United States Department of Labor
Employees' Compensation Appeals Board

R.R., Appellant	)	
and	)	**Docket No. 15-1055**
	)	**Issued: December 16, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Media, PA, Employer	)	

Appearances:
Stephen V. Barszcz, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On April 8, 2015 appellant, through counsel, filed a timely appeal from an October 8, 2014 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 has more than 16 percent permanent impairment of his left lower extremity.

FACTUAL HISTORY

On December 3, 2005 appellant, a 53-year-old custodian, sustained a traumatic injury in the performance of duty while throwing a bag of trash into a dumpster. An imaging study obtained three days later revealed a herniated disc eccentric and to the left at L4-5 causing

[1] 5 U.S.C. § 8101 *et seq.*

compression of the L5 nerve root. It also revealed multiple levels of degenerative disc disease. OWCP accepted appellant's claim for displaced lumbar intervertebral disc, left. On June 29, 2006 appellant underwent a left-sided L4-5 hemilaminectomy and discectomy. A thorough decompression of the L5 nerve root was felt to be achieved. Appellant also underwent a left-sided L5-S1 far lateral approach to far lateral disc herniation with lateral facetectomy and foraminotomy. Again it was felt that a thorough decompression of the L5 level had been achieved.

Appellant later filed a schedule award claim (Form CA-7) and submitted a March 25, 2013 evaluation from Dr. Arthur F. Becan, Jr., an orthopedic surgeon. Dr. Becan noted an antalgic gait, but made no mention of footwear modifications, orthotics, or the use of a cane or crutch. He noted posterior midline tenderness and left-sided paravertebral tenderness extending from L3 to S1, as well as left-sided iliolumbar ligament tenderness. Sitting root sign was 60 degrees on the left, 90 on the right. Straight leg raising in the supine position was 40 on the left, 80 on the right. Extremes of motion caused low back and left leg pain. There was hyperesthesia to sensation on the left. Extensor halluces longus strength was graded at 3/5 on the left, 5/5 on the right. Quadriceps strength was graded 3/5 on the left, 5/5 on the right. Hamstring and gastrocnemius were graded 5/5 bilaterally. Ankle jerk reflexes were absent on the left, 3+ on the right.

After reviewing appellant's medical records, including a number of clinical studies, Dr. Becan diagnosed chronic post-traumatic lumbosacral strain and sprain, herniated L4-5 and L5-S1 discs, bulging L3-4 disc, left-sided radiculopathy at L4-S1, status post lumbar laminectomy and discectomy at L4-5 and L5-S1, postoperative complex regional pain syndrome (CRPS), failed low back syndrome, and status post interventional pain management with multiple sympathetic blocks to the lumbosacral spine.

Dr. Becan rated appellant's left lower extremity impairment using Table 2 of "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition," *The Guides Newsletter* (American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (6th ed. 2009) (July/August 2009). For appellant's class 1 moderate 3/5 extensor halluces longus strength, he found 13 percent impairment of the left lower extremity, the highest impairment rating allowed for the L5 nerve root. Likewise, for appellant's class 1 moderate 3/5 quadriceps strength, he found 13 percent impairment of the left lower extremity, the highest impairment rating allowed for the L4 nerve root. Turning to Table 16-12, page 535 of the A.M.A., *Guides* (6th ed. 2009), he found a default four percent impairment of the left lower extremity due to a mild-to-moderate peripheral sensory deficit CRPS of the sciatic nerve. Dr. Becan adjusted this to nine percent impairment, the maximum allowed for such an impairment, due to a severe functional history and very severe clinical studies. Combining the three basic impairments, he noted that appellant had 31 percent total impairment of the left lower extremity.

An OWCP medical adviser reviewed the impairment evaluation and noted that Dr. Becan's calculations were inconsistent with those of other physicians, particularly in regard to motor strength loss. Using *The Guides Newsletter*, he found a default three percent lower extremity impairment for moderate sensory deficit of the L4 and L5 nerve roots and a default two percent impairment for moderate sensory deficit of the S1 nerve root. The medical adviser also found a default five percent impairment for mild motor deficit of the L5-S1 nerve root.

These spinal nerve root impairments totaled 13 percent. With this, the medical adviser combined a default four percent impairment for mild-to-moderate peripheral sensory deficit (CRPS, objectively verified) of the sciatic nerve, for a total left lower extremity impairment of 16 percent.

On June 17, 2013 OWCP issued a schedule award for 16 percent impairment of appellant's left lower extremity.

Appellant requested reconsideration and argued that Dr. Becan's rating had more probative value than that of the medical adviser, who did not physically examine appellant.

In a decision dated September 26, 2013, OWCP reviewed the merits of appellant's case and denied modification of the June 17, 2013 schedule award. It explained that Dr. Becan had incorrectly applied the A.M.A., *Guides*, while the medical adviser correctly applied them.

