United States Department of Labor
Employees' Compensation Appeals Board

E.M., Appellant	)	
and	)	**Docket No. 14-0178**
	)	**Issued: September 28, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Eatontown, NJ, Employer	)	

Appearances:
Richard A. Daniels, 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 October 28, 2013[1] appellant, through her representative, filed a timely appeal of an April 30, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) addressing her schedule award claim. Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

[1] Under the Board's *Rules of Procedure*, an appeal must be filed within 180 days from the date of issuance of an OWCP decision. An appeal is considered filed upon receipt by the Clerk of the Appellate Boards. *See* 20 C.F.R. § 501.3(e)-(f). One hundred and eighty days from April 30, 2013, the date of OWCP's last decision was October 28, 2013. Since using October 30, 2013, the date the appeal was received by the Clerk of the Appellate Boards would result in the loss of appeal rights, the date of the postmark is considered the date of filing. The date of the U.S. Postal Service postmark is October 28, 2013, rendering the appeal timely filed. *See* 20 C.F.R. § 501.3(f)(1).

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant met her burden of proof to establish permanent impairment to a scheduled member.

On appeal, appellant's representative argued that the report of the impartial medical examiner comingled information and was not based on a proper application of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) or *The Guides Newsletter*. He contended that additional development of the medical evidence was necessary or, in the alternative, that the reports of the attending an orthopedic surgeon were entitled to the weight of the evidence.

FACTUAL HISTORY

On March 9, 2008 appellant, then a 57-year-old clerk, picked up a tub and experienced burning in her left side. She underwent a magnetic resonance imaging (MRI) scan of her lumbar spine on April 15, 2008 which demonstrated mild degenerative changes, of the lumbar spine including disc bulges and facet degenerative changes at L2-S1 with a small left herniated disc at L3-4. OWCP accepted appellant's claim for inguinal hernia without obstruction on May 16, 2008. On May 23, 2008 it accepted lumbosacral spondylosis, lumbosacral radiculopathy, and lumbar herniated disc.

Dr. John M. DeSio, a treating Board-certified anesthesiologist, examined appellant on April 8, 2010. He noted her complaints of low back and occasional left leg pain. Dr. DeSio found that lower extremity strength was normal on the left and right. Sensory examination revealed no areas of diminished sensation in either lower extremity. Dr. DeSio also found negative straight leg raising. He diagnosed preexisting lumbar spondylosis, lumbosacral radiculopathy, degenerative disc disease L4-5, herniated disc, and sciatica. Appellant reported increased pain on May 13, 2010.

Appellant requested a schedule award on June 23, 2010. In an April 9, 2010 report, Dr. Arthur Becan, an orthopedic surgeon, noted a history of back injury and reported her physical findings. He found that appellant had loss of muscle strength on manual muscle testing in the quadriceps, 3/5 on the left, as well as hamstrings 4+/5 and gastrocnemius 4/5. Dr. Becan also found decreased sensation in the left lower leg at the L4, L5 and S1 nerve root distribution. He noted that appellant's left quadriceps was 42 centimeters on the left compared to 43 centimeters on the right. Gastrocnemius circumference was 38 centimeters on the right and 36 centimeters on the left. Dr. Becan found decreased sensibility on the left through Semmes-Weinstein monofilament testing and loss of ankle jerk reflexes bilaterally. He noted that appellant demonstrated an antalgic gait and was unable to heel or toe walk. Dr. Becan found bilateral midline tenderness extending from L2 to S1 with restricted range of motion in the lumbar spine causing low back and left leg pain on forward flexion, backward extension, left lateral flexion, right lateral flexion, left, and right rotation. He diagnosed chronic post-traumatic lumbosacral strain and sprain, herniated discs at L2-3 and L3-4 confirmed on MRI scan and left lumbosacral radiculopathy.

Dr. Becan used the A.M.A., *Guides*[3] to find that appellant had a class 2 motor strength deficit of the left extensor hallucis longus or 25 percent impairment in accordance with Table 16-12 of the A.M.A., *Guides*.[4] He found that her functional history grade modifier was 2[5] and that her grade modifier for clinical studies was 2.[6] Based on appellant's MRI scan and in applying the formula, Dr. Becan found a left lower extremity impairment of 25 percent. He also rated appellant's motor strength deficit for her left quadriceps as class 2 impairment or 14 percent of the left lower extremity.[7] Dr. Becan found that she had a class 1 severe sensory deficit of the left L4 nerve root or two percent impairment after applying the grade modifiers.[8] He also found a class 1 severe sensory deficit of the left L5 and S1 nerve root for 14 percent impairment after applying the grade modifiers. Dr. Becan concluded that appellant had 46 percent impairment of her left lower extremity due to her accepted employment injuries. He found that she reached maximum medical improvement on April 9, 2010.

OWCP referred the medical record to its medical adviser and on August 1, 2010 Dr. Andrew A. Merola, a Board-certified orthopedic surgeon, reviewed the reports from Dr. DeSio dated April 8, 2010, Dr. Becan dated April 9, 2010, and noted that there were major differences between the findings that he was unable to reconcile. Dr. Merola recommended that Dr. Becan clarify his findings or send appellant for an independent medical examination.

In a report dated November 8, 2010, Dr. DeSio noted that appellant had obtained excellent relief from her injection, but fractured both ankles falling down stairs. Appellant was also diagnosