United States Department of Labor
Employees' Compensation Appeals Board

E.D., Appellant	)	
and	)	**Docket No. 13-2024**
	)	**Issued: April 24, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Eustis, FL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Miriam D. Ozur, Esq., for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 3, 2013 appellant, through his attorney, filed a timely appeal from a June 12, 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 this case.

ISSUE

The issue is whether appellant sustained ratable impairments of his lower extremities due to accepted lumbar injuries.

[1] 5 U.S.C. § 8101 *et seq.*

On appeal, counsel asserts that OWCP's rating methodology for extremity impairment originating in the spine amounts to junk science.[2]

FACTUAL HISTORY

OWCP accepted that on February 11, 2008 appellant, then a 60-year-old rural carrier associate, sustained a lumbar strain and an aggravation of degenerative disc disease while placing a parcel into a locker. Appellant stopped work on February 1, 2008 and did not return. He received compensation for total disability through November 30, 2011.[3]

Appellant was first followed by Dr. Evans E. Amune, an attending Board-certified anesthesiologist, who diagnosed an aggravation of degenerative lumbar disc disease and administered lumbar epidural injections.[4]

An October 27, 2010 electromyography (EMG) and nerve conduction velocity (NCV) study performed as part of a second opinion examination[5] showed no radiculopathy or other neurologic abnormality in either lower extremity.

In a November 16, 2010 report, Dr. Stephen M. Pirris, an attending Board-certified neurosurgeon, noted that appellant had considerable diffuse muscle atrophy and was "very thin and almost cachectic." On examination, he found "diffuse mild weakness because of the overall atrophy" without focal weakness or numbness.[6]

Dr. Samy F. Bishai, an attending Board-certified orthopedic surgeon, followed appellant beginning October 19, 2011. He found that appellant had not reached maximum medical

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[2] On December 13, 2013 the Director submitted a response to counsel's pleading, asserting that OWCP's adoption of the methodology set forth in the July/August 2009 *The Guides Newsletter* for rating extremity impairment originating in the spine was proper under FECA, the Federal (FECA) Procedure Manual and Board precedent. Counsel for appellant provided a December 27, 2013 reply, reiterating his assertion that *The Guides Newsletter* was flawed and represented "junk science."

[3] On August 27, 2009 OWCP obtained a second opinion from Dr. Narideur S. Aujla, a Board-certified orthopedic surgeon, who found appellant able to perform sedentary duty. Following a vocational rehabilitation effort, by notice dated September 22, 2011 and finalized November 30, 2011, it reduced appellant's compensation to zero effective that day, based on his ability to earn wages in the selected position of customer service representative. By decision dated June 25, 2012, an OWCP hearing representative affirmed the September 22, 2011 reduction of appellant's compensation.

[4] A December 16, 2009 lumbar MRI scan showed L3-4 and L4-5 disc bulges with flattening on the ventral thecal sac and mild bilateral arthritis of the hips. March 15, 2010 lumbar x-rays showed disc space narrowing at L4-5 and L5-S1. A May 4, 2011 lumbar magnetic resonance imaging (MRI) scan showed lower lumbar degenerative disc disease unchanged since December 16, 2009, stable mild ventral thecal sac and lateral recess stenosis at L4-5, foraminal narrowing at L3 on the right and bilaterally at L4.

[5] OWCP obtained an updated second opinion from Dr. David Lotman, a Board-certified orthopedic surgeon, who opined on March 10, 2011 that appellant could perform light-duty work.

[6] Dr. Terry W. Kuhlwein, an attending Board-certified family practitioner, provided an August 2, 2011 whole person impairment rating. However, FECA does not provide for impairments of the whole person. *D.H.*, 58 ECAB 358 (2007).

improvement. Dr. Bishai diagnosed bulging discs at L4-5 and L5-S1 without frank stenosis and lumbar radiculopathy. He submitted periodic reports from January 17 to August 15, 2012 noting weakness in the extensor halluces longus, quadriceps and plantar flexors of the toes bilaterally, worse on the left, numbness of the left fourth and fifth toes, radicular symptoms into both legs. Dr. Bishai noted identical range of motion measurements in all reports.

Dr. Bishai ordered a February 22, 2012 NCV and EMG study showing "[l]eft L4-5 anterior split of the sciatic trunk appear partially entrapped," "[r]ight S1 posterior split appear equally, partial entrapped." He also ordered a June 7, 2012 lumbar MRI scan demonstrating a new indentation of the right ventral portion of the thecal sac at L4-5.

