United States Department of Labor
Employees' Compensation Appeals Board

M.W., Appellant	)	
and	)	**Docket No. 13-1013**
	)	**Issued: November 15, 2013**
DEPARTMENT OF VETERANS AFFAIRS, ATLANTA VETERANS ADMINISTRATION MEDICAL CENTER, Decatur, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 20, 2013 appellant, through her attorney, timely appealed the February 14, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

ISSUES

The issues are: (1) whether appellant's degenerative arthritis and January 2004 lumbar surgery are causally related to her accepted employment injury; and (2) whether appellant has a ratable impairment to a scheduled member.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

Appellant, a 57-year-old retired licensed practical nurse (LPN), injured her lower back in the performance of duty on June 22, 1994.[2] OWCP initially accepted her claim for lumbosacral strain. In February 1995, itaccepted a synovial cyst of the lumbosacral spine.[3] OWCP authorized the lumbar surgery.[4] Appellant received wage-loss compensation. In April 1995, she returned to work in a part-time, light-duty capacity. Appellant was released to resume her regular, full-time LPN duties in late September 1995. OWCP paid wage-loss compensation for intermittent periods of disability through August 1996.

Dr. Charles L. Clifton Jr., a Board-certified anesthesiologist, saw appellant on January 10, 2000 and diagnosed spinal stenosis with radicular low back pain.[5] It had been about three and a half years since he last treated her. On January 21, 2000 Dr. Clinton administered a lumbar epidural steroid injection.[6]

The record reflects a possible work-related back injury in October 2001, but there was no record of a new claim having been filed. Appellant also underwent additional lumbar surgery on or about January 7, 2004;but the surgical report is not part of the record. OWCP did not authorize additional surgery under the current claim;moreover, there is no record of her having sought OWCP's approval regarding her January 2004 surgery.Appellant advised OWCP that the Office of Personnel Management granted her disability retirement effective June 2004.

On December 7, 2010 appellant filed a claim for a schedule award (Form CA-7).In a December 9, 2010 report, Dr. F. Daniel Koch, a Board-certified orthopedic surgeon,[7]diagnosed severe degenerative arthritis and statuspost lumbar fusion/arthrodesis. He stated that appellantexperienced chronic low back pain due to the severity of her condition and the hardware in her lumbar spine.

By letter dated January 7, 2011, OWCP advised appellant that Dr. Koch's December 9, 2010 report was insufficient to establish that the diagnosed conditions -- degenerative arthritis and status post lumbar fusion/arthrodesis -- were causally related to her June 22, 1994 employment injury. Appellant was afforded 30 days to submit a rationalized medical opinion addressing causal relationship. OWCP also requested a copy of the surgical report for her

[2] Appellant reportedly injured herself transferring a patient from a bed to a wheelchair.

[3] A July 19, 1994 lumbar magnetic resonance imaging (MRI) scan revealed L5-S1 mild degenerative disc disease. There was also evidence of left-sided synovial cyst with significant compression of the exiting left S1 nerve root.

[4] On January 13, 1995 Dr. Nettleton S. Payne II, a Board-certified neurosurgeon, performed an exploration and decompression, excision of synovial mass and partial facetectomy.

[5] Appellant had low-grade spinal stenosis dating back several years as evidenced by a May 10, 1996 lumbar MRI scan.

[6] OWCP did not pay for the treatment appellant received from Dr. Clifton on January 10 and 21, 2000.

[7] Dr. Koch performed additional lumbar surgery on or about January 7, 2004.

lumbar fusion/arthrodesis and any additional treatment records pertaining to the newly diagnosed conditions.

In a separate letter also dated January 7, 2011, OWCP acknowledged receipt of appellant's December 7, 2010 claim for a schedule award. It explained that FECA did not authorize schedule awards for permanent impairment of the spine; but to the extent her accepted employment injury caused spinal nerve impairment to an extremity, a schedule award for any affected extremities was possible. OWCP provided guidance on rating spinal nerve extremity impairment under FECA and the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*(A.M.A., *Guides*) (2008). Appellant was afforded 30 days to submit the requested information in support of her schedule award claim.OWCP did not receive any additional evidence in the allotted timeframe.