Appellant requested reconsideration. He submitted a November 15, 2013 report from Dr. Becan, who took issue with several aspects of the medical adviser's impairment recommendation. Appellant noted that the medical adviser avoided the use of grade modifiers and assigned five percent impairment for mild motor deficit of the left L5-S1 nerve roots without a physical examination to ascertain the degree of muscle weakness and without rating the nerve roots separately. Based on his evaluation and physical examination, it remained Dr. Becan's opinion that appellant suffered a final left lower extremity impairment of 31 percent.

In a decision dated March 5, 2014, OWCP reviewed the merits of appellant's case and denied modification of the June 17, 2013 schedule award. It noted that Dr. Becan had examined appellant 12 days after appellant injured his shoulder and sustained a concussion in a motor vehicle accident. OWCP added that appellant had been examined in 2011 by Dr. Robert E. Liebenberg, a Board-certified orthopedic surgeon and impartial medical examiner selected to resolve a conflict over issues of total disability, who found that appellant had reached maximum medical improvement. There was, at that time, evidence of some continuing radiculopathy of L5 and perhaps S1. Neurologic examination revealed that strength was intact, while strength testing revealed some weakness of the knee flexors on the left side compared to the right. Otherwise strength was intact. Dr. Liebenberg observed no present sign of reflex dystrophy or objective signs of CRPS.

Appellant again requested reconsideration and submitted a June 27, 2014 report from Dr. Becan. Dr. Becan reviewed medical records pertaining to the motor vehicle accident on March 3, 2013 and noted that they made no mention of appellant's low back. As there was no evidence that appellant had injured his low back or left lower extremity in the accident, Dr. Becan opined that neither was affected by the accident. He added that his evaluation and physical findings would be more accurate as to appellant's condition than an evaluation performed by Dr. Liebenberg in 2011.

In a decision dated October 8, 2014, OWCP reviewed the merits of appellant's case and denied modification of the June 17, 2013 schedule award.

On appeal, appellant renews his objections and suggests that OWCP should obtain additional medical opinion evidence in regard to the appropriate impairment rating.

LEGAL PRECEDENT

The schedule award provision of FECA[2] and the implementing regulations[3] set forth the number of weeks of compensation payable for permanent impairment from loss or loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[4]

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. OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[6]

Diagnosis-based impairment is the primary method of evaluating the lower limb. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment (no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss). This will provide a default impairment rating, which can be adjusted slightly up or down based on grade modifiers, such as functional history and clinical studies.[7]

ANALYSIS

OWCP accepted that appellant sustained a displaced lumbar intervertebral disc, left, on December 3, 2005 when he attempted to throw a bag of trash into a dumpster. An imaging study at that time showed a herniated disc at L4-5 compressing the L5 nerve root, for which appellant underwent surgical decompression. The question presented is the extent of permanent impairment the accepted medical condition has caused to appellant's left lower extremity.

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* has therefore developed an approach to rating such impairment in *The Guides Newsletter* (July/August 2009). OWCP

[2] *Id*. at § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[5] *Supra* note 3; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010).

[7] A.M.A., *Guides* 497.

procedures advise that impairment to the upper or lower extremities caused by a spinal injury should be rated consistent with *The Guides Newsletter*.[8]

Dr. Becan, an orthopedic surgeon, referred to *The Guides Newsletter* when he evaluated appellant's impairment. Table 2 provides that moderate motor deficit of the L5 nerve root equates to 13 percent impairment of the lower extremity. This is the rating Dr. Becan determined for appellant's moderate 3/5 strength of the extensor halluces longus, involving the affected L5 nerve root. Grade modifiers do not matter in this instance, as 13 percent is the maximum impairment value allowed for an L5 motor deficit.

OWCP's medical adviser noted, however, that Dr. Becan's findings with respect to motor deficits were inconsistent with the findings of other doctors. When Dr. Liebenberg, an orthopedic surgeon and impartial medical examiner, examined appellant approximately 18 months earlier, appellant's strength was largely intact, and he was found to have achieved maximum medical improvement.

As the A.M.A., *Guides* note, the examiner should consider the patient's diagnosis, the reliability of findings on examination, and the results of previous examinations and observations as recorded in the medical records documenting previous treatment. More objective findings, such as atrophy, are given greater relative weight over findings that require patient participation, such as demonstration of active range of motion or strength and reports of tenderness. Inconsistencies and discrepancies between what is observed, what has been previously reported, and what is otherwise expected should be noted. Examination findings that differ significantly from previously recorded observation after the probable date of maximum medical improvement should be reported. These findings may be excluded from the impairment calculation.[9] For appellant's moderate 3/5 quadriceps strength, Dr. Becan also found 13 percent impairment of the left lower extremity, the highest impairment rating allowed for the L4 nerve root. There are two problems with this rating. Again, Dr. Becan should have attempted to reconcile this finding with those of Dr. Liebenberg, who found only some weakness of knee flexors on the left compared to the right (Dr. Becan graded hamstrings 5/5 bilaterally). Moreover, it is not clear from the early medical records or the June 29, 2006 operative report whether the December 3, 2005 work incident injured the L4 nerve root. OWCP accepted a single displaced lumbar intervertebral disc, left, which an imaging study three days after the incident showed to be a herniated disc eccentric and to the left at the L4-5 level causing compression of the L5 nerve root. Appellant's surgery included a procedure to address a far lateral disc herniation at the L5-S1 level, which again was compressing the L5 nerve root. It did not appear that the L4 nerve root was affected at that time. OWCP did not accept appellant's claim for degenerative disc disease at multiple levels or any additional medical condition that might have subsequently arisen as a result of his underlying degenerative condition. Dr. Becan did not attempt to establish a causal relationship between what happened at work on December 3, 2005 and any injury to the L4 spinal nerve root.

