United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 12-1626**
	)	**Issued: March 13, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Fort Monmouth, NJ, Employer	)	

Appearances:
Capp P. Taylor, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 26, 2012 appellant filed a timely appeal from a May 9, 2012 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 the case.

ISSUE

The issue is whether appellant has more than three percent impairment of his right and left lower extremities for which he received a schedule award.

FACTUAL HISTORY

On December 5, 2003 appellant, then a 61-year-old program analyst injured his back when he slipped on ice while in the performance of duty. He stopped work on December 8, 2003

[1] 5 U.S.C. §§ 8101-8193.

and returned to work full duty on May 5, 2004. OWCP accepted appellant's claim for lumbosacral sprain/strain, spondylolisthesis at L5-S1 and spondylosis at L5.

From May 13, 2009 to June 3, 2010, appellant was treated by Dr. Shafaat Ahmed, a Board-certified orthopedist, for acute back symptoms of sciatica, back pain, muscle spasms and radiculopathy from the December 5, 2003 injury. Dr. Ahmed diagnosed traumatic low back pain syndrome with musculoligamentous strain, spondylolysis at L5 with grade 1 spondylolisthesis for L5-S1 and probable compression of T11. On April 20, 2010 he noted a December 31, 2003 magnetic resonance imaging (MRI) scan of the lumbar spine revealed spondylolysis at L5 and spondylolisthesis at L5-S1. A June 4, 2004 electromyogram (EMG) revealed subacute and chronic bilateral S1 and left-sided L5 radiculopathy, lumbosacral sprain, possible lumbosacral radiculopathy, lumbar facet syndrome exacerbation of both sides and lumbar paraspinal spasms. Dr. Ahmed noted sensory changes in the L5-S1 distribution bilaterally in the legs, with mild difficulty walking tiptoe and on his heels. He opined that appellant had permanent residual injuries from the December 5, 2003 fall with impairment in the presence of chronic persistent low back pain, spondylolysis and grade 1 spondylolisthesis. Dr. Ahmed opined that appellant had seven percent whole body impairment pursuant to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). On June 3, 2010 he recommended a dosepak and advised appellant to return in two weeks.

On June 3, 2010 appellant filed a claim for a schedule award.

By letter dated June 23, 2010, OWCP requested that Dr. Ahmed submit a report in accordance with the sixth edition of the A.M.A., *Guides*.[2] It advised that, under FECA, awards for permanent impairment may not be made for the spine; however, such awards could be paid for impairment of the lower extremities caused by an injury to a spinal nerve. OWCP informed Dr. Ahmed that, in rating impairment of the lower extremities caused by a spinal injury, it had adopted the approach outlined in the July to August 2009 edition of *The Guides Newsletter*.[3] Dr. Ahmed was afforded 30 days to submit the requested information.

In a July 27, 2010 report, OWCP's medical adviser reviewed the medical evidence from Dr. Ahmed and found that he had not reached maximum medical improvement as a medrol dosepak was recommended and he would see appellant in two weeks.

In letters dated July 29, 2010 and January 13, 2011, OWCP advised appellant that he was not at maximum medical improvement. Therefore, a schedule award could not be determined.

On September 21, 2011 OWCP referred appellant to Dr. Steven Lancaster, a Board-certified orthopedic surgeon, to determine if he had permanent impairment as a result of the accepted work-related injury. In an October 10, 2011 report, Dr. Lancaster reviewed the records and examined appellant. He noted findings of positive straight leg raises, bilaterally; dorsiflexors of the ankle were 5/5 bilaterally and symmetric; quadriceps strength was 4/5

[2] A.M.A., *Guides* (6th ed. 2008).

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

bilaterally and symmetric; normal range of motion of the knees; dorsiflexors at the ankles were intact, bilaterally; decreased sensation subjectively along the lateral aspects of both calves to the feet and the reflexes were equal and symmetric, bilaterally. Dr. Lancaster diagnosed spondylolysis at L5, spondylolisthesis at L5-S1 with neurodiagnostic positive radiculopathy at L5 and S1. He noted that maximum medical improvement occurred in 2004 or 2005. Dr. Lancaster referenced the A.M.A., *Guides*, Table 16-12, page 534, Peripheral Nerve Impairment, and noted that appellant had a documented dermatomal pattern for loss of sensation with nerve conduction studies about the lateral femoral cutaneous nerve and sural nerve. He noted a default rating of three percent with a grade 2 modifier for Functional History (GMFH) (antalgic gait), a grade two modifier for Physical Examination (GMPE) and a grade one modifier for Clinical Studies (GMCS) for sensory deficit. Dr. Lancaster advised that appellant had three percent lower extremity impairment rating for the lateral femoral cutaneous nerve and three percent lower extremity impairment rating for the superficial peroneal nerve for six percent impairment for the left leg. He noted that appellant had three percent for the right leg due to S1 radiculopathy. Dr. Lancaster opined that appellant had nine percent lower extremity impairment pursuant to the A.M.A., *Guides* due to radiculopathy from his spinal condition.