On February 15, 2011OWCP issued two separate decisions. It denied a schedule award for permanent impairment related to appellant's accepted claims and denial to expand her June 22, 1994 traumatic injury claim to include degenerative arthritis and status post lumbar fusion/arthrodesis.

Appellant requested an oral hearing from both decisions which was held on June 10, 2011. She testified regarding the June 22, 1994 employment incident and her two lumbar surgeries. Appellant explained that OWCP paid for the first surgery and Medicaid paid for her subsequent lumbar fusion/arthrodesis. The hearing representative afforded appellant the opportunity to submit additional evidence posthearing;however, appellant did not receive any additional medical evidence.

By decision dated September 7, 2011, the hearing representative affirmed both decisions dated February 15, 2011.

On October 7, 2011 appellant requested reconsideration. OWCP received additional medical reports and treatment records dating back to November 2001.

Dr. David A. Schiff examined appellant on November 30, 2001 for complaints of left-sided lower back pain radiating down her left leg to her posterior and calf.[8] He noted a history of back surgery in 1995 due to an on-the-job injury. The surgery alleviated appellant's pain, but she continued to experience numbness. Appellant advised that she had four to five epidural steroid injections since her surgery. Dr. Schiff also noted that in mid-October 2001 she"was doing some heavy lifting at work" which seemed to provoke her symptoms. Recent x-rays revealed moderate degenerative disc changes at L5-S1, with a left-sided laminectomy defect. There was also evidence of subtle degenerative anterolisthesis. Dr. Schiff diagnosed left S1 radiculopathy, acute and chronic. He referred appellant for physical therapy and lumbar epidural steroid injections.

On January 8, 2002 appellant saw Dr. Richard J. Stork, a Board-certified anesthesiologist with a subspecialty in pain medicine,who noted that she was status post lumbar discectomy in January 1995. Dr. Stork also noted that she"reinjured her back in [October 2001] ... following a

[8] Dr. Schiff is a Board-certified physiatrist with a subspecialty in pain medicine.

lifting incident....” He diagnosed lumbar degenerative disc disease and administered selective nerve root blocks at left L5 and S1.

Appellant returned for a follow-up visit on February 4, 2002. The initial injection provided pain relief for approximately two weeks. During the third week appellant experienced severe left leg pain and was treated in the emergency room. She also reported having fallen at some point between the January 8, 2011 injection and the recurrence of her left leg pain. Dr. Stork referred appellant for a lumbar MRI scan and advised her to return for a second selective nerve root blockafter the MRI scan.

A February 6, 2002 lumbar MRI scan revealed: (1) transitional lumbosacral junction; (2) status post L5 hemilaminectomy; (3) moderate facet arthropathy at L5-S1; and (4) no evidence of recurrent disc herniation.

On March 6, 2002 appellant received another selective nerve root block at L5, left.

On July 29, 2002 Dr. Stork performed discograms at L3-4, L4-5 and L5-S1. The results revealed a normal disc at L3-4. Appellant’s L4-5 disc was reportedly nonpainful, but the discogram showed a right annular tear. Dr. Stork also noted that appellant’s L5-S1 disc was positive, painful and showed significant degeneration and annular tears with epidural leakage. Following the discogram, appellant underwent a lumbar computed tomography (CT) scan that same day. Her July 29, 2002 CT scan revealed extensive degenerative disc disease and spondylosis at L5-S1. There was no definite focal disc herniation suggested at L3-4 and L4-5. It is unclear what, if any, treatment appellant received immediately following her July 29, 2002 diagnostic studies.

Dr. Howard B. Krone, a Board-certified orthopedic surgeon, examined appellant on May 29, 2003. He noted that in 1995, Dr. Payne performed a discectomy at L5-S1for left radiculitis. Dr. Krone also noted that, in 2001, appellant reinjured her back while lifting at her job. Appellant had not worked since 2001. X-rays of the lumbar spine showed some mild degenerative changes at L4-5 and L5-S1. Dr. Krone’s initial impression was postlaminectomy syndrome with possible scarring or re-herniation of the disc. However, he wanted to review appellant’s previous lumbar MRI scan and discogram. Dr. Krone prescribed pain medication and advised her to return once she obtained her previous medical records, including the MRI scan and discogram.

