United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant **and** **DEPARTMENT OF THE ARMY, LETTERKENNY ARMY DEPOT, Chambersburg, PA, Employer**	**Docket No. 12-1242** **Issued: April 11, 2013**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 11, 2012 appellant filed a timely appeal from an April 11, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) denying medical treatment and a May 10, 2012 merit decision which denied an additional 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.

ISSUES

The issues are: (1) whether appellant sustained a recurrence of his accepted February 10, 2006 work injury requiring medical treatment; and (2) whether appellant has established that he sustained permanent impairment of the lower extremities due to his accepted work injury.[2]

---

[1] 5 U.S.C. § 8101 *et seq.*

[2] On appeal appellant has explained that his appeal concerns the denial of his schedule award for impairment of his lower extremities, due to his accepted back injury.

FACTUAL HISTORY

On March 1, 2006 appellant, then a 57-year-old electrical equipment repairer, filed a claim for traumatic injury, alleging that he sustained injuries to his shoulder and back when he fell to the floor because his chair collapsed on February 20, 2006. OWCP accepted his claim for right shoulder strain and lumbosacral strain.

On February 16, 2007 appellant filed a claim for schedule award.

In a June 1, 2007 report, Dr. Bruce Edwards, a Board-certified orthopedic surgeon, indicated that appellant had reached maximum improvement. He also opined that appellant had sustained a nine percent permanent impairment of his right upper extremity.

Appellant also submitted a June 20, 2007 report from Dr. Daniel Sullivan, a Board-certified physician in physical medicine and rehabilitation, which indicated that he had a six percent whole-person impairment due to his back condition.

By decision dated September 11, 2007, OWCP accepted appellant's schedule award claim for nine percent permanent impairment of the right upper extremity, but declined to grant a schedule award for his lower extremities on the grounds that the medical evidence failed to support that he had permanent impairment of one or both of his lower extremities.

Appellant disagreed with the schedule award decision and requested a hearing before the Branch of Hearings and Review on November 7, 2007.

In a May 19, 2008 OWCP decision, the hearing representative affirmed the September 11, 2007 decision. It noted that impairment ratings based on whole-person impairment were not a basis for rating permanent impairment of a lower extremity due to a back injury.

On June 14, 2008 appellant filed a request for reconsideration. By decision dated September 18, 2008, OWCP denied modification of the May 19, 2008 decision.

Appellant advised OWCP on October 9, 2009 that he had not received medical treatment for more than a year but wished to receive treatment due to increasing pain.

On November 13, 2009 OWCP advised appellant that his case was open for medical treatment related to the accepted work-related conditions. There is no evidence that he received any further medical treatment until 2011.

By report dated January 31, 2011, Dr. Jamal Ali, a Board-certified neurologist, noted that appellant's motor examination revealed no atrophy, the muscle bulk and tone were normal and strength was 5/5 in all extremities. He also indicated that appellant had mild tenderness at the lumbar spine. Dr. Ali stated that there was a severe decrease in vibration sensation at the toes, and a decreased pinprick sensation at the left second toe and lateral aspect of the foot. He noted appellant's work-related injury in February 2006. Dr. Ali opined that the severe impairment in the vibration sensation at the toes raises the possibility of underlying radiculopathy process with superimposed peripheral polyneuropathy.

On February 14, 2011 Dr. Ali performed electromyogram (EMG) and nerve conduction studies which showed chronic radiculopathy involving L4 and L5 as well as chronic severe sensory peripheral polyneuropathy. He recommended a magnetic resonance imaging (MRI) scan of the lumbosacral spine for further evaluation of the radiculopathy.

An MRI scan performed on April 11, 2011 showed no disc herniation, but revealed multiple disc osteophyte complexes with neural encroachment severe at L4-5 on the left and severe on the right at L3-4 and L4-5. The report was signed by Dr. Raymond Tu, a Board-certified physician in progressive radiology.

On April 25, 2011 Dr. Ali reviewed the MRI scan and the neurological studies, and diagnosed appellant with polyradiculopathy, lumbar spondylosis and diffuse sensory more than motor peripheral polyneuropathy.

Appellant filed a claim for schedule award on April 25, 2011 for permanent impairment due to his work-related lumbar condition.

