United States Department of Labor
Employees' Compensation Appeals Board

E.L., Appellant	)	
and	)	**Docket No. 12-259**
	)	**Issued: January 4, 2013**
U.S. POSTAL SERVICE, BELLMAWR CARRIER ANNEX, Bellmawr, NJ, Employer	)	

Appearances:
Thomas R. Uliase, 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 November 17, 2011 appellant, through his attorney, filed an appeal from the September 1, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied 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 the claim.[2]

ISSUE

The issue is whether appellant sustained permanent impairment of the lower extremities due to his accepted lumbar condition.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The record includes evidence received after the September 1, 2011 decision. As this evidence was not part of the record when OWCP issued its decision, the Board is precluded from considering it for the first time on appeal. 20 C.F.R. § 501.2(c).

FACTUAL HISTORY

Appellant, a 38-year-old letter carrier, has an accepted claim for a herniated disc at L3-4, which arose on or about July 25, 2002.[3] On December 29, 2008 he filed a claim for a schedule award. In a report dated September 24, 2009, Dr. Steven M. Allon, a Board-certified orthopedic surgeon, rated 39 percent bilateral lower extremity peripheral nerve impairment based on combined motor/sensory deficits involving the sciatic nerve and motor deficit involving the femoral nerve.[4] He stated that the rating was based on Table 16-12, Peripheral Nerve Impairment, Lower Extremity Impairment, A.M.A., *Guides to the Evaluation of Permanent Impairment* 534-35 (6th ed. 2008).

Dr. Andrew A. Merola, a district medical adviser, reviewed the evidence and disagreed with the impairment rating by Dr. Allon. In an April 18, 2010 report, he explained that the femoral nerve principally involved the L3 nerve root, which was reportedly outside appellant's diagnostic criteria. With respect to the sciatic nerve root impairment, Dr. Merola noted that combined motor/sensory deficits of 25 percent to the right lower extremity and 23 percent to the left.

OWCP referred appellant for a second opinion evaluation to Dr. Robert F. Draper, a Board-certified orthopedic surgeon, for an opinion on the extent of permanent impairment to the lower extremities due to the accepted back condition. Dr. Draper examined appellant on August 5, 2010 and reviewed the diagnostic studies of record. A magnetic resonance imaging (MRI) scan of 2002 showed a central herniated disc at L4-5, with disc dessication at L4-5 and L5-S1. A study of 2005, showed a transitional vertebrae that represented sacralization of L4, with a tiny central disc herniation at L4-5 due to degenerative disc disease. Dr. Draper noted that appellant underwent 12 radiofrequencey ablation procedures to relieve pain which provided temporary relief. Appellant declined surgery for his lumbar condition. On examination, he noted normal lumbar lordosis and palpation of the spinal midline did not elicit pain. The paraspinal musculature was non tender. Dr. Draper found that motor strength in the lower extremities was full and equal and straight leg raising tests were negative bilaterally at 90 degrees. Reflex testing of the lumbar nerve roots was found to be normal in both legs. Dr. Draper found that appellant had reached maximum medical improvement as of January 2007 with no decrease in strength, atrophy, anklosis or sensory changes or deficits. He found that appellant had a history of paresthesias in the lower extremities consistent with lumbar radiculopathy at S1. Applying the A.M.A., *Guides*, Table 16-12, appellant had one percent impairment of each leg due to mild sensory deficit of the common peroneal nerve.

[3] OWCP also accepted that appellant sustained recurrences of disability on March 8 and April 6, 2006. On December 7, 2006 appellant sustained an employment-related traumatic injury which OWCP accepted for lumbar sprain (xxxxxx856).

[4] Dr. Allon examined appellant on September 9, 2008 and initially provided an impairment rating under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2001). OWCP later asked appellant's counsel to submit an impairment rating under the sixth edition of the A.M.A., *Guides* (2008).

Based on the differing impairment ratings by Dr. Allon and Dr. Draper, OWCP found a conflict in medical opinion and referred appellant to Dr. Roy B. Friedenthal, a Board-certified orthopedic surgeon, selected as the impartial medical specialist.