Dr. Krone saw appellant in follow up on July 22, 2003. Appellant had forgotten to bring the previously requested films, but she provided a copy of the discogram report. Dr. Krone commented that it showed extensive arthritis involving L5-S1. There was not only loss of disc at the area of appellant’s discectomy, but also severe facet arthritis. Dr. Krone advisedthat appellant could not work due to the severity of her pain. He also noted that she might be a candidate for fusion at L5-S1. Dr. Krone prescribed Darvocet for pain and referred appellant to Dr. Koch for further evaluation.

Dr. Koch initially examined appellant on July 28, 2003. At the time, appellantcomplained of pain primarily across her back and into both legs. Dr. Koch noted that there was no history of any weakness, numbness or neurological problems. He also noted that

appellant had a laminectomy in the 1990s, but complained of severe pain since then. Dr. Koch commented that she had epidurals and physical therapy since surgery with no real relief in her pain. He stated that appellant's x-rays, MRI scans and discograms showed what appeared to be a spondylolisthesis of L5 on S1. Dr. Koch ratedthat she would benefit from decompression and fusion.

In an October 10, 2003 follow-up report, appellant reportedly continued to experience quite a bit of pain in her back and down her legs. Dr. Koch noted that, since their last meeting, she had addressed some other medical concerns and she was now looking more seriously at lumbar decompression and fusion. He indicated that, with spondylolisthesis and a positive discogram, appellant was a good surgical candidate. The plan was to proceed with surgery after January 1, 2004. Dr. Koch submitted an October 30, 2003 Medicaid precertification form requesting authorization for a posterior decompression with spinal fusion and instrumentation to be performed on January 7, 2004. The diagnosis was spondylolisthesis. No additional information has been provided regarding appellant's anticipated January 2004 lumbar surgery. Also, there is no medical evidence of record regarding her postsurgery recovery period. The next documented treatment with Dr. Koch was more than three years later.

In a December 29, 2006 report, Dr. Koch noted that appellant was a returning patient for whom he performed a decompression and fusion several years ago. He indicated that she still had some pain in her hip and was being treated with chronic pain medication. Appellant's physical examination was reportedly unchanged and she was neurologically stable. X-rays showed that her fusion was likely solid. Dr. Koch recommended continued conservative treatment. He prescribed pain medication (Lotrab) and a muscle relaxant (Soma) and advised appellant to followup in six months. Dr. Koch continued to see her at six-month intervals over the next five years.

At her June 15, 2007 follow-up examination, Dr. Koch diagnosed chronic mechanical back pain status post lumbar fusion, stable. Hesaw appellant again on December 7, 2007 at which time she requested a referral for evaluation for epidurals. Dr. Koch referred her to his colleague, Dr. Leslie A. Cone-Sullivan, a Board-certified physiatrist.

In a January 8, 2008 report, Dr. Cone-Sullivan diagnosed left lumbar radiculopathy, lumbar stenosis and lumbar degenerative disc disease. She also noted a history of lumbar surgeries in approximately 1995 and 2001. Dr. Cone-Sullivan's report did not include a history of any employment-related back injuries. She scheduled appellant for left L5, S1 transforaminal epidural steroid injections, which were administered on March 4, 2008.

Appellant followed up with Dr. Koch fromMarch 19 to December 4, 2009. A March 4, 2008 epidural reportedly took the edge off her pain and according to Dr. Koch, she seemed to be doing reasonably well with no significant changes for more than 20 months.

In a February 4, 2010 report, Dr. Koch noted that appellant had been his patient for years and was treated for injuries related to her back and subsequent chronic back pain. He further noted that she had undergone lumbar decompression and fusion, but continued to complain of chronic pain for which she was regularly prescribed medication. Dr. Koch indicated that

appellant had been entirely compliant with her treatment plan, however, she continued to suffer incapacitating chronic lower back pain. He advised that she was presently totally disabled.

Dr. Koch's treatment notes from July 7, 2010to August 10, 2011 reflect ongoing pain medication management for appellant's chronic lumbar complaints. Appellant's latest x-rays reportedly revealed an intact fusion at L5-S1. However, there was an apparent listhesis present above the previous fusion. Dr. Koch also submitted a February 2, 2011 permanent impairment rating of "15 [percent] total body."

By decision dated February 14, 2013, OWCP denied modification of the hearing representative's September 7, 2011 decision.

