United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 09-1175**
	)	**Issued: May 10, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, Employer	)	

Appearances:
Mark E. Meyer, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 31, 2009 appellant, through his representative, filed a timely appeal from the November 18, 2008 and March 9, 2009 merit decisions of the Office of Workers' Compensation Programs which denied an increased schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant has more than 21 percent permanent impairment of his right leg and any impairment of his left leg.

FACTUAL HISTORY

On January 25, 2006 appellant, then a 45-year-old custodian, sustained a low back injury in the performance of duty while dumping trash. The Office accepted his claim for lumbar sprain/strain, spinal stenosis at L4-5, postoperative infection and chondromalacia of the right

patella. Appellant underwent spinal surgery on September 5 and December 15, 2006. He underwent a chondroplasty of the right patella on March 9, 2007.[1]

Appellant filed a claim for a schedule award. On September 21, 2007 Dr. Alexander S. Bailey, an attending surgeon, rated 10 percent impairment of the whole person based on a category III spinal impairment, which he reduced 50 percent for preexisting conditions. On October 9, 2007 Dr. Lowry Jones, Jr., an attending orthopedic surgeon, reported that appellant's permanent impairment "with direct trauma, complaint of patellofemoral pain, and crepitation on examination, joint space narrowing, is equivalent to a five percent permanent partial impairment at the level of the knee." An Office medical adviser reviewed the medical evidence and advised that the impairment ratings should not be accepted. Neither Dr. Bailey nor Dr. Jones provided adequate findings on examination and Dr. Bailey had rated impairment to the spine.

The Office referred appellant to Dr. George Varghese, a physiatrist, for a second opinion evaluation of impairment. On January 28, 2008 Dr. Varghese reviewed the history of injury and medical treatment, noting prior lumbar spinal fusion surgeries in 1994 and 1997 and right knee arthroscopy with chondroplasty of the patella in March 2007. He related appellant's complaints of low back and right knee pain. Appellant localized his pain to the low back, with the left side being slightly worse than the right. Additionally, he stated that this pain radiated down his buttocks and the posterior side of his left leg down to his left foot and toes. Straight leg raise was positive for the left leg in both the seated and supine position and positive for the right in the supine position. Patrick's test was positive bilaterally. Sensation in the right lower extremity was intact to light touch and pinprick. Sensation of the left lower extremity was diminished to both light touch and pinprick in the L5-S1 nerve root distribution. Examination of the right knee revealed mild atrophy of the right quadriceps of 1.5 centimeters. Right knee extension was to 0 degrees and flexion was to 80 degrees. Appellant had mild pain with palpation of the medial portion of the patella. Anterior drawer and Lachman's tests were negative as were valgus and varus stress. Dr. Varghese found that muscle strength testing was 5/5 with hip flexion, knee extension and flexion, but mildly decreased around the ankle. He advised that appellant had reached maximum medical improvement following his low back and right knee surgery. With reference to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, appellant had 10 percent impairment under Table 17-10 for loss of range of motion based on flexion of less than 110 degrees. Dr. Varghese noted that pain was incorporated under the range of motion rating and, as no loss of strength was noted, there was no basis for an impairment rating. Under Table 17-6, he rated impairment due to mild atrophy as five percent. Dr. Varghese noted, however, that the cross-usage chart at Table 17-2 precluded combining impairment for range of motion with atrophy. Therefore, the higher rating of 10 percent represented appellant's right leg impairment. Impairment to the right lower extremity due to the accepted lumbar back pain was rated under Table 15-18, which provided a maximum of five percent impairment for the L5 and S1 nerve roots. Dr. Varghese found that, under Table 15-15, the extent of sensory deficit was Grade 2 or 80 percent. Multiplying the maximum impairment values for each nerve root by the sensory deficit grade resulted in four percent

[1] Other accepted claims include: OWCP File No. xxxxxx238 (lumbar strain, date of injury May 4, 1982); OWCP File No. xxxxxx901 (herniated lumbar disc, date of injury January 23, 1995). Appellant had a lumbar fusion at L4-S1.

