United States Department of Labor
Employees' Compensation Appeals Board

G.S., Appellant	)	
and	)	**Docket No. 12-521**
	)	**Issued: July 20, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRTION, Salem, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 10, 2012 appellant's representative filed a timely appeal from a December 1, 2011 Office of Workers' Compensation Programs' (OWCP) schedule award decision. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of appellant's claim for a schedule award.

ISSUE

The issue is whether appellant met her burden of proof to establish that she has an impairment caused by her accepted employment injuries that would entitle her to a schedule award.

FACTUAL HISTORY

On March 9, 2006 appellant, then a 42-year-old food service worker, sustained a low back injury in the performance of duty. She stopped work on that date. On April 21, 2006

[1] 5 U.S.C. § 8101 *et seq.*

OWCP accepted the claim for lumbago, sprain of lumbosacral joint ligament and lumbosacral spondylosis without myelopathy. It paid wage-loss compensation benefits.

On October 29, 2009 appellant filed a claim for a schedule award. In a September 10, 2009 report, Dr. Stuart Goodman, a Board-certified neurologist, noted her history of injury and treatment. On neurological examination, he noted positive straight leg raising on the left side with decreased sensation in the left L5 dermatome. Dr. Goodman explained that appellant's motor examination revealed strength to be essentially equal and normal throughout. He advised that reflexes were "1+/4" with plantar response flexor. Dr. Goodman found that appellant's sensory examination revealed a slight decrease in the left lumbar L5 dermatome but otherwise was intact to vibration, touch, pinprick and position testing. He explained that the cerebellar examination revealed normal finger-to-nose and heel-to-shin testing and her Romberg was negative. Dr. Goodman referred to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2008) (A.M.A., *Guides*) Table 17.4, Lumbar Spine Regional Grid and finds that appellant was class 1.[2] He referred to Table 17.5, Adjustment Grid and determined that she qualified for a grade modifier 1.[3] Dr. Goodman referred to Table 17.6, Functional History adjustment and utilized a grade modifier 2.[4] He utilized Table 17.7, Physical Examination adjustment and found a grade modifier 2.[5] Dr. Goodman opined that appellant had six percent permanent impairment of the left lower extremity.

In an April 28, 2010 report, OWCP's medical adviser disagreed with Dr. Goodman's impairment rating as it was based on the section of the A.M.A., *Guides* pertaining to whole person or spinal impairments, which was inappropriate for the evaluation of lower extremity radiculopathy impairments. Regarding the spine, he noted that the approach to the evaluation of spinal nerve impairment (such as radiculopathy affecting the extremities) was consistent with the A.M.A., *Guides* and was discussed in the July/August issue of *The Guides Newsletter*.[6] The medical adviser explained that *The Guides Newsletter* was an official publication of the American Medical Association and states, "*The Guides Newsletter* provides updates, authoritative guidance, and AMA interpretations and rationales for the use of the A.M.A., *Guides.* He indicated that the A.M.A., *Guides* did not provide a separate approach to rating spinal nerve impairments and that an approach consistent with values assigned for spinal impairment in prior editions and the methodology applied in the sixth edition was provided. The medical adviser explained that "[t]he proposed new tables provided values for rating spinal nerve impairment by means of the process defined for the sixth edition in rating peripheral nerve injuries. He noted that Dr. Goodman found a slight decrease in sensation to the L5 dermatome, "yet it is intact to touch and pinprick" and there was no magnetic resonance imaging (MRI) scan evidence of L5 nerve root impingement. The medical adviser concluded that the sensory deficits

[2] A.M.A., *Guides* 570.

[3] *Id.* at 575.

[4] *Id.* at 576.

[5] *Id.*

[6] Rating Spinal Nerve Extremity Impairment Using the sixth edition, *The Guides Newsletter* (A.M.A., Chicago, IL), July/August 2009.

provided by Dr. Goodman were questionable and there were no reliable, consistently documented sensory deficits to qualify as lumbar radiculopathy. He explained that Dr. Goodman's report indicated equal strength and there was no evidence of motor weakness. The medical adviser opined that appellant did not warrant an impairment rating and noted that the maximum rating would be a one percent leg rating if the reported findings were ratable.

In a June 7, 2010 decision, OWCP denied appellant's claim for a schedule award. It found that the medical evidence of record did not support a permanent impairment to a scheduled member or function of the body. On June 17, 2010 appellant's representative requested a telephonic hearing.