In a letter dated June 1, 2011, OWCP advised appellant of the evidence needed to support his schedule award claim.

OWCP received a June 13, 2011 report from Dr. Ali wherein he stated that he was not trained to conduct final impairment ratings, but he believed that appellant had reached maximum medical improvement. Dr. Ali opined that appellant's sensory symptoms of the lower extremities could be permanent as a result of his February 10, 2006 work injury, but he could not determine the impairment rating. He also noted that appellant's lumbar MRI scan and nerve conduction studies showed evidence of lumbar root impingement and bilateral radiculopathy, and such a finding could be triggered by a fall; however, he also clarified that the finding of diffuse peripheral neuropathy was not work related. Dr. Ali further stated that appellant's examination did not show muscle weakness of the lower extremities. He recommended that the claimant be seen by a neurologist who is familiar with the A.M.A., *Guides*.

On July 21, 2011 appellant filed a notice of recurrence, claiming a recurrent need for medical treatment. He noted that he continued to suffer from symptoms from the February 10, 2006 work injury.

Along with his claim, appellant submitted a July 13, 2011 treatment note issued by Dr. Bruce Edwards, a Board-certified orthopedic surgeon, who noted that appellant's lateral elbow pain condition had improved since he had participated in physical therapy.

By letter dated August 12, 2011, OWCP requested that appellant submit additional medical evidence in support of his requested recurrence of medical treatment. In response, appellant submitted a statement dated August 18, 2011 summarizing his claims and explaining why he sought further treatment from Dr. Ali.

On September 12, 2011 OWCP denied appellant's recurrence claim on the grounds that the evidence submitted was insufficient to establish that his current medical condition was due to his accepted work injury.

Appellant disagreed with the decision and on September 26, 2011 requested an oral hearing. He submitted additional statements discussing his condition.

OWCP referred appellant for a second opinion evaluation with Dr. Robert Draper, a Board-certified orthopedic surgeon, to determine whether appellant sustained permanent impairment as a result of the February 10, 2006 work incident. Dr. Draper, in his December 1, 2011 report, discussed the history of appellant's injury and the subsequent treatment, and diagnosed him with right shoulder rotator cuff tendinopathy, acromioclavicular (AC) joint osteoarthritis, lumbosacral strain with degenerative bulging of the lumbar spine at L2-3, L3-4, L4-5, facet joint osteoarthritis L4-5, and L4-5 radiculopathy left lower extremity and right lower extremity by EMG and nerve conduction tests. He opined that appellant had reached maximum medical improvement. Under the sixth edition of the A.M.A., *Guides*, appellant had three percent permanent impairment of the right upper extremity for the diagnosis of AC joint disease, a class 1 impairment. Dr. Draper noted that appellant's net adjustment for his grade modifiers for Physical Examination (GMPE), Clinical Studies (GMCS), and Functional History (GMFH) did not change the three percent default rating for this class 1 impairment. For lumbar spine, he used *The Guides Newsletter* July/August 2009 for the sixth edition to rate appellant's spinal nerve extremity impairment. Dr. Draper stated that appellant had a class 1 impairment for L4 and L5 mild sensory deficit, which was two percent for the right and left lower extremity. He selected a mild sensory deficit because there was no real sensory deficit found on clinical examination, but appellant still had complaints of paresthesia and numbness. Dr. Draper stated that "these impairments are determined to be attributable to the work injury."

OWCP requested that Dr. Draper clarify the right shoulder impairment rating. By supplemental report dated December 15, 2011, Dr. Draper stated that appellant would have an eight percent impairment of the right upper extremity using the loss of range of motion method under Table 15-34 for his range of motion deficits. He also clarified that appellant's net adjust for his GMPE, GMCS and GMFH did not change the class 1 impairment due to his lumbar pathology.