In an October 19, 2011 report, Dr. H.P. Hogshead, OWCP's medical adviser, reviewed the evidence and found that appellant reached maximum medical improvement in 2005. He noted that Dr. Lancaster found bilateral sensory loss in the internal calf going down to his feet and no motor loss noted except for a mild quadriceps strength deficit bilaterally which was unrelated to the accepted L5-S1 spondylolisthesis. Dr. Hogshead noted that Dr. Lancaster used Table 16-12, page 534, of the A.M.A., *Guides* for calculation of impaired sensation which was not correct. He noted that OWCP rated lower extremity impairment resulting from spinal nerve root deficit as published in *The Guides Newsletter*, July to August 2009. Dr. Hogshead utilized Table 2, Spinal Nerve Impairment, Lower Extremity found in *The Guides Newsletter*. In rating the S1 injury, appellant had a class 1 moderate sensory impairment for three percent impairment of the right leg and a class 1 moderate sensory impairment for three percent impairment of the left leg based on the June 4, 2004 EMG study.

In reports dated October 4 to 18, 2011, Dr. Ahmed diagnosed low back pain syndrome, spondylolysis at L5, grade 1 spondylolisthesis of L5 over S1 and rule out compression fracture at T11.

In a November 8, 2011 decision, OWCP granted appellant schedule awards for three percent impairment of the right leg and three percent impairment of the left leg. The period of the awards was from November 19, 2004 to March 19, 2005.

Appellant requested a telephonic oral hearing which was held on March 6, 2012. In reports dated November 2, 2011 to February 28, 2012, Dr. Ahmed diagnosed chronic back pain syndrome, lumbar spondylolysis at L5 with defects at pars interarticularis and grade 1 spondylolisthesis of L5-S1. In an April 3, 2012 report, Dr. Jairo D. Libreros, a Board-certified neurologist, diagnosed gait disturbances with left more than right radiculopathy secondary to disc bulges at L5-S1 disc, spondylolisthesis at L5-S1 and spondylolysis at L5 disc associated with motor and sensory EMG changes. He noted motor strength was 4/5 on the left, the gait revealed a limp on the left side with sensory deficit in the posterior calf on the left and the lateral foot bilaterally, deep tendon reflexes were intact and equal bilaterally in biceps, triceps,

brachioradialis with deficits on the left at the patellar and ankle. Dr. Libreros noted tenderness and muscle spasm in the lumbar paraspinal muscles on the left with limitation of range of motion and positive straight leg raises bilaterally. He opined that appellant sustained a 22 percent permanent impairment of both lower extremities. Dr. Libreros referenced Table 13-12, Station and Gait Table of the A.M.A., *Guides*, noting that appellant has a history of left extremity buckling, antalgic gait and sensory motor loss demonstrated by diagnostic testing of June 4, 2004. He applied *The Guides Newsletter*, July to August 2009, Table 2, page 6 and noted S1 moderate sensory deficit on the right, class 1 for three percent impairment and S1 moderate sensory deficit on the left, class 1 for three impairment. Dr. Libreros opined that the impairment from *The Guides Newsletter*, should be combined with the Station and Gait Table, 13-12. He indicated that *The Guides Newsletter* did not suggest that it preempted the A.M.A., *Guides* and opined that the station and gait abnormality resulted from the radiculopathy from the spine injury. Dr. Libreros opined that appellant had 19 percent impairment under Table 13-12, Station and Gait, and also three percent impairment pursuant to *The Guides Newsletter* for a total impairment of 22 percent for the right and left legs. He submitted an April 3, 2012 EMG which showed bilateral L4-5 and L5-S1 radiculopathy.

In a decision dated May 9, 2012, OWCP's hearing representative affirmed OWCP's decision dated November 8, 2011.

LEGAL PRECEDENT

Section 8107 of FECA[4] and its implementing federal regulations[5] 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.[6] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[7]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[8] 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id.* at § 10.404(a).

