United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 13-1642**
	)	**Issued: January 7, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Durham, NC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 1, 2013 appellant, through her attorney, filed a timely appeal from a May 28, 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 case.

ISSUE

The issue is whether OWCP properly denied appellant's claim for a schedule award.

FACTUAL HISTORY

This is the second appeal in the present case. In a December 14, 2011 decision, the Board affirmed a December 3, 2010 OWCP decision denying disability compensation for the

[1] 5 U.S.C. §§ 8101-8193.

period July 27, 2007 to December 3, 2010.[2] The relevant facts and circumstances of this case are incorporated herein by reference.[3]

On January 6, 2012 appellant filed a claim for a schedule award due to permanent impairment to his back.

By letter dated January 30, 2012, OWCP requested appellant's treating physician, Dr. Anand Joshi, a Board-certified orthopedic surgeon, to submit a report in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] It advised that under FECA, awards for permanent impairment may not be made for the spine; however, such awards can be paid for impairment of the upper or lower extremities caused by an injury to a spinal nerve. OWCP informed Dr. Joshi that, for rating impairment of the upper or lower extremities caused by a spinal injury, it had adopted the approach outlined in the July to August 2009 *The Guides Newsletter*.[5]

In an April 2, 2012 report, Dr. Joshi advised that appellant was not yet at maximal medical improvement and he could not perform an impairment rating until that time. He further noted that he had not diagnosed her with a spinal nerve injury (radiculopathy), but had diagnosed her with radiculitis. In a letter dated April 10, 2012, OWCP advised appellant that Dr. Joshi had not placed her at maximum medical improvement and therefore no schedule award could be determined at that time.

On September 12, 2012 appellant, through her attorney, again requested a schedule award. She submitted a report from Dr. William C. Daniels, a Board-certified orthopedic surgeon, dated August 20, 2012. Dr. Daniels noted that appellant had undergone nerve conduction studies on August 1, 2012 which showed no abnormalities and no evidence of peripheral neuropathy. Examination revealed normal gait, some limitation of motion of the lumbar spine and pelvis, tenderness at L1-2 and S1, no spasms, no evidence of scoliosis and normal lordosis. Dr. Daniels noted sensation was patchy to pinprick and light touch in the bilateral lower extremities below the knees with some identification of pinprick on the lateral aspect of the left foot as well as the first dorsal interspace with questionable sensation to pinprick on the right at the first dorsal web space. He diagnosed sprain of the back and lumbar region, degeneration of lumbar or lumbosacral intervertebral disc and spinal stenosis, lumbar region. Dr. Daniels noted that pursuant to the A.M.A., *Guides*, appellant's pain disability questionnaire was 113, and she had and a gross score of 28 for the lower limb. He opined that there was evidence of degenerative changes in her lumbosacral spine and some degree of bulging, with no

[2] Docket No. 11-846 (issued December 14, 2011).

[3] On July 24, 2007 appellant, a temporary medical technician, injured her back while lifting boxes. OWCP accepted her claim for a lumbar sprain/strain and an aggravation of lumbar disc disease with radiculopathy at L3-4 with lumbar spinal stenosis at L3-4. Appellant stopped work on July 30, 2007 and was terminated from her position for cause on August 10, 2007, for failing to follow medical center policies.

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

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

evidence of extruded disc or nerve root compression. Dr. Daniels noted that appellant demonstrated some mild/moderate loss of strength on the left side. He advised that the findings of mixed sensory changes in the bilateral lower extremities could be consistent with the diagnoses of early diabetic neuropathy but noted that she had significant symptoms on the left side since her work injury. Dr. Daniels noted no evidence of definitive peripheral neuropathy. He referenced A.M.A., *Guides*, Table 16-12, page 535, Peripheral Nerve Impairment, for the lower extremity and noted that appellant exhibited tibial nerve dysfunction. Dr. Daniels determined that she was class 1, which yielded a grade C, default impairment of two percent for a moderate sensory deficit or moderate motor deficit, below the mid-calf. He noted that using a combination of appellant's clinical history, current symptoms and questionnaire values, pursuant to Table 17-6, page 575, for functional history adjustment he noted a grade modifier 2, for physical examination he noted a grade modifier 1 and for clinical studies he noted a grade modifier of 0. Dr. Daniels opined that for the tibial nerve, applying the grade modifier for functional history and physical examination for a net grade modifier adjustment score of +1 for three percent lower extremity impairment. He opined that appellant was difficult to evaluate because of overlapping factors of a previous injury combined with persistent, chronic left lower extremity pain, weakness and numbness in the presence of a diabetic condition. Dr. Daniels noted the possibility of early diabetic neuropathy but noted that the findings of weakness primarily below the knee along with sensory changes would suggest some degree of peripheral nerve involvement.