OWCP forwarded Dr. Draper's report, along with other medical records in file, to Dr. Christopher R. Brigham, a medical consultant. By report dated December 29, 2011, Dr. Brigham agreed with Dr. Draper's opinion that appellant had an eight percent permanent impairment in his right upper extremity. He disagreed with Dr. Draper's impairment rating for appellant's lower extremities. Dr. Brigham noted that, before an impairment rating is decided, it must first be determined if there is verifiable radiculopathy, and whether or not any residual sensory or motor deficits exist. He noted that Dr. Draper had found normal motor and sensory examination findings and that appellant's lumbar MRI scan did not reveal any disc herniation or stenosis that impinged on a spinal nerve root. Dr. Draper's diagnosis of lumbar radiculopathy was based on the result of electrodiagnostic tests, but these tests alone were not sufficient to support a diagnosis of verifiable lumbar radiculopathy under the sixth edition. As he noted normal sensory and motor findings, the clinical findings did not support impairment of the lower extremities.

By decision dated January 9, 2012, OWCP again denied appellant's claim for a schedule award of his lower extremities or for an additional award of the right arm.

On January 17, 2012 appellant disagreed with the January 9, 2012 schedule award decision and requested a review of the written record.

On February 16, 2012 OWCP conducted a telephone hearing with appellant with regard to his recurrence of medical treatment claim. During the hearing, appellant testified that he sustained a lumbar condition on February 10, 2006 when the chair he was sitting in broke and he fell to the floor, landing on his lower back and shoulder. He stated that he received treatment for his lumbar condition and was diagnosed with a lumbosacral strain, and that he continued to have numbness and tingling in his lower extremities. Appellant also indicated that he did not receive any treatment between 2007 and 2011 for his back or shoulder as it was not allowed by his claims examiner. He further stated that he had no intervening injuries to his shoulder or lower back between 2007 and 2011. OWCP held the record open for 30 days following the hearing.

In an April 11, 2012 decision, OWCP denied appellant's claim of recurrence of medical treatment on the grounds that appellant failed to submit sufficient evidence to support his need for medical treatment subsequent to January 2011 causally related to and necessitated by the February 10, 2006 work injury.

On May 10, 2012 OWCP found that appellant had not submitted any probative medical evidence to establish that he has sustained greater permanent impairment than what he had already been awarded for his accepted work injury to his right shoulder, and that he had not established that he had any permanent impairment of the lower extremities causally related to the accepted injury.

LEGAL PRECEDENT -- ISSUE 1

In a claim for recurrence, this burden of proof requires that a claimant establish the causal relationship of the claimed recurrence to the previously accepted injury.[3] A recurrence of medical condition means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a need for further medical treatment after release from treatment, nor is an examination without treatment.[4]

For recurrences of medical conditions, the claimant must provide medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.[5] Where no such rationale is present, the medical evidence is of limited probative value.[6] The claimant must also furnish medical evidence of bridging symptoms

[3] Federal (FECA) Procedural Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.2 (September 2010).

[4] 20 C.F.R. § 10.5(y).

[5] *Robert H. St. Onge*, 43 ECAB 1169 (1992); *Dennis J. Lasanen*, 43 ECAB 549 (1992).

[6] *Mary A. Ceglia*, 55 ECAB 626 (2004); *Albert C. Brown*, 52 ECAB 152 (2000).

between the present condition and the accepted injury which support the physician's conclusion of a causal relationship.[7]

ANALYSIS -- ISSUE 1

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

OWCP's April 11, 2012 decision denied appellant's recurrence of a medical condition on the grounds that Dr. Ali's medical reports diagnosed polyradiculopathy, lumbar spondylosis and diffuse sensory and motor peripheral polyneuropathy, while OWCP had only accepted a lumbar sprain. It found that Dr. Ali failed to provide a well-rationalized medical opinion as to whether appellant's current conditions, for which he sought further medical treatment, were related to the accepted employment injury.

The Board notes that OWCP failed to consider the December 1, 2011 medical report from its second opinion physician, Dr. Draper, who diagnosed appellant with a lumbosacral strain with degenerative bulging of the lumbar spine at L2-3, L3-4, L4-5, facet joint osteoarthritis L4-5, and L4-5 radiculopathy left lower extremity and right lower extremity. Dr. Draper opined generally that the impairments were determined to be attributable to the work injury. The Board notes that when OWCP referred appellant to Dr. Draper on November 4, 2011, it only requested that he address the degree of appellant's permanent impairment. Dr. Draper was not asked to address whether appellant required further medical treatment as a result of the accepted injury.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[8] While the claimant has the burden to establish entitlement to compensation, it shares responsibility in the development of the evidence to see that justice is done.[9] OWCP should have sought further clarification of his opinion, if necessary, to determine whether the diagnosed conditions were causally related to the accepted injury and whether they required further medical care. Dr. Ali and Dr. Draper's reports constitute substantial, uncontradicted evidence in support of appellant's claim and are sufficient to require that the case be remanded for further development of the claim.[10]

---

[7] *C.W.*, Docket No. 07-1816 (issued January 16, 2009); *Ricky S. Storms*, 52 ECAB 349 (2001).