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1.5 (January 2010).

[9] A.M.A., *Guides* 496; *see also* 24 (consistency).

Lastly, Dr. Becan found a default of four percent impairment of the left lower extremity due to a mild-to-moderate peripheral sensory deficit CRPS of the sciatic nerve, which he adjusted to nine percent impairment due to a severe functional history and very severe clinical studies. When Dr. Liebenberg examined appellant a year and a half earlier, he observed no objective signs of chronic regional pain syndrome. Dr. Becan did not address this finding. Also, there is no history of an injury or trauma to the left lower extremity. It is therefore not clear why Dr. Becan would assign nine percent impairment due to a peripheral nerve lesion. Appellant's accepted injury was a herniated disc compressing on the L5 spinal nerve root. Impairment should therefore be rated consistent with *The Guides Newsletter* on rating spinal nerve extremity impairment.

CRPS is a particularly challenging diagnosis to rate. CRPS II, the diagnosis previous known as causalgia, is considered when appropriate signs, and symptoms are present in the clinical setting of an unambiguous injury to a specific peripheral nerve.[10] Again, it does not appear that when appellant threw a bag of trash into a dumpster on December 3, 2005 that he sustained an unambiguous injury to a specific peripheral nerve.

Since a subjective complaint of pain is the hallmark of this diagnosis, and since all of the associated physical signs and radiological findings can be the result of disuse, an extensive differential diagnosis process is necessary. Differential diagnoses which must be ruled out include disuse, atrophy, unrecognized general medical problems, somatoform disorders, factitious disorder, and malingering. A diagnosis of CRPS may be excluded in the presence of any of these conditions or any other conditions which could account for the presentation. This exclusion is necessary due to the general lack of scientific validity for the concept of CRPS, and due to the reported extreme rarity of CRPS. The A.M.A., *Guides* notes that any of the differential diagnoses would be far more probable.[11]

The A.M.A., *Guides* also notes that scientific findings actually indicated that whenever this diagnosis is made, it is probably incorrect. The A.M.A., *Guides* therefore provides that CRPS may be rated only when certain criteria are met: (1) the diagnosis is confirmed by objective parameters in Table 16-13; (2) the diagnosis has been present for at least one year, to assure the accuracy of the diagnosis and to permit adequate time to achieve maximum medical improvement; (3) the diagnosis has been verified by more than one physician; and (4) a comprehensive differential diagnostic process, which may include psychological evaluation and psychological testing, has clearly ruled out all other differential diagnoses.[12]

Dr. Becan did not follow these protocols when he combined impairment for CRPS with L5 and L4 spinal nerve root impairments. The Board notes that such a combination is not allowed. The rating for CRPS is a "stand alone" approach. If impairment is assigned for CRPS, no additional impairment is assigned for pain from the chapter on pain-related impairment, nor is

[10] *Id*. at 538.

[11] *Id*. at 538-39.

[12] *Id*. at 539.

CRPS impairment combined with any other approach for the same extremity from the chapter on the lower extremities.[13]

For these reasons, the Board finds that Dr. Becan's conclusion that appellant has 31 percent total impairment of the left lower extremity, due to a combination of L5 and L4 spinal nerve root impairment and CRPS impairment, is of little probative value. Dr. Becan's impairment rating does not appear to be based on the accepted medical condition or on a proper application of the A.M.A., *Guides*.

The rating given by the medical adviser is also not probative. He assigned ratings for the L4, L5, and S1 spinal nerve roots without explaining how the accepted medical condition warranted such consideration. The medical adviser did not explain how he graded the sensory deficits of the L4 and L5 spinal nerve roots as mild or the S1 spinal nerve root as moderate. He did not explain how he judged the motor deficit of the "L5-S1" spinal nerve root to be mild or why he gave only one rating for two spinal nerve roots. The medical adviser did not apply grade modifiers for functional history or clinical studies, as required by *The Guides Newsletter*, and like Dr. Becan, he improperly combined the spinal nerve root impairments with CRPS impairment.

As the medical evidence developed in this case is insufficient to determine appellant's permanent impairment for the accepted medical condition, the Board will remand the case for further development. OWCP shall refer him, together with a statement of accepted facts and his medical record, to a second-opinion physician for a proper evaluation of impairment. After such further development as may become necessary, OWCP shall issue an appropriate *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision. Further, development of the medical evidence is warranted.

[13] *Id*. at 540.

ORDER

IT IS HEREBY ORDERED THAT the October 8, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action.

Issued: December 16, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board