On October 9, 2012 appellant filed for a schedule award. In support of his claim, he submitted a September 4, 2012 report from Dr. Bishai, who opined that appellant had attained maximum medical improvement. On examination, Dr. Bishai found weakness in the extensor halluces longus and plantar flexors bilaterally, and in the left dorsiflexors and quadriceps. He also found blunted sensation in the lateral aspects of both feet and legs, as well as the fourth and fifth toes on the left. Dr. Bishai diagnosed bilateral lumbar radiculopathy. Referring to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*), Lumbar Regional Grid, he assigned a class 2 impairment. Referencing the nerve Impairment Lower Extremities grid, Dr. Bishai assigned 3 percent impairment due to sensory loss and 13 percent impairment for motor deficit of each leg, Dr. Bishai totaled these percentages to equal 16 percent impairment of each lower extremity.

In an October 15, 2012 report, an OWCP medical adviser reviewed Dr. Bishai's opinion. He noted that the February 22, 2012 NCV studies were not reliable as they did not use standard medical terminology. The medical adviser recommended a second opinion examination.

On November 20, 2012 OWCP obtained a second opinion from Dr. Jonathan D. Black, a Board-certified orthopedic surgeon, who reviewed the medical record and a statement of accepted facts provided by OWCP. Dr. Black related appellant's complaints of back pain, bilateral leg weakness, numbness in both feet and severe numbness in the left small toe. On examination, he noted diminished lumbar flexion and extension, exaggerated pain responses, hypersensitivity to palpation of the lumbar paraspinals, full motor strength in both legs, full sensation to sharp and soft touch in all dermatomes of the lower extremities, intact sensation throughout both feet, bilaterally absent deep tendon reflexes and bilaterally negative straight leg raising tests. Dr. Black noted that the October 27, 2010 EMG/NCV study showed no radiculopathy or other objective cause for appellant's complaints of numbness in the left fifth toe. He opined that appellant reached maximum medical improvement no later than November 14, 2010. Referring to the July/August 2009 *The Guides Newsletter*, Dr. Black found that appellant had no ratable impairment of the legs as he was neurologically intact, with no objective weakness or sensory loss. On December 12, 2012 an OWCP medical adviser concurred with Dr. Black's assessment of no impairment to the legs.

By decision dated December 17, 2012, OWCP denied appellant's schedule award claim on the grounds that the medical evidence did not establish a ratable impairment of either lower extremity originating in the spine. It accorded Dr. Black the weight of the medical evidence.

In a December 20, 2012 letter, appellant requested a telephonic hearing, held on April 10, 2013. At the hearing, counsel asserted that electrodiagnostic and imaging studies showed objective neurologic abnormalities and that OWCP should not have relied on the October 27, 2010 EMG/NCV study. Appellant submitted additional evidence.

In reports from December 14, 2012 to May 10, 2013, Dr. Bishai repeated previous measurements and findings. He reiterated appellant's complaints of continued bilateral lumbar radiculopathy with paresthesias into both feet, greater on the left. Dr. Bishai obtained January 8 and May 10, 2013 functional capacity evaluations demonstrating limited motion throughout the spine. Appellant also submitted a March 19, 2013 lumbar computerized tomography (CT) scan demonstrating degenerative disc disease at L3-4 and L5-S1 contributing to multilevel canal and foraminal stenosis without definite soft disc herniation or impingement. An April 25, 2013 lumbar MRI scan showed degenerative changes at L4-5 without focal disc herniation.[7]

In a June 12, 2013 decision, an OWCP hearing representative affirmed the December 17, 2012 decision, finding that the evidence submitted did not establish a ratable impairment of either leg. The hearing representative found that reliance on the October 31, 2010 study was appropriate as Dr. Black found that appellant had reached maximum medical improvement as of November 14, 2010. The hearing representative further found that OWCP properly discounted the February 22, 2012 electrodiagnostic study as testing performed for Dr. Bishai "did not conform to industry standards." The hearing representative noted that Dr. Bishai found identical lumbar ranges of motion and examination findings from August 15, 2010 to May 10, 2013, indicating that he did not perform "careful, objective physical exam[ination]s."