In a January 5, 2011 report, Dr. Friedenthal reviewed the history of injury, statement of accepted facts and provided a thorough review of the medical treatment records. He noted that surgery had been recommended but declined in favor of conservative treatment and radiofrequency lesioning. Dr. Friedenthal examined appellant on November 9, 2010 and noted a well-developed 36-year-old male who ambulated with a normal gait, stood at 5'8" and weighed 225 pounds. The back showed no spinal deformity with range of motion and side bending performed with complaint of pain. Tenderness to light touch was reported in the lumbar and sacral regions without anatomic pattern. There was no parathoracic or paralumbar muscle spasm and appellant was able to toe and heel walk. Straight leg raising produced complaint of low back pain at 45 degrees without a radicular component. Sitting root testing was negative bilaterally and was the Bragard sign. Neurologic evaluation of the lower extremities revealed no sensory deficit in any distribution and motor testing was characterized by give-way weakness in both lower extremities. At times, full contraction could be elicited with distraction techniques and no focal myotomal deficit was evident. Dr. Friedenthal characterized the apparent weakness as clearly under voluntary control. Deep tendon reflexes were full and symmetric

Review of the diagnostic imaging studies revealed probable transitional disc space narrowing at L5-S1 with mild hypertrophic changes. There were degenerative end plate changes at L4-5 with no root compression. No acute bony or soft tissue changes were seen. A post-discography CT scan of 2005 revealed no clear injection at the narrowing L5-S1 level with cleavage at L4-5. The annular discs were maintained and mild facet degeneration noted at L4-5 and L2-3. Normal discs were identified with no focal herniation noted. An MRI scan of March 22, 2005 noted at L4-5, a mild central herniation of disc with tiny extruded disc material. There was no gross compression of the thecal sac or neural foramina. Desiccation of disc material secondary to degenerative change was noted. No nerve root compression was identified. A May 18, 2006 EMG and nerve conduction studies listed a history of back pain radiating to the left greater than right. Examination found normal bulk and tone with equal and symmetric reflexes. No sensory deficit was reported. The study indicated that the EMG abnormalities were trivial and did not meet the criteria for radiculopathy. The findings were suspicious, however, for radiculopathy affecting the left L4 nerve root distribution with no EMG evidence of general neuropathy.

Dr. Friedenthal noted that, while appellant described significant complaints of low back pain of variable intensity, radiculopathy was not confirmed on clinical evaluation. The radiographic studies did not demonstrate significant central canal or root compression and EMG did not reveal evidence of radiculopathy or peripheral neuropathy. The studies revealed degenerative changes to the spine without evidence of any annular ligament disruption. The changes found were consistent with the degenerative disc process and did not imply traumatic origin. Dr. Friedenthal stated that, other than Dr. Allon, none of the examining physicians had found objective evidence of neurologic impairment. He stated that the variable weakness described was a subjective finding that reflected voluntary factors. There was no evidence of muscle atrophy, dermatomal sensory loss and no reflex asymmetry found. Dr. Friedenthal noted that his clinical findings were consistent with those of prior examining physicians, with the

exception of Dr. Allon. He stated that his clinical assessment was in line with that made by Dr. Draper; however, there was no evidence of peripheral nerve impairment. Dr. Friedenthal commented that Dr. Draper incorrectly used Table 16-12 of the A.M.A., *Guides* to address subjective complaints in the absence of objective deficit. He concluded that appellant did not sustain any permanent impairment of the lower extremities based on the accepted lumbar condition. Dr. Friedenthal found that appellant reached maximum medical improvement as of April 6, 2006.

On January 24, 2011 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the medical record. He concurred with Dr. Friedenthal's rating of zero (0) percent impairment to the lower extremities. Dr. Magliato noted that Dr. Friedenthal's examination found no objective neurological deficit to the lower extremities and no permanent impairment.

By decision dated February 23, 2011, OWCP denied appellant's claim for a schedule award.