[8] *Phillip L. Barnes*, 55 ECAB 426 (2004).

[9] *Donald R. Gervasi*, 57 ECAB 281(2005); *William B. Webb*, 56 ECAB 156 (2004).

[10] *Cheryl A. Monnell*, 40 ECAB 545 (1989); *Bobby W. Hornbuckle*, 38 ECAB 626 (1987); *Horace Langhorne*, 29 ECAB 820 (1978).

LEGAL PRECEDENT -- ISSUE 2

The schedule award provision of FECA[11] and its implementing regulations[12] 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[13] For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[14] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[15]

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by GMFH, GMPE and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that he sustained a permanent impairment of the lower extremities caused by the accepted employment injury.

Appellant's claim has been accepted for lumbar sprain. Neither FECA nor the regulations provide for a schedule award for loss of use of the back or to the body as a whole. However, the schedule award provisions of FECA include the extremities and a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of such impairment originates in the spine.[18]

Dr. Tu's April 11, 2011 MRI scan noted that appellant had multiple disc osteophyte complexes with neural encroachment severe at several locations. Dr. Ali in his June 13, 2011 medical report diagnosed appellant with lumbar root impingement and bilateral radiculopathy, based upon appellant's lumbar MRI scan and nerve conduction studies. He opined that these

---

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

[13] *See Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[14] *See Ronald R. Kraynak*, 53 ECAB 130 (2001).

[15] 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).

[16] A.M.A., *Guides* 494-531.

[17] *Id*. at 521.

[18] *J.Q*., 59 ECAB 366 (2008).

findings could be triggered by a fall; however, he also clarified that the finding of diffuse peripheral neuropathy was not work related. Dr. Ali did not provide an impairment rating as he related that he was not properly trained to do so.

Dr. Draper's December 1, 2011 report diagnosed appellant with lumbosacral strain with degenerative bulging of the lumbar spine at L2-3, L3-4, L4-5, facet joint osteoarthritis L4-5 and L4-5 radiculopathy left lower extremity and right lower extremity. He found two percent permanent impairment for his right and left lower extremities. He opined that these conditions were causally related to appellant's accepted injury. Dr. Draper noted, however, that sensory and motor examinations were normal. He explained that he had selected mild sensory deficit because there was no real sensory deficit on clinical examination, but appellant still complained of numbness and paresthesias.

Dr. Brigham, a medical consultant, noted in a December 29, 2011 report that appellant's lumbar MRI scan did not reveal any evidence of a disc herniation or stenosis that impinged on any spinal nerve root. Dr. Draper's diagnosis of lumbar radiculopathy was based on the result of electrodiagnostic tests, but the tests alone were not sufficient to verify lumbar radiculopathy. He explained that the sixth edition of the A.M.A., *Guides* at page 576, required that the diagnosis of radiculopathy required additional clinical findings of specific dermatomal distributions of pain, numbness, and/or parasthesias. Since subjective sensory changes were more difficult to assess, these should be supported by other finding of radiculopathy. As 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 radiologic findings to be considered. Dr. Brigham concluded that, as Dr. Draper had reported normal sensory examination findings, the tests of February 14, 2011, alone, did not verify lumbar radiculopathy.

The Board finds that the report from Dr. Brigham is well rationalized and represents the weight of the medical evidence. Appellant has not met his burden of proof to establish that he sustained a verifiable lower extremity radiculopathy, causally related to his accepted work injury. The Board therefore finds that appellant has not established that he is entitled to a schedule award for permanent impairment of his lower extremities.

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 the case must be remanded to OWCP for further development of the medical evidence regarding appellant's request for further medical treatment. The Board also finds that appellant has not established that he is entitled to a schedule award for permanent impairment of his lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 10, 2012 is affirmed. The April 11, 2012 OWCP decision is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: April 11, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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