LEGAL PRECEDENT

The schedule award provision of FECA[8] and its implementing regulations[9] 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 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.[10]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[11] Because neither FECA nor the regulations provide for the

[7] Appellant also submitted a January 18, 2013 report fragment and a March 2, 2013 report from a nurse. As these reports were not signed by a physician, they do not constitute medical evidence. *See Merton J. Sills*, 39 ECAB 572, 575 (1988).

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *Id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[11] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

payment of a schedule award for the permanent loss of use of the back,[12] no claimant is entitled to such an award.[13] However, in 1966, amendments to FECA modified the schedule award provision 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. As the schedule award provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[14]

The sixth edition of the A.M.A., *Guides* (2008) provides a specific methodology for rating spinal nerve extremity impairment, set forth in the July/August 2009 *The Guides Newsletter*.[15] It was designed for situations in which a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[16] The Board has recognized the adoption of this methodology as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[17]

ANALYSIS

OWCP accepted that appellant sustained a lumbar strain and an aggravation of degenerative lumbar disc disease. Appellant claimed a schedule award on October 9, 2012. In claiming a schedule award, he asserted that the accepted lumbar injuries caused a ratable permanent impairment of both legs. Although FECA does not provide for a schedule award for the back or spine, impairment of the extremities due to a spinal injury may be compensable.[18] However, appellant did not submit sufficient medical evidence to establish impairment of either leg due to the accepted lumbar conditions.

Dr. Amune, an attending Board-certified anesthesiologist, did not address the issue of permanent impairment. Dr. Pirris, an attending Board-certified neurosurgeon, observed diffuse muscle atrophy throughout the extremities but did not opine that the accepted lumbar injuries influenced this systemic condition. Dr. Bishai, an attending Board-certified orthopedic surgeon, diagnosed bilateral lumbar radiculopathy. However, an OWCP medical adviser found that the February 22, 2012 electrodiagnostic testing on which Dr. Bishai based this diagnosis was not

[12] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[13] *Thomas Martinez*, 54 ECAB 623 (2003).

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

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

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

[17] *D.S.*, Docket No. 14-12 (issued March 18, 2014); *D.S*, Docket No. 13-2011 (issued February 18, 2014).

[18] *See Thomas J. Engelhart*, *supra* note 14.

reliable due to its nonstandard medical terminology. As the extent of neurologic impairment was not ascertainable from those tests, Dr. Bishai's opinion is insufficient to meet appellant's burden of proof.[19]

OWCP obtained a second opinion from Dr. Black, a Board-certified orthopedic surgeon and second opinion physician. After reviewing the complete medical record and statement of accepted facts, as well as thorough clinical examination, Dr. Black opined that appellant had no objective neurologic abnormality referable to the accepted lumbar injuries. He noted that October 27, 2010 EMG and NCV studies showed no objective neurologic abnormality in either lower extremity. Dr. Black opined that appellant had no ratable impairment of either leg. An OWCP medical adviser concurred with this assessment. OWCP therefore issued its December 17, 2012 decision denying a schedule award for the lower extremities, based on Dr. Black's opinion as the weight of the medical evidence.

Following a hearing, appellant submitted additional reports from Dr. Bishai reiterating prior findings. He also submitted new lumbar imaging studies that did not demonstrate neurologic impairment of the lower extremities. OWCP therefore issued its June 12, 2013 decision affirming the prior denial of a schedule award.

The Board finds that OWCP properly accorded Dr. Black the weight of the medical evidence. Dr. Black's report clearly explains why appellant had no objective evidence of a neurologic condition originating in the spine affecting either lower extremity.[20] Therefore, OWCP's June 12, 2013 decision denying a schedule award was proper under the law and facts of the case.

On appeal, counsel asserts that OWCP's rating methodology for extremity impairment originating in the spine amounts to junk science. However, as set forth above, OWCP's reliance on the July/August 2009 *The Guides Newsletter* as incorporated into the Federal (FECA) Procedure Manual is a proper exercise of OWCP's discretion.[21]

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 established that he sustained a ratable permanent impairment of either upper extremity causally related to accepted lumbar injuries.

[19] *Renee M. Straubinger*, 51 ECAB 667 (2000) (where the Board found that before the A.M.A., *Guides* can be utilized, a description of the claimant's impairment must be obtained from his or her physician with the description in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations).

[20] *S.S.*, Docket No. 13-2044 (issued February 20, 2014).

[21] *Supra* note 15.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 12, 2013 is affirmed.

Issued: April 24, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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