT -- ISSUE 2

Under 20 C.F.R. § 10.606(b), a claimant may obtain review of the merits of his or her claim by showing that the Office erroneously applied or interpreted a specific point of law; by advancing a relevant legal argument not previously considered by the Office; or by constituting relevant and pertinent evidence not previously considered by the Office.[5] Evidence that repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case.[6]

ANALYSIS

In the present case, appellant has not shown that the Office erroneously applied or interpreted a specific point of law; he has not advanced a relevant legal argument not previously considered by the Office and he has not submitted relevant and pertinent evidence not previously considered by the Office. The evidence appellant submitted is not pertinent to the issue on appeal. None of the medical reports from Dr. Tabaro contain a probative rationalized opinion indicating that appellant had a ratable permanent impairment stemming from his accepted lower

[4] "Whole man" impairment ratings are not provided for under the Act. *Dennis R. Blackwell*, 41 ECAB 98 (1989).

[5] 20 C.F.R. § 10.606(b)(1); *see generally* 5 U.S.C. § 8128(a).

[6] *Howard A. Williams*, 45 ECAB 853 (1994).

back condition. His reports, which were issued several years prior to appellant's schedule award request, merely restated the diagnoses of appellant's condition and indicated he had lower back pain. As such, Dr. Tabaro's opinion was cumulative and repetitive of arguments which the Office considered in its previous decision. The Board has held that the submission of evidence which does not address the particular issue involved in the case does not constitute a basis for reopening the claim.[7] Dr. Tabaro's reports did not present any additional evidence pertaining to the relevant issue of whether appellant sustained a permanent impairment causally related to his accepted lower back condition. The May 2008 hospital admission slip contained no medical evidence and was therefore lacking in probative value. Appellant's reconsideration request failed to show that the Office erroneously applied or interpreted a point of law nor did it advance a point of law or fact not previously considered by the Office. The Office did not abuse its discretion in refusing to reopen appellant's claim for a review on the merits.

CONCLUSION

The Board finds that appellant has not sustained any permanent impairment to a scheduled member of his body causally related to his accepted lower back condition, thereby entitling him to a schedule award under 5 U.S.C. § 8107. The Board finds that the Office properly refused to reopen appellant's case for reconsideration on the merits of his claim under 5 U.S.C. § 8128(a).

ORDER

IT IS HEREBY ORDERED THAT the September 2 and June 18, 2008 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: June 3, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[7] *See David J. McDonald*, 50 ECAB 185 (1998).