United States Department of Labor
Employees' Compensation Appeals Board

S.K., Appellant	)	
and	)	**Docket No. 09-1099**
	)	**Issued: January 28, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Rochester, MN, Employer	)	

Appearances:
Alf E. Sivertson, Esq., for the appellant
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 March 17, 2009 appellant, through his representative, filed a timely appeal from the June 20, 2008 merit decision of the Office of Workers' Compensation Programs, which found an eight percent permanent impairment of his left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case. The Board also has jurisdiction to review the Office's January 16, 2009 nonmerit decision denying reconsideration.

ISSUES

The issues are: (1) whether appellant has more than an eight percent permanent impairment of his left lower extremity; and (2) whether the Office properly denied appellant's request for reconsideration.

FACTUAL HISTORY

On May 10, 2006 appellant, then a 48-year-old mail handler, sustained a traumatic injury in the performance of duty when he bent over to pick up mail. The Office accepted his claim for

exacerbation of chronic back and leg pain. Appellant previously injured his back on January 10, 1996 while unloading an all-purpose container.[1] He felt a sharp pain in his hip and all the way down his left leg. The Office accepted that claim for low back strain, lumbosacral radiculopathy and disc protrusion. It authorized a left L5-S1 partial hemilaminectomy, foraminotomy and discectomy.[2]

On July 30, 2007 and again on March 14, 2008 appellant filed a claim for a schedule award. He submitted the May 21, 2007 report of Dr. Russell Gelfman, a consulting physiatrist, who related appellant's history, including a total body impairment rating of 23.5 percent given by Dr. David A. Holland in 2000. Dr. Gelfman described appellant's complaints and his findings on physical examination.[3] He diagnosed multilevel degenerative disc disease L3-5, prior left hemilaminectomy and L5 discectomy, headaches and old radiculopathies at L4 (left), L5 (bilateral) and S1 (left). On the subject of impairment, Dr. Gelfman stated:

> "I presume that the reason for this evaluation is that he is felt to be at maximal medical improvement unless he is able to attend the Pain Rehabilitation Center Program. Therefore, a final impairment rating would be appropriate; however, I do not have ready access to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* [(A.M.A., *Guides*)] [f]ourth [e]dition as the [f]ifth [e]dition is the current text. It is not clear to me if this would be rated based on his old injury or the new event that he describes having been last year. Once these administrative issues are certified, a final rating can be provided."

On July 10, 2007 Dr. Gelfman noted that appellant's May 10, 2006 injury, when he bent over at work, was considered a new injury and not related to his previous back problems. He stated that appellant had substantial impairment from his prior injury "and since I did not see him at a time of his prior injury, impairment assessment is difficult." Dr. Gelfman reported that according to the fifth edition of the A.M.A., *Guides*, appellant had a five percent whole person impairment based on Diagnosis-Related Estimate Lumbar Category II due to "nonverifiable radicular complaints in the form of bilateral shooting pain into his groin area."[4]

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[1] File No. xxxxxx409 (Master File).

[2] The record also indicates that appellant slipped on ice and sustained a lumbosacral sprain on February 1, 1994. On September 12, 1995 he sustained a lumbar sprain handling mail. On November 30, 1995 appellant sustained a lumbosacral sprain pulling a mailbag off a truck.

[3] "Cervical range of motion is functional. Lumbar range of motion is splinted with flexion and extension. There is a well-healed lumbar incision. [Appellant] has a mildly antalgic gait on the left. He can get up on toes and rock back onto heels. Upper extremity strength is normal. Lower extremity strength shows give way as noted in Dr. Toni J. Hanson's note from last August. [Appellant's] reflexes are intact except for the absent left gastroc-soleus reflex which is old. He has decreased pinprick in a stocking distribution and also over the anterolateral thighs bilaterally. Straight leg raising results in severe pain at about 45 degrees of hip flexion."

[4] *See* A.M.A., *Guides* 384 (5th ed. 2001) (Table 15-3). Chapter 15 of the A.M.A., *Guides* provides criteria for evaluating permanent impairment of the spine. *Id*. at 373.

On May 12, 2008 an Office medical adviser reviewed appellant's chart. He identified five physicians who submitted notes to the medical record for review. The Office medical adviser noted the complaints and findings reported by Dr. Gelfman, as well as findings from other physicians and the results from an updated magnetic resonance imaging scan and a recent electromyogram. He reported that previous physicians had recommended whole body impairment ratings, which the Office did not recognize. The Office medical adviser stated that the only ratable impairment was for residual pain and weakness in the S1 nerve root on the left.

The Office medical adviser found a three percent impairment of the left lower extremity due to Grade 3 pain in the S1 nerve root distribution. He also found a five percent impairment due to Grade 4/5 strength in the S1 nerve root distribution, for a total combined impairment of eight percent. The Office medical adviser stated that there was no objective data to support any impairment of the right lower extremity. He reported that the date of maximum medical improvement was estimated to have occurred long ago, as there appeared to be no material improvement in appellant's condition for many years. "However, for simplicity, I have chosen the date of Dr. Gelfman's note as the date of [maximum medical improvement,] May 21, 2007."

