United States Department of Labor
Employees' Compensation Appeals Board

G.D., Appellant	)	
and	)	**Docket No. 11-1688**
	)	**Issued: June 5, 2012**
U.S. MARSHALS SERVICE, Concord, NH, Employer	)	

Appearances:
James D. Muirhead, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 15, 2011 appellant, through his attorney, filed a timely appeal from the May 9, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) which affirmed a schedule award. 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has more than an eight percent permanent impairment of his left leg for which he received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 17, 2001 appellant, then a 44-year-old Chief Deputy U.S. Marshal, was injured while moving a file cabinet. OWCP accepted his claim for aggravation of arthritis of the spine. Appellant received wage-loss compensation benefits.[2]

In a February 21, 2001 report, Dr. William J. Bruton, a Board-certified orthopedic surgeon, noted that appellant was seen for back pain. Lumbar spine x-rays showed significant narrowing at L5-S1 and diagnosed degenerative disc disease. A February 26, 2001 magnetic resonance imaging (MRI) scan of the lumbar spine read by Dr. Gerard V. Smith, a Board-certified diagnostic radiologist, revealed moderate degenerative disc disease, facet arthritis at L4-5 without spinal foraminal stenosis, central disc herniation at L5-S1 with extensive degenerative disc disease, mild-to-moderate facet arthritis and reactive narrow changes in the adjacent vertebral bodies.

In an April 10, 2002 report, Dr. William C. Meade, a Board-certified orthopedic surgeon and an OWCP referral physician, noted appellant's history and examined appellant. Reflexes in the lower extremities were equal and no clonus. Sensation in the left L5 distribution was decreased and it was possible his extensor hallucis longus on the left side was weak. Dr. Meade noted that the straight leg test was positive at 80 degrees causing left buttocks pain. He noted that appellant was able to touch his toes, with his knees bent to six inches off the floor. Dr. Meade also found that appellant had 10 degrees of extension and a lateral bend of 15 degrees both ways.

On April 1, 2010 appellant filed a claim for a schedule award. He submitted a January 18, 2010 report from Dr. David Weiss, an osteopath,[3] who described the history of injury and examined appellant. Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (6th ed. 2009) (*hereinafter,* A.M.A., *Guides*), he rated 36 percent impairment to the left leg. Appellant complained of daily and constant low back pain and stiffness. He had radicular pain into the bilateral lower extremities, left greater than right, with numbness and tingling into the left lower extremity and foot. Appellant had difficulty with household chores and caring for his children but did not have any difficulty with his self-care. He could sit and stand comfortably for five minutes but had difficulty when walking more than 20 minutes and sleeping. Appellant also had difficulty with climbing stairs, going from a seated to a standing position, repetitive bending and twisting and lifting more than 50 pounds. This resulted in him no longer being able to engage in basketball, golf, working out at the gym or prolonged driving. Dr. Weiss explained that appellant had a pain level from 2 to 8 out of 10 involving the lumbar spine as objectified by using the visual analogue scale. The Pain Disability Questionnaire (PDQ) revealed a raw score of 71, which was equivalent to a moderate pain disability. Appellant ambulated with a slapping gait with the left leg consistent with early drop foot pathology. The lumbar spine had muscle spasm and tenderness over the posterior midline and posterior superior iliac spine had tenderness bilaterally. There was also tenderness at the

[2] Appellant has a prior claim No.xxxxxx112 for a low back injury on March 1, 1991. He was treated conservatively with physical therapy.

[3] Dr. Weiss also provided findings for the right lower extremity.

L4-5 and L5-S1 facet joints. Appellant had found forward lumbar flexion of 50 degrees, backward extension of 15 degrees and left lateral flexion of 10 degrees. All ranges of motion had pain at the extremes. The sitting root sign was positive on the left at 35 degrees producing radicular pain down the left leg. Straight leg raising was positive on the left at 75 degrees producing radicular pain down the left leg. The extensor hallucis longus was graded at 4/5 motor strength on the left. Manual muscle strength testing of the legs revealed the hip flexors were graded at 3/5 on the left while the gastrocnemius was graded at 4/5 on the left. Semmes-Weinstein monofilament testing revealed a diminished sensibility at 4.31 milligrams over the S1 dermatome on the left. Dr. Weiss diagnosed chronic post-traumatic lumbosacral strain and sprain, herniated nucleus pulposus L5-Sl, right lumbar radiculopathy, post-traumatic lumbar facet joint syndrome superimposed upon preexisting age-related facet joint arthropathy and left foot drop. He noted appellant's symptoms, including radicular pain into both legs, greater on the left and numbness and tingling into the left leg to the foot.