sensory loss for the L5 and S1 nerves. Dr. Varghese rated impairment due to loss of strength in the S1 nerve distribution, noting that Table 15-18 provided a maximum impairment of 20 percent. Under Table 15-16, he found the extent of motor deficit to be Grade 4 or 20 percent. Multiplying the maximum impairment value by the strength deficit resulted in four percent impairment of the right leg. Dr. Varghese applied the Combined Values Chart to find total impairment due to right leg radiculopathy of 12 percent.

An Office medical adviser reviewed Dr. Varghese's evaluation and found it acceptable. He noted that the 10 percent impairment due to loss of right knee motion when combined with 12 percent impairment due to unilateral spinal nerve root impingement totaled 21 percent impairment of the right leg.

On March 12, 2008 the Office granted a schedule award for 21 percent permanent impairment of appellant's right lower extremity.

Appellant requested reconsideration, noting that he also had impairment on the left side. He submitted an October 17, 2008 report from Dr. Bailey, who assigned a 13 percent whole person impairment based on a category III spinal impairment. Dr. Bailey found no evidence of a significant preexisting condition to reduce that rating.

An Office medical adviser reviewed Dr. Bailey's rating and noted that the Office did not utilize body impairment ratings for lumbar spine conditions.

In a decision dated November 18, 2008, the Office reviewed the merits of appellant's case and denied modification of its March 12, 2008 decision. It found that Dr. Bailey's whole person rating for the lumbar spine did not permit consideration of lower extremity impairment for radicular residuals, which was the only basis for a lower extremity impairment rating due to a lumbar spine condition.

Appellant again requested reconsideration. In a November 26, 2008 report, Dr. Bailey addressed impairment to the left lower extremity with reference to Dr. Varghese's rating of the right side. He found four percent impairment of the left lower extremity due to altered pain and sensations in the L5 and S1 nerve distributions, both of which he graded at 80 percent. Dr. Bailey found an additional 4 percent impairment due to weakness in the S1 nerve distribution, which he graded at 20 percent.

An Office medical adviser reviewed Dr. Bailey's rating and noted that the physician addressed impairment without any review of the relevant medical history or findings on examination to support the gradings for sensory and motor deficits.

In a March 9, 2009 decision, the Office denied modification of its prior decision. It found that appellant had not submitted sufficient medical evidence to establish additional impairment due to his accepted conditions.

On appeal, appellant contends that the Office improperly disregarded or failed to consider Dr. Bailey's opinion, which established his disability.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] 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*.[3]

No schedule award is payable for a member, organ or function of the body not specified in the Act or the implementing regulations.[4] Neither the Act nor the implementing federal regulations provide for the payment of a schedule award for the permanent loss of use of the back or the spine.[5] Moreover, schedule awards are not payable for impairment ratings expressed in terms of the whole person rather than a specific scheduled member.[6]

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.[7]

To support a schedule award, the file must contain competent medical evidence that describes the impairment in sufficient detail for the adjudicator to visualize the character and degree of impairment.[8] The report of the examination must always include a detailed description of the impairment which includes, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent description of the impairment.[9] The Office should advise any physician evaluating permanent impairment to use the fifth edition of the A.M.A., *Guides* and to report findings in accordance with those guidelines.[10]

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[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *William Edwin Muir*, 27 ECAB 579 (1976); *see* 20 C.F.R. § 10.404.

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

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

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

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.b(2) (August 2002).

[9] *Id*. at Chapter 2.808.6.c(1).

[10] *Id*. at Chapter 2.808.6.a (noting exceptions).