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

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

schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[9]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.[10] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in the July to August 2009 edition of *The Guides Newsletter*.[11]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH and if electrodiagnostic testing were done, GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[13]

ANALYSIS

Appellant's claim was accepted by OWCP for lumbosacral sprain/strain, spondylolisthesis at L5-S1 and spondylosis at L5. On June 3, 2012 he filed a claim for a schedule award. The Board finds that the medical evidence of record establishes three percent impairment to appellant's left and right lower extremities. The Board finds that the weight of the medical evidence rests with the opinion of Dr. Hogshead who provided impairment rating that comports with the sixth edition of the A.M.A., *Guides.*

The April 20, 2010 report of Dr. Ahmed found seven percent whole body impairment.

This identifies proposed Table 2 of *The Guides Newsletter*, July to August 2009 which is to be used in rating lower extremity impairments caused by spinal nerve injury.[14] Moreover, Dr. Lancaster provided a whole person spinal impairment which is not allowed under FECA.[15] This reduced the probative value of his impairment rating.

In an October 19, 2011 report, Dr. Hogshead reviewed the medical record. He noted that Dr. Lancaster found bilateral sensory loss in the internal calf going down to the feet on examination but had improperly used Table 16-12, page 534, of the A.M.A., *Guides* for

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

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

[11] *See supra* note 3.

[12] *Supra* note 2 at 533.

[13] *Id.* at 521.

[14] *Supra* note 3.

[15] *See id.*

calculation of impaired sensation. Dr. Lancaster advised that OWCP recognizes only extremity impairment resulting from spinal nerve root deficit which are published in *The Guides Newsletter*, July to August 2009. Dr. Hogshead utilized Table 2, Spinal Nerve Impairment, Lower Extremity found in *The Guides Newsletter*. In rating the S1 injury, appellant had a class 1 moderate sensory impairment for three percent impairment of the right lower extremity and a class 1 moderate sensory impairment for three percent impairment of the left lower extremity pursuant to the June 4, 2004 EMG.

The Board finds that Dr. Hogsherd properly reviewed the medical record and evaluated appellant's bilateral lower extremity impairment in accordance with OWCP procedures found at Exhibit 4 of Section 3.700. There is no medical evidence in conformance with the A.M.A., *Guides* showing a greater impairment. The Board finds that, as the medical adviser properly applied the A.M.A., *Guides* to Dr. Lancaster's clinical findings, his opinion represents the weight of the medical evidence in this case.[16]

Appellant submitted an April 3, 2012 report from Dr. Libreros, who opined that appellant had 22 percent permanent impairment of the both lower extremities but this report is of limited probative value. Dr. Libreros referenced appellant's history of left leg buckling, antalgic gait and sensory motor loss demonstrated by diagnostic testing of June 4, 2004. He applied *The Guides Newsletter*, July to August 2009, Table 2, noting appellant was a class 1, S1 moderate sensory deficit, for three percent impairment. For the left lower extremity appellant was a class 1, S1 moderate sensory deficit, for three percent impairment. Dr. Libreros opined that the impairment from *The Guides Newsletter*, July to August 2009 should be combined with the Station and Gait Table, 13-12 of the A.M.A., *Guides*. He rated 19 percent impairment under Table 13-12, Station and Gait and an additional three percent impairment under the Newsletter for a total impairment of 22 percent for each leg. The Board finds this application of the A.M.A., *Guides* was not correct. Nerve root injuries are rated as impairment involving the extremities rather than as part of the spine. The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as lower extremity impairment. Section 3.700 of OWCP's procedures identifies Table 2 of *The Guides Newsletter*, July to August 2009 to be used in rating lower extremity impairments caused by spinal nerve injury.[17] Additionally the Board notes that Table 13-12, addresses whole person impairment, not impairment of the legs, based on the central nervous system deficits. As noted, awards are not paid for whole person impairment under FECA.

On appeal, appellant contends that he is entitled to 22 percent impairment of each leg as found by Dr. Libreros, who combined the impairment rating determined using *The Guides Newsletter*, July to August 2009 with the Station and Gait rating found in Table, 13-12. Counsel asserts that *The Guides Newsletter* does not suggests that it preempts the A.M.A., *Guides*. The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment as was the case in prior editions. Instead, OWCP procedures provide that such lower extremity impairments are to be rated as provided in Exhibit

[16] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

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

4 of Section 3.700 of OWCP's procedures. This identifies Table 2 of *The Guides Newsletter*, July to August 2009 for rating lower extremity impairments caused by spinal nerve injury.[18] *The Guides Newsletter* does not provide that the lower extremity impairment for spinal nerve injuries are to be used in conjunction with or in addition to the Table 13-2, Station and Gait.[19]

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 no more than a three percent impairment of the right and left lower extremities, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 9, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 13, 2013
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[18] *Id*.

[19] Instead, the A.M.A., *Guides* generally provide that only one diagnosis in a region be used to rate impairment. *See* A.M.A., *Guides* 529.