Dr. Weiss attributed appellant's findings to his accepted conditions and rated appellant for peripheral nerve impairment. He utilized the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[4] Dr. Weiss determined that appellant had a class 1 severe sensory deficit for the left L5 and S1 nerve roots (sciatic), which was equivalent to 12 percent.[5] He utilized grade modifiers based on Functional History (GMFH) of 2 based on the PDQ score of 71. Dr. Weiss utilized a grade modifier of 2 based on Clinical Studies (GMCS) and determined that appellant had 14 percent impairment to the left lower extremity after net adjustment. For the left gastrocnemius/extensor, hallucis longus (sciatic), he advised that appellant had a class 1 and IV/V motor strength deficit or a 12 percent left lower extremity impairment.[6] Dr. Weiss advised that appellant fell into a class 2 with a 3 out of 5 for motor strength deficit left hip flexors and warranted a 14 percent left lower extremity impairment after net adjustment.[7] He combined the values and determined that final impairment to the left lower extremity was equal to 36 percent. Dr. Weiss opined that appellant reached maximum medical improvement on January 18, 2010.

In a report dated November 9, 2010, Dr. Christopher R. Brigham, Board-certified in occupational medicine and an OWCP medical adviser, noted appellant's history and reviewed the report of Dr. Weiss. He utilized the A.M.A., *Guides* and determined that appellant reached maximum medical improvement on April 10, 2002, the date of Dr. Meade's evaluation. Dr. Brigham explained that Dr. Weiss' objective findings did not support his rating. He noted

[4] A.M.A., *Guides* 521.

[5] *Id*. at 535.

[6] *Id.*

[7] *Id.*

that evaluating spinal nerve impairment (such as radiculopathy affecting the extremities) under the A.M.A., *Guides* was discussed in the July/August issue of *The Guides Newsletter*.[8] Dr. Brigham explained that the A.M.A., *Guides* did not provide a separate approach to rating spinal nerve impairments affecting the extremities but that the proposed tables in the newsletter provided a process for such a rating. He explained that "[t]he proposed new tables provided values for rating spinal nerve impairment by means of the process defined for the [s]ixth [e]dition in rating peripheral nerve injuries. Due to the need for consistency with the [s]ixth [e]dition's Chapter 17, The Spine and Pelvis, all impairment values are class 1." Dr. Brigham noted that page 430 of the A.M.A., *Guides* explained the process for the upper extremity and noted that the lower extremity process was similar. For the left leg, he determined that the findings were not consistent. Dr. Brigham advised that in an earlier report, Dr. Meade reported that appellant had decreased sensation in the left L5 distribution as well as 4+/5 weakness of the extensor hallucus longus. He explained it was reasonable to assign impairment for mild sensory and motor deficits due to the L5-S1 disc herniation. For motor deficits, Dr. Brigham referred to Proposed Table 2, Spinal Nerve Impairment: Lower Extremity Impairments. He noted that appellant was a class 1, for mild motor deficit related to the 4+/5 weakness of the extensor hallucus longus with a default impairment of five percent of the leg. Dr. Brigham referred to section 16.3a, Adjustment Grid -- Functional History and Table 16-6, Functional History Adjustment -- Lower Extremities, and determined that, based on the PDQ score of 71, appellant was assigned a grade modifier 2.[9] He referred to section 16.3b, Adjustment Grid -- Physical Examination, and advised that physical examination adjustment was excluded since this factor was used to place in the correct diagnostic class.[10] Dr. Brigham referred to section 17.3c, Adjustment Grid -- Clinical Studies, and Table 16.8, Clinical Studies Adjustment -- Spine, and advised that appellant was assigned a grade modifier 1, based on imaging studies confirming mild pathology with disc injury and L5 nerve pathology.[11] He concluded that appellant had a functional history grade modifier 2, physical examination N/A and clinical studies grade modifier 1. Dr. Brigham determined that net adjustment compared to diagnosis class 1 equated to +1, which warranted a grade D and translated into seven percent left leg impairment for motor deficit.

For sensory deficit, Dr. Brigham referred to Proposed Table 2, Spinal Nerve Impairment, and utilized a class 1 rating for mild sensory deficit related to the diminished sensation in the L5 distribution, and advised that this translated to a default impairment of one percent left leg impairment. He referred to section 16.3a, Adjustment Grid -- Functional History, and Table 16-6, Functional History Adjustment -- Lower Extremities[12] and advised that appellant was not

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibit 1, 4). Exhibit 1 provides that impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article Rating Spinal Nerve Extremity Impairment using the sixth edition in the July-August 2009 edition of *The Guides Newsletter* published by the American Medical Association. The July-August 2009 edition of *The Guides Newsletter* is set forth at exhibit 4.