ANALYSIS

Appellant's claim was accepted for injury to his lumbar spine and right knee, for which he underwent surgery. The Office granted appellant a schedule award for impairment of his right leg based on the report of Dr. Varghese, a second opinion medical specialist, who reviewed appellant's history and complaints and described findings on physical and neurologic examination. Based on his examination, Dr. Varghese rated impairment of the right lower extremity based on the applicable standards of the A.M.A., *Guides*. With reference to the accepted right knee injury, he determined that appellant had 10 percent impairment due to loss of knee flexion, which he measured to be 80 degrees. Table 17-10, page 537 of the A.M.A., *Guides* provides that knee flexion less than 110 degrees is a mild lower extremity impairment of 10 percent.[11] Dr. Varghese also rated impairment of the right leg due to the accepted back condition and appellant's radiculopathy, which affected both sensory and strength with respect to the L5 and S1 nerve roots. Table 15-18 provides a five percent maximum impairment for sensory loss affecting these nerve roots. Dr. Varghese rated the extent of sensory deficit affecting the right leg as Grade 2, or 80 percent. Multiplying the 5 percent maximum value by the 80 percent grade totals 4 percent sensory impairment of the L5 and S1 nerve roots, or a total of 8 percent sensory loss.

Dr. Varghese found mildly decreased muscle strength at 4+/5 with ankle plantar flexion on the right. He identified this as a mild weakness in the S1 nerve root distribution for which Table 15-18 provides a maximum loss of function of 20 percent. Dr. Varghese graded the motor deficit at 20 percent, or Grade 4, under Table 15-16. He multiplied 20 percent loss of function by the 20 percent motor deficit to find 4 percent impairment for radicular weakness. Dr. Varghese combined the 8 percent sensory and 4 percent motor impairments, to total 12 percent impairment based on radiculopathy. In turn, the 10 percent impairment based on loss of range of motion was combined with the 12 percent radiculopathy component, to find 21 percent total to the right leg. The Board finds that the report of Dr. Varghese constitutes the weight of medical opinion pertaining to the right lower extremity. It is based on an accurate review of the accepted conditions, a report which sets forth the findings on examination and an explanation of how the impairment rating was achieved with reference to the applicable standards of the A.M.A., *Guides*.

The Board notes, however, that Dr. Varghese also provided a finding pertaining to appellant's left leg, stating that there were symptoms of radiculopathy affecting the member. Dr. Varghese noted that sensation in the left leg was extremely diminished to both light touch and pin prick. However, he did not provide a specific impairment rating for the left knee. On appeal, appellant does not question the right leg schedule award but contends that the Office ignored the findings relative to his left leg. As found by the Office, the reports submitted from Dr. Bailey contain deficiencies which do not permit for an informed review of his stated impairment rating involving the left leg. Dr. Bailey did not provide adequate findings based on examination to support his rating. He offered no clinical basis for his grading of sensory and motor deficits and appears to have followed the rating made by Dr. Varghese. The Board finds

[11] Dr. Varghese also rated impairment due to atrophy but noted that Table 17-2, the cross usage chart, precluded combining impairment for loss of motion with loss due to atrophy.

that the Office properly rejected the rating as insufficient to establish appellant's left leg impairment.

However, this does not mean that the Office may ignore the findings of Dr. Varghese as they relate to appellant's left leg. As it attempted development of the medical evidence, it has the obligation to see that justice is done.[12] Dr. Varghese's clinical findings raise a question about the extent of impairment to appellant's left leg. The Board finds that clarification of his medical opinion is warranted. The case will be remanded for further development of the medical evidence.

CONCLUSION

The Board finds that appellant has 21 percent impairment of his right leg, for which he received a schedule award. The case is not in posture for decision as to the extent of impairment to his left leg.

ORDER

IT IS HEREBY ORDERED THAT the March 9, 2009 and November 18, 2008 decisions of the Office of Workers' Compensation Programs be affirmed with regard to the impairment to appellant's right leg. The decisions are set aside and the case is remanded for further action consistent with this opinion as to the extent of impairment to appellant's left leg.

Issued: May 10, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[12] *See Richard E. Simpson*, 55 ECAB 490 (2004).