LEGAL PRECEDENT -- ISSUE 1

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[9] This burden includes the necessity of furnishing evidence from a qualified physician who concludes that the diagnosed condition is causally related to the employment injury.[10] The physician's opinion must be based on a complete and accurate factual and medical history and supported by sound medical reasoning.[11]

ANALYSIS -- ISSUE 1

The Board finds that OWCP properly declined to expand appellant's June 22, 1994 traumatic injury claim to include degenerative arthritis and status post lumbar fusion/arthrodesis. Three physicians -- Drs. Schiff, Stork and Krone --obtained a history that she reinjured her back lifting at work in October 2001. Dr. Koch, who operated on appellant and saw her regularly for several years, did not provide a particularly comprehensive history of injury. In fact, his various reports did not reference her initial 1994 employment injury or her reported October 2001 reinjury. Dr. Koch's colleague, Dr. Cone-Sullivan, did not include a history of any employment-related back injuries.No physician of record has specifically attributed appellant's lumbar degenerative arthritis and/or her 2004 lumbar fusion/arthrodesis to the accepted June 22, 1994 employment injury or OWCP-authorized January 13, 1995 lumbar surgery. Under the circumstances, OWCP properly declined to expand her claim.

Regarding the acceptance of additional conditions, appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision.[12]

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[9] *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[10] *E.g., D.G.*, 59 ECAB 734, 737-38 (2008).

[11] *Id.* at 738.

[12] 5 U.S.C. § 8128(a); 20 C.F.R. §§ 10.605-10.607.

LEGAL PRECEDENT -- ISSUE 2

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.[13] 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.[14] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[15]

No schedule award is payable for a member, function or organ of the body that is not specified in FECA or in the implementing regulations.[16] The list of schedule members includes the eye, arm, hand, fingers, leg, foot and toes.[17] Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[18] By authority granted under FECA, the Secretary of Labor expanded the list of schedule members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina and skin.[19]

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.[20] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[21] The sixth edition of the A.M.A., *Guides* (2008) provides a specific methodology for rating spinal nerve extremity impairment.[22] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper

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[13] *Id*. at § 8107(c)(1).

[14] 20 C.F.R. § 10.404 (2012).

[15] *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 (February 2013).

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

[17] 5 U.S.C. § 8107(c).

[18] *Id.*

[19] 5 U.S.C. § 8107(c)(22); 20 C.F.R. § 10.404(b).

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

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

[22] The methodology and applicable tables were published in the July/August 2009 edition of *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition."

and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the FECA Procedure Manual.[23]

ANALYSIS - ISSUE 2

Appellant bears the burden of establishing permanent impairment.[24] In January 2011, OWCP advised her of the necessity of submitting an impairment rating in accordance with the A.M.A., *Guides* (6th ed. 2008). In light of her accepted lumbar condition, appellant received specific instructions on rating spinal nerve extremity impairment. The medical evidence submitted is not sufficient. Although Dr. Koch indicated that appellant had a permanent impairment rating of "15 [percent] total body," he did not otherwise address the basis for his rating or provide a specific rating for lower extremity impairment consistent with both FECA and the A.M.A., *Guides* (6th ed. 2008). FECA does not provide for impairment of the whole body.[25] Dr. Koch did not provide any specific findings from physical examiner that the district medical adviser might rely upon in determining the existence and extent of impairment. Before a case can be referred to the district medical adviser, the attending physician should describe the impairment in sufficient detail to permit clear visualization of the impairment and the restrictions and limitations which have resulted.[26]

The evidence of record does not support appellant's claim for a schedule award with respect to her June 22, 1994 employment injury. Accordingly, OWCP properly denied her claim.

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 OWCP properly declined to accept degenerative arthritis and appellant's latest lumbar surgery as being causally related to her June 22, 1994 employment injury. Appellant also failed to establish that she has a ratable impairment of a scheduled member.

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

[24] 20 C.F.R. § 10.115(f).

[25] *See supra* note 20.

[26] Federal (FECA) Procedure Manual, Part 3-- Medical, *Schedule Awards*, Chapter 3.700.3a(2).

ORDER

IT IS HEREBY ORDERED THAT the February 14, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 15, 2013
Washington, DC

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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

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