[9] A.M.A., *Guides* 516.

[10] *Id.* at 517.

[11] *Id.* at 518, 519.

[12] *Id.* at 516.

assigned a grade modifier as this was already used in the motor adjustment. Regarding, section 16.3b, Adjustment Grid -- Physical Examination,[13] Dr. Brigham noted that physical examination adjustment was excluded as this factor was used to place in the correct diagnostic class. He referred to section 17.3c, Adjustment Grid -- Clinical Studies and Table 16.8, Clinical Studies Adjustment -- Spine, and explained that appellant was assigned grade modifier 1, based on imaging studies confirming mild pathology with disc injury and L5 nerve pathology.[14] Dr. Brigham determined that the net adjustment compared to diagnosis class 1 was 0, which was equivalent to a grade C and translated into one percent leg impairment. He combined the seven percent leg impairment for motor deficits and one percent leg impairment for sensory deficits to arrive at eight percent impairment of the left lower extremity.[15]

On November 24, 2010 OWCP granted appellant a schedule award for eight percent permanent impairment of the left leg. The award covered a period of 23.04 weeks from April 10 to September 18, 2002.

In a letter dated December 20, 2010, appellant's representative requested a telephonic hearing, which was held on April 4, 2011.

In a December 17, 2010 report, Dr. Weiss disagreed with the findings of Dr. Brigham. He noted that, while permanent impairment evaluation must be performed in accordance with the A.M.A., *Guides*, Dr. Brigham used *The Guides Newsletter* to calculate impairment. He suggested that it was not the appropriate standard to evaluate schedule losses. Dr. Weiss noted that OWCP's medical adviser relied on Dr. Meade's April 10, 2002 findings. He further noted that Semmes-Weinstein monofilament testing was not performed to ascertain the degree of sensory deficit and a mild sensory deficit was arbitrarily assigned by the medical adviser to calculate the sensory impairment in the left leg. Dr. Weiss noted that he agreed regarding the grade modifier for functional history. Regarding clinical studies, he noted that OWCP's medical adviser found a grade 1, whereas he believed that appellant was a grade 2 based on the need to undergo anterior lumbar underbody fusion. Dr. Weiss opined that his January 18, 2010 findings were valid and in accordance with the A.M.A., *Guides*.

In a May 9, 2011 decision, an OWCP hearing representative affirmed the November 24, 2010 decision.[16] He found that Dr. Brigham properly applied the A.M.A., *Guides* and that his opinion represented the weight of the medical evidence.

[13] *Id.* at 517.

[14] *Id.* at 518 and 519.

[15] Dr. Brigham determined that there was no impairment on the right leg.

[16] OWCP's medical adviser also noted that appellant had claimed a schedule award for the right lower extremity; but advised that OWCP had not issued a decision regarding this.

LEGAL PRECEDENT

The schedule award provision of FECA,[17] and its implementing federal regulations,[18] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[19] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[20] For decisions issued after May 1, 2009, the sixth edition will be used.[21]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[22] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[23]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter* offers an approach to rating spinal nerve impairments consistent with sixth edition methodology.[24] OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[25]

ANALYSIS

In support of his claim for a schedule award, appellant provided reports dated January 18 and December 17, 2010 from Dr. Weiss who examined appellant and provided an impairment rating of 36 percent for the left leg. Dr. Weiss based his impairment calculation upon peripheral nerve impairments at Table 16-12.[26] However, the sixth edition of the A.M.A., *Guides* provides

[17] 5 U.S.C. § 8107.

[18] 20 C.F.R. § 10.404.

[19] *Id*. at § 10.404(a).

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[21] FECA Bulletin No. 09-03 (issued March 15, 2009).

[22] A.M.A., *Guides* 494-531; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[23] A.M.A., *Guides* 521.

[24] *L.J.*, Docket No. 10-1263 (issued March 3, 2011).

[25] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[26] A.M.A., *Guides* 535.

a specific methodology for rating spinal nerve extremity impairment.[27] It was designed to be used when a particular jurisdiction mandated ratings for extremities and precluded ratings for the spine.[28] The Board notes that Table 16-12, Peripheral Nerve Impairment, is not the preferred method adopted by OWCP for rating the lower extremities due to spinal nerve impairment. OWCP's medical adviser explained that Dr. Weiss did not utilize the July/August issue of *The Guides Newsletter*.[29] The Board notes that this is also addressed in section 16.4c Peripheral Nerve Rating Process.[30] While Dr. Weiss questioned why the newsletter was used to rate impairment, OWCP has, as noted, adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[31] Board precedent is well settled that when an attending physician's report gives an estimate of impairment but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP is correct to follow the advice of its medical adviser or consultant where he has properly applied the A.M.A., *Guides*.[32]