On June 9, 2010 OWCP referred appellant to Dr. William C. Andrews, a Board-certified orthopedic surgeon, for a second opinion. In a June 23, 2010 report, Dr. Andrews noted appellant's history of injury and examined her. He noted that she had stiffness and paravertebral lumbar muscle spasm and positive straight leg raising on the left. Dr. Andrews further noted that appellant had no motor deficit in the lower extremities; however, she complained of intermittent numbness. He determined that her sensation was intact and diagnosed lumbosacral strain with radicular left leg pain.

In a September 14, 2010 decision, an OWCP hearing representative found the case was not in posture for hearing. He vacated the June 7, 2010 decision and remanded the case for further development of the medical evidence to determine whether appellant sustained any impairment due to her injury. The hearing representative noted that Dr. Andrews found intact sensation and explained that clarification was needed regarding the objective nature of the radiculopathy and whether appellant had permanent partial impairment.

By letters dated November 29, 2010 and February 7, 2011, OWCP referred appellant for a follow-up examination with Dr. Andrews. In a February 23, 2011 report, Dr. Andrews examined appellant and noted that she had definite numbness in the L5 distribution on the left side consistent with a left lower extremity radiculopathy. He further advised that she also had leg symptoms, a positive straight leg raise and a positive Lasegue sign. Dr. Andrews opined that appellant did not demonstrate a definite motor deficit upon examination, and that she had full range of motion of the upper and lower extremities.

In a July 5, 2011 report, the medical adviser noted appellant's history of injury and treatment. He referred to page 576 of the A.M.A., *Guides* and advised that a diagnosis of radiculopathy required clinical findings including specific dermatomal distribution of pain, numbness and/or paresthesias. Furthermore, subjective complaints of sensory changes were more difficult to assess; therefore, these complaints should be consistent and supported by other findings of radiculopathy. The medical adviser noted that the A.M.A., *Guides* also indicated that there may be associated weakness and loss of reflex and a root tension sign was usually positive. He also advised that the A.M.A., *Guides* noted that the identification of a condition that may be associated with radiculopathy (such as a herniated disc) on an imaging study was not sufficient to make a diagnosis of radiculopathy; clinical findings must correlate with the radiographic findings in order to be considered. The medical adviser noted that to confirm a diagnosis of radiculopathy, the A.M.A., *Guides* required clinical findings including dermatomal distribution of pain, numbness and/or paresthesias. He advised that MRI scan findings of the lumbar spine

did not reveal any evidence of disc herniation or stenosis impinging upon the left nerve root. Furthermore, the medical adviser indicated that, despite findings consistent with mild foraminal narrowing possible in the L5-S1 level, this alone would not be dispositive of lumbar radiculopathy. He noted that the A.M.A., *Guides* also required examination findings. The medical adviser opined that, absent other corroborating findings, there did not appear to be sufficient evidence to support a verifiable lumbar radiculopathy. He indicated that there were no consistently documented findings of loss of sensation to light touch in the left lower extremity that were reliable for rating purposes. The medical adviser explained that the medical records consistently documented intact sensation to light touch. He opined that there were no sensory or motor deficits related to a verifiable lumbar radiculopathy and thus no ratable impairment to either lower extremity.

By decision dated July 21, 2011, OWCP denied appellant's claim for a schedule award. It found that there was no evidence of permanent impairment.

On August 1, 2011 appellant's representative requested a telephonic hearing, which was held on October 17, 2011. During the hearing, he argued that appellant had numbness and positive straight raise and Lasègue's tests. Appellant's representative also questioned the validity of the medical adviser's report.

By decision dated December 1, 2011, OWCP's hearing representative affirmed the July 21, 2011 decision.

LEGAL PRECEDENT

A schedule award can be paid only for a condition related to an employment injury. The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[7]

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[8] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[9] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[10] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[11]

[7] *Veronica Williams*, 56 ECAB 367 (2005).

[8] 5 U.S.C. § 8107.

[9] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[10] 20 C.F.R. § 10.404.

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010); *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

Although the A.M.A., *Guide*s includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[12] In 1960, amendments to FECA 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. Therefore, as the schedule award provisions of FECA 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.[13]

For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* Rating Spinal Nerve Extremity Impairment Using the sixth edition (July/August 2009) is to be applied.[14]

ANALYSIS

The evidence of record is insufficient to establish that appellant is entitled to a schedule award in accordance with the sixth edition of the A.M.A., *Guides*.