On June 20, 2008 the Office issued a schedule award for an eight percent impairment of the left lower extremity. It awarded 23.04 weeks of compensation and the period of the award began on May 21, 2007, the date of maximum medical improvement.

On September 24, 2008 appellant signed an appeal request form requesting reconsideration. On December 10, 2008 his representative submitted the request and offered two grounds for reconsideration:

> "The first is that the [Office] erred in basing its award on the period from May 21, 2007 to October 29, 2007. You have in your file two CA-7 [c]laim for [c]ompensation forms. One is dated July 28, 2007 and the other is dated February 4, 2008. On each of those forms the date of injury for which [appellant] is seeking a scheduled award is May 10, 2006. Given [his] medical history as detailed in Dr. Gelfman's July 19, 2007 report that is a part of the record, the period of award should go back to the date of injury on May 10, 2006.
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> "Secondly, the determination of an impairment of eight percent to the left lower extremity should have been a total body impairment disability rating. Again, this is based on the history of [appellant's] injuries that date back to 1996. In February 2000, Dr. David A. Holland assigned a total body impairment of 23.5 percent using the [A.M.A., *Guide* fourth edition.] See the History of Present Illness section in Dr. Gelfman's report. Thus, the degree and nature of permanent disability portion of your [a]ward of [c]ompensation should be a total body impairment rating of at least 23.5 percent."

In a decision dated January 16, 2009, the Office denied appellant's request for reconsideration on the grounds that his request neither raised substantive legal questions nor included new and relevant evidence. It noted that his legal contentions concerning the period of the award and whole body impairment were not proper.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act[5] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[6]

No schedule award is payable for a member, function or organ of the body not specified in the Act or in the regulations.[7] Because neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[8] no claimant is entitled to such an award.[9]

Amendments to the Act modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of the Act include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[10]

The Act does not authorize the payment of schedule awards for the permanent impairment of "the whole person." Payment is authorized only for the permanent impairment of specified members, organs or functions of the body.[11] Section 8107(c)(2) provides 288 weeks' compensation for the complete loss of a lower extremity.[12] Partial losses are compensated proportionately.[13]

The period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the employment injury. Maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.[14] The determination of the date of maximum

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *William Edwin Muir*, 27 ECAB 579 (1976).

[8] The Act itself specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[9] *E.g., Timothy J. McGuire*, 34 ECAB 189 (1982).

[10] *Rozella L. Skinner*, 37 ECAB 398 (1986).

[11] *Ernest P. Govednick*, 27 ECAB 77 (1975).

[12] 5 U.S.C. § 8107(c)(2).

[13] *Id.* at § 8107(c)(19). Thus, the Office awards 23.04 weeks' compensation for an eight percent impairment of the left lower extremity.

[14] *Marie J. Born*, 27 ECAB 623 (1976).

improvement is factual in nature and depends primarily on the medical evidence.[15] The date of maximum medical improvement is usually considered to be the date of the evaluation by the attending physician, which is accepted as definitive by the Office.[16] Once an impairment has reached maximum medical improvement, a permanent impairment rating may be performed.[17]

For schedule award purposes, maximum medical improvement should not be fixed at some distant time in the past on a date that was prior to the time that the employee was able to return to work on a regular basis, unless the evidence clearly and convincingly establishes that maximum improvement had in fact been reached by that date and unless the employee's rights can be fully protected.[18] If the date of maximum improvement is to be fixed at a distant past date, such as a year previously, while the employee was still disabled (and therefore usually entitled to compensation for temporary disability), the rules for determining the date of maximum improvement remain the same as in all other situations; however, in such a situation the type of evidence needed to support the retroactive finding of fact, adverse to the employee's best interest, must be stronger than that which might otherwise be sufficient.[19]

The attending physician should make the impairment evaluation whenever possible. The report of the examination should include, except in uncomplicated amputations, an estimate of the impairment in terms of percentage. Where this information is missing, the claims examiner may ask the attending physician to provide it. If this fails, the claims examiner may ask the district medical adviser to calculate the percentage. After obtaining all the necessary medical evidence, the file should be routed to the district medical adviser for opinion concerning the nature and percentage of impairment. The percentage should be computed in accordance with the A.M.A., *Guides*, fifth edition. As a matter of course, the district medical adviser should provide rationale for the percentage of impairment specified. When more than one evaluation of the impairment is present, however, it will be especially important for the medical adviser to provide such medical reasoning.[20]

ANALYSIS -- ISSUE 1

The Office issued a schedule award for an eight percent permanent impairment of appellant's left lower extremity. It based this award on the Office medical adviser's May 12,

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[15] *Franklin L. Armfield*, 28 ECAB 445 (1977).