Dr. Brigham explained his findings for the left lower extremity in his November 9, 2010 report. As noted, he discussed why he evaluated spinal nerve impairments to the left leg under the July/August issue of *The Guides Newsletter*. For the left lower extremity, Dr. Brigham had mild sensory and motor deficits in the L5 distribution. For motor deficits, he referred to Proposed Table 2, Spinal Nerve Impairment: Lower Extremity Impairments. In section 16.3a, Adjustment Grid -- Functional History, and Table 16-6, Functional History Adjustment -- Lower Extremities, based on the PDQ score of 71 appellant was assigned a grade modifier 2.[33] Dr. Brigham referred to section 16.3b, Adjustment Grid -- Physical Examination, and noted that Physical Examination Adjustment was excluded as it was used to place in the correct diagnostic class.[34] He referred to section 17.3c, Adjustment Grid -- Clinical Studies, and Table 16.8, Clinical Studies Adjustment -- Spine, and advised that appellant was assigned a grade modifier 1, based on imaging studies confirming mild pathology with disc injury and L5 nerve pathology.[35] Dr. Brigham concluded that appellant had a functional history grade modifier 2, physical examination N/A, and clinical studies grade modifier 1. Dr. Brigham determined that the net adjustment compared to diagnosis class 1 is +1, which warranted a grade D and translated into seven percent lower extremity impairment.

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[27] *Supra* note 25.

[28] *Id.*

[29] Rating Spinal Nerve Extremity Impairment using the sixth edition, *The Guides Newsletter* (A.M.A., Chicago, IL), July/August 2009. *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibit 1, 4). Exhibit 1.

[30] A.M.A., *Guides* 533.

[31] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibit 1, 4); *T.T.*, Docket No. 10-880 (issued November 9, 2010).

[32] *J.Q.*, Docket No. 06-2152 (issued March 5, 2008); *Laura Heyen*, 57 ECAB 435 (2006).

[33] A.M.A., *Guides* 516.

[34] *Id.*at 517.

[35] *Id.* at 518-19.

Regarding a sensory deficit, Dr. Brigham explained that in Proposed Table 2, Spinal Nerve Impairment, there was a class 1 rating for mild sensory deficit related to the diminished sensation in the L5 distribution, which translated to a default impairment of one percent of the leg. He referred to section 16.3a, Adjustment Grid - Functional History, and Table 16-6, Functional History Adjustment -- Lower Extremities[36] and advised that appellant was not assigned a grade modifier as this was used in the motor adjustment. Regarding, section 16.3b, Adjustment Grid -- Physical Examination,[37] Dr. Brigham noted that physical examination adjustment was excluded as this was used to place in the correct diagnostic class. He referred to section 17.3c, Adjustment Grid -- Clinical Studies and Table 16.8, Clinical Studies Adjustment -- Spine, advised that appellant was assigned grade modifier 1, based on imaging studies confirming mild pathology with disc injury and L5 nerve pathology.[38] Dr. Brigham determined that the net adjustment compared to diagnosis class 1 was 0, which was equivalent to a grade C and translated into one percent lower extremity impairment. He combined the seven percent impairment for motor deficits and one percent for sensory deficits on the left to arrive at eight percent left leg impairment.[39] The Board finds that Dr. Brigham's November 9, 2010 report properly applied the findings of Dr. Weiss to the A.M.A., *Guides,* and establishes that appellant has no more than an eight percent permanent impairment of his left lower under the sixth edition of the A.M.A., *Guides*.

On appeal, appellant's representative contends that Dr. Weiss' opinion was sufficient to create a conflict in the medical evidence. However, his opinion did not comport with the A.M.A., *Guides.* Thus, Dr. Weiss' report is insufficient to create a conflict.[40] Appellant's representative also argued that no decision had been rendered on the right lower extremity. The Board notes that as no decision has been rendered, it cannot address this issue on appeal.[41]

Appellant may request a schedule award or increased 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 has not met his burden of proof to establish that he has more than an eight percent permanent impairment of his left lower extremity, for which he received a schedule award.

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[36] *Id.* at 516.

[37] *Id.* at 517.

[38] *Id.* at 518-19.

[39] *Id*. at 604.

[40] *See John D. Jackson*, 55 ECAB 465 (2004) (a simple disagreement between two physicians does not, of itself, establish a conflict; to constitute a conflict of medical opinion, the opposing physicians' reports must be of virtually equal weight and rationale).

[41] 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the May 9, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 5, 2012
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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