Appellant requested a hearing before an OWCP hearing representative. In a note dated June 15, 2011, Dr. David Weiss, a Board-certified orthopedic surgeon, stated his disagreement with Dr. Friedenthal's conclusion with respect to motor and sensory deficit. He expressed support for the impairment rating of his associate, Dr. Allon, on September 9, 2008.[5]

After conducting a hearing on June 21, 2011, the Branch of Hearings & Review issued a September 1, 2011 decision affirming the denial of a schedule award.

LEGAL PRECEDENT

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.[6] 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 under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[8]

[5] Dr. Weiss and Dr. Allon, who authored the September 9, 2008 report, are associated at Regional Independent Medical Evaluations. Dr. Weiss did not state that he examined appellant prior to preparation of his June 15, 2011 note.

[6] 5 U.S.C. § 8107(c).

[7] 20 C.F.R. § 10.404.

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010). For a total or 100 percent loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

No schedule award is payable for a member, function or organ of the body that is not specified in FECA or the implementing regulations.[9] Neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[10] However, a schedule award is permissible where the employment-related back condition affects the upper and/or lower extremities.[11]

FECA provides that, if there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[12] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[13] Where OWCP has referred the employee to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[14]

ANALYSIS

Appellant's claim for a low back injury was accepted by OWCP for a herniated disc at L3-4. In 2008, he filed a claim for a schedule award for permanent impairment of his legs. In support of his claim, appellant submitted an impairment rating by Dr. Allon, who rated 39 percent impairment to both legs based on sensory and motor loss involving the sciatic and femoral nerves. Dr. Merola, a medical adviser, reviewed the report and disagreed with rating methodology used by Dr. Allon. Appellant was thereafter referred to Dr. Draper for a second opinion examination. On August 5, 2010 Dr. Draper set forth findings on examination and rated a Class 1, mild sensory deficit involving the common peroneal nerve of one percent to each lower extremity. OWCP properly found a conflict in medical opinion between Dr. Allon, for appellant, and Dr. Draper, for the government. It referred appellant to Dr. Friedenthal, a Board-certified orthopedic surgeon, for an impartial medical examination on the issue of permanent impairment.

Dr. Friedenthal examined appellant on November 9, 2010 and provided a thorough review of the medical records from each examining physician and the diagnostic studies. He reviewed the statement of accepted facts and noted that appellant had declined surgery in favor of conservative treatment and facet injections. On examination, the back showed no spinal deformity with range of motion and side bending performed with complaint of pain. Tenderness to light touch was reported in the lumbar and sacral regions without an anatomic distribution

[9] *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

[10] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a(3) (January 2010).

[12] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The district medical adviser, acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

[13] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[14] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

pattern. There was no parathoracic or paralumbar muscle spasm and appellant was able to toe and heel walk. The neurologic evaluation of the lower extremities revealed no sensory deficit in any nerve distribution and motor testing was characterized by give-way weakness. At times, full contraction could be elicited with distraction techniques and no focal myotomal deficit was evident. Dr. Friedenthal characterized the apparent weakness as under appellant's voluntary control. Deep tendon reflexes were full and symmetric. While appellant described significant complaints of low back pain of variable intensity, radiculopathy was not confirmed on clinical evaluation. The radiographic studies did not demonstrate significant central canal or root compression and EMG did not reveal evidence of radiculopathy or peripheral neuropathy. He concluded that appellant did not sustain any permanent impairment of the lower extremities based on the accepted lumbar disc condition and stated that maximum medical improvement was reached on April 6, 2006. Based on this opinion, OWCP found that appellant did not sustain any permanent impairment of his lower extremities.

On appeal, counsel contested the medical opinion of Dr. Friedenthal. The Board finds that the special weight of medical opinion is represented by the report of the impartial medical specialist,[15] who provided a thorough review of the medical evidence of record, including the impairment evaluation by Dr. Allon and Dr. Draper. The impartial medical specialist set forth findings on examination of appellant and found that the subjective complaints were not supported by objective evidence of radiculopathy into either lower extremity due to the accepted disc herniation at L3-4.

Appellant may submit new evidence of argument relevant to his impairment with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. §8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not established that he sustained impairment to his lower extremities based on his accepted lumbar condition.

[15] *See Phillip H. Conte*, 56 ECAB 213 (2004).

ORDER

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

Issued: January 4, 2013
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