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a (October 1990); *see Richard Larry Enders*, 48 ECAB 184 (1996) (the date of maximum medical improvement was the date of the audiologic examination used as the basis of the schedule award).

[17] A.M.A., *Guides* 19 (5th ed. 2001).

[18] *Marie J. Born*, *supra* note 14 at 631.

[19] *Marie J. Born*, 28 ECAB 89, 93 (1976) (granting petition for reconsideration and reaffirming the Board's decision). Claimants are precluded from concurrently receiving compensation for permanent impairment and compensation for wage loss on the theory that these are parallel remedies for the same injury. *Marie J. Born*, *supra* note 14 at 628.

[20] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.c, .6.d (August 2002).

2008 review. Although the medical adviser identified the tables he used in the A.M.A., *Guides*, he did not appear to base his rating on any particular medical evaluation. Instead, he looked at appellant's entire chart. He referenced five physicians, findings from Dr. Gelfman (though not by name), findings from other physicians and results from diagnostic tests. Therefore, it appears he drew from numerous sources. Even when it came to assigning a date of maximum medical improvement, he selected the date of Dr. Gelfman's note, May 21, 2007, "for simplicity." He believed it actually occurred long ago based on the lack of improvement in appellant's condition for many years.

Dr. Gelfman offered no evaluation of impairment on May 21, 2007. He did not grade appellant's sensory loss under Table 15-15, page 424 of the A.M.A., *Guides*. Dr. Gelfman did not grade appellant's motor deficits under Table 15-16 and when he did offer a rating on July 10, 2007, he did not rate impairment of the left lower extremity. He rated impairment of appellant's spine based on nonverifiable radicular complaints in the form of bilateral shooting pain into the groin area. The Act provides no compensation for impairment of the spine.

Therefore, it is not clear what evidence allowed the Office medical adviser to derive an impairment rating for appellant's left lower extremity. If he used some combination of diagnostic test results and findings from various physicians, he should have explained why he selected those sources and how those sources supported his rating of impairment. This rationale is important because the Office medical adviser did not examine appellant and because the Board must review the accuracy of his determination.

The Office medical adviser should explain how his grading of sensory loss is consistent with his report of decreased sensation in a nonanatomic distribution in both legs "not implicating any specific dermatome or nerve root." He should explain how his grading of motor loss is consistent with the report by many physicians of normal lower extremity strength or the report by one physician of "give-way" weakness, implying lack of full effort. He should explain why appellant received no rating for the reported numbness in his right lower extremity.

In applying the A.M.A., *Guides*, the Office medical adviser should explain, under Table 15-15, how he identified the area or dermatome of involvement and the innervating nerve and how he was able to grade the severity of the sensory loss. He should explain, under Table 15-16, what motion and what muscles were involved and how he was able to grade the severity of the motor deficit. The Office medical adviser should also better justify the date of maximum medical improvement.

Without sufficient medical rationale to support the rating given by the Office medical adviser, the Board is unable to determine whether appellant has an eight percent permanent impairment of his left lower extremity. The Board will therefore set aside the Office's June 20, 2008 schedule award decision and remand the case for further development of the medical evidence and an appropriate final decision on appellant's entitlement under 5 U.S.C. § 8107.

The Board's disposition of the Office's June 20, 2008 merit decision renders the Office's January 16, 2009 denial of reconsideration moot. On appeal, appellant makes the same arguments he made in his request for reconsideration. The period of the award correctly begins on the date of maximum medical improvement, which is usually the date of the physician's

impairment evaluation, not the date of injury. Appellant must keep in mind that any rating he receives will entitle him to a limited number of weeks of compensation, as specified in section 8107(c) of the Act. The length of the award will not increase if the period begins at an earlier date. Appellant may not receive compensation for wage loss and a schedule award for physical impairment at the same time, so fixing the date of maximum medical improvement at some point in the past when he might have been entitled to compensation for wage loss would not be to his benefit.

Appellant argues for an impairment rating of the total body, such as one physician reported in February 2000. However, it is well established that the Office may make no such award. Section 8107 of the Act provides compensation only for enumerated members, organs and functions of the body. Appellant may therefore receive a schedule award for permanent impairment of one or both lower extremities, but he may not receive an award for impairment to the whole person.[21]

Finally, appellant adds that the Office has closed his case but that it should be reopened on an indefinite basis to pay for ongoing medication needs stemming directly from his May 2006 injury. Specifically, he asks that the Office pay the deduction for his prescriptions. The Board's jurisdiction is limited to reviewing final decisions of the Office.[22] The matter that appellant raises here was not the subject of the Office's June 20, 2008 merit decision and is beyond the scope of this appeal.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the medical evidence is warranted.

[21] *Ernest P. Govednick, supra* note 11.

[22] 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the June 20, 2008 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Issued: January 28, 2010
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