In a November 16, 2012 report, OWCP's medical adviser noted that Dr. Daniels' August 20, 2012 report provided a three percent impairment rating. He indicated that Dr. Daniels' use of the peripheral nerve section of the A.M.A., *Guides*, Table 16-12, page 535 was improper. The medical adviser noted that OWCP allowed for extremity impairment resulting from spinal nerve root deficit but there was no evidence in the record of radiculopathy. He noted that electrodiagnostic studies in 2008 and August 1, 2012 did not indicate spinal nerve root impairment and no spinal surgery was performed. The medical adviser found that there was no evidence in the record for a ratable impairment related to the accepted conditions. Therefore there was zero percent impairment of the left and right lower extremities.

In a decision dated December 17, 2012, OWCP denied appellant's claim for a schedule award based on the report of OWCP's medical adviser, who found no basis for a schedule award.

On December 26, 2012 appellant requested an oral hearing which was held on March 14, 2013. She submitted a June 20, 2011 report from Dr. Joshi, who treated her for low back pain radiating into the legs. Dr. Joshi noted numbness and tingling in both legs and radicular symptoms reproduced with side bending. He noted that a magnetic resonance imaging scan of the lumbar spine dated June 8, 2011 revealed grade 1 retrolisthesis of L4-5, bilateral joint arthropathy at L3-4 with mild left and central stenosis, disc bulge at L4-5 with a right central disc protrusion, bilateral joint arthropathy, mild right and left foraminal stenosis and mild disc bulge at L5-S1 with joint arthropathy and foraminal stenosis. Dr. Joshi diagnosed bilateral lumbosacral radiculitis and bilateral L5-S1 foraminal stenosis, grade 1 retrolisthesis at L4-5, right central disc protrusion at L4-5 and bilateral L4-5 and L5-S1 joint arthropathy. He recommended spinal injections.

In a decision dated May 28, 2013, OWCP's hearing representative affirmed the decision dated December 17, 2012.

LEGAL PRECEDENT

Section 8107 of FECA[6] and its implementing federal regulations[7] 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.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

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.[10] 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 schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[11]

ANALYSIS

Appellant's claim was accepted by OWCP for lumbar sprain/strain, aggravation of lumbar disc disease with radiculopathy at L3-4 and lumbar spinal stenosis at L3-4. On November 7, 2012 she filed a claim for a schedule award. The Board finds that the medical evidence of record does not establish that appellant sustained permanent impairment of the lower extremities.

Appellant submitted an August 20, 2012 report from Dr. Daniels, who opined that pursuant to Table 16-12, page 535 of the A.M.A., *Guides*, she had peripheral nerve impairment for which he calculated a three percent permanent impairment. Dr. Daniels calculated an impairment rating as it related to tibial nerve dysfunction. However, the Board finds that he did not properly follow the rating process outlined in the A.M.A., *Guides* for performing a peripheral nerve rating. The process in the A.M.A., *Guides* directs the rating physician to use the

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

[8] *Id.* at § 10.404(a).

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

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

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

adjustment grids in Chapter 16 and to exclude any adjustment for physical examination as neurologic examination findings define the impairment values in Table 16-7.[12] Dr. Daniels, as noted, used adjustment grids in Chapter 17, for the spine, which are different than the adjustment grids in Chapter 16, for the legs.[13] He also included an adjustment for physical examination contrary to the language of the A.M.A., *Guides* which states that there should be no adjustment for physical examination.[14] Dr. Daniels also appeared to attribute appellant's impairment in part to mixed sensory changes in the bilateral lower extremities consistent with the diagnoses of early diabetic neuropathy, a condition not accepted as work related.[15] Thus, as his report did not properly follow the procedures set forth in the A.M.A., *Guides*, it is of limited probative value.

In his November 16, 2012 report, OWCP's medical adviser noted that Dr. Daniels improperly used the peripheral nerve section of the A.M.A., *Guides*. He also noted that there was no evidence in the record of radiculopathy and noted that electrodiagnostic studies in 2008 and August 1, 2012 did not indicate spinal nerve root impairment. The medical adviser properly found that there was no evidence in the record for a ratable impairment related to the accepted conditions. Therefore, the Board finds that there was zero percent impairment of the left and right lower extremities.

Appellant submitted a June 20, 2011 report from Dr. Joshi, who treated her for low back pain radiating into the legs. However, Dr. Joshi did not provide an impairment rating and opined, in his report dated April 2, 2012, that she had not yet reached maximum medical improvement as of April 2, 2012. The Board notes that it is well established that a schedule award cannot be determined and paid until a claimant has reached maximum medical improvement and as of June 20, 2011 appellant had not reached maximum medical improvement.[16]

The Board finds that there is no medical evidence in conformance with the A.M.A., *Guides* showing a ratable impairment of the legs.

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.

[12] *See* A.M.A., *Guides* 533.

[13] *Compare* Table16-6, functional history -- lower extremities, page 516, with Table 17-6, functional history adjustment -- spine, page 575.

[14] *See supra* note 12 at section 16.4c(3)(b).

[15] *See Veronica Williams*, 56 ECAB 367 (2005) (a schedule award can be paid only for a condition related to an employment injury; the claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment).

[16] *See Joseph R. Waples*, 44 ECAB 936 (1993).

CONCLUSION

The Board finds that appellant is not entitled to a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 28, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 7, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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