OWCP accepted appellant's claim for claim for lumbago. It expanded the claim to include sprain of lumbosacral joint ligament and lumbosacral spondylosis without myelopathy

Appellant claimed a schedule award on October 29, 2009. However, she did not submit any evidence from a physician finding that she had permanent impairment of a schedule body member, caused or aggravated by her accepted conditions and which followed the A.M.A., *Guides* in rating permanent impairment. For example, the record contains a September 10, 2009 report from Dr. Goodman, who opined that appellant had a six percent impairment of the left lower extremity. However, he incorrectly utilized the section of the A.M.A., *Guides* pertaining to spinal impairments instead of the July/August issue of *The Guides Newsletter*.[15] As noted above, for peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* Rating Spinal Nerve Extremity Impairment Using the sixth edition (July/August 2009) is to be applied.[16] Dr. Goodman did not adequately explain how he used the A.M.A., *Guides* to rate impairment or rate impairment to a scheduled member pursuant to the A.M.A., *Guides*. Furthermore, with regard to radiculopathy, he did not provide any objective evidence of upper or lower extremity radiculopathy. The

[12] *Pamela J. Darling*, 49 ECAB 286 (1998).

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

[14] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[15] Rating Spinal Nerve Extremity Impairment using the sixth edition, *The Guides Newsletter* (A.M.A., Chicago, IL), July/August 2009.

[16] *See supra* note 14.

medical adviser explained that peripheral neuropathy impairment tables could not be used if there was no objective radiculopathy. His opinion is of diminished probative value.[17]

OWCP subsequently referred appellant to Dr. Andrews for a second opinion examination. In a June 23, 2010 report, Dr. Andrews noted that appellant had no motor deficits in the lower extremity; however, she complained of intermittent numbness. He determined that her sensation was intact and diagnosed lumbosacral strain with radicular left leg pain. In a February 23, 2011 supplemental report, Dr. Andrews provided findings to include definite numbness in the L5 distribution on the left side consistent with a left lower extremity radiculopathy. However, he opined that appellant did not show a definite motor deficit on examination, and that she had full range of motion of the upper and lower extremities.

In a July 5, 2011 report, OWCP's medical adviser noted appellant's history of injury and treatment and reviewed Dr. Andrews' reports. He referred to page 576 of the A.M.A., *Guides* and explained that a radiculopathy diagnosis required clinical findings including specific dermatomal distribution of pain, numbness and/or paresthesias. This provision cautioned that subjective complaints of sensory changes were more difficult to assess; "therefore, these complaints should be consistent and supported by other findings of radiculopathy." The medical adviser advised that to confirm a diagnosis of radiculopathy, the A.M.A., *Guides* required clinical findings including dermatomal distribution of pain, numbness and/or paresthesias. He explained that there was no evidence of disc herniation or stenosis impinging upon the left nerve root and mild foraminal narrowing possible in the L5-S1 level, would not be dispositive of lumbar radiculopathy. The medical adviser noted that the A.M.A., *Guides* also required examination findings and there was not sufficient evidence to support a verifiable lumbar radiculopathy as there were no consistently documented findings of loss of sensation to light touch in the left lower extremity that were reliable for rating purposes. He stated that the medical evidence supported intact sensation to light touch. The medical adviser opined that there were no sensory or motor deficits related to a verifiable lumbar radiculopathy and thus no ratable impairment to either lower extremity. The Board finds that he properly applied the A.M.A., *Guides* in calculating appellant's permanent impairment. As the July 5, 2011 report of the medical adviser provides the only evaluation which conforms to the A.M.A., *Guides*, it constitutes the weight of the medical evidence and establishes that appellant has no ratable impairment to either lower extremity.

Appellant did not submit any other medical evidence to support that she was entitled to a schedule award, under the sixth edition of the A.M.A., *Guides*, for a scheduled member of the body under FECA. Accordingly, the Board finds that appellant has not established entitlement to a schedule award.[18]

[17] *See J.G.*, Docket No. 09-1128 (issued December 7, 2009) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[18] Although appellant's counsel, before OWCP, questioned the validity of the medical adviser's July 5, 2011 report, the Board notes that OWCP procedures contemplate that the medical adviser provide a reasoned opinion regarding impairment in schedule award claims. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (January 2010). As explained, the medical adviser explained the reasons why appellant had no ratable leg impairment. Regarding counsel's argument of bias by the medical adviser, appellant submitted no evidence showing any bias by the medical adviser.

Appellant may request a schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant did not establish that she sustained permanent impairment to her lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the December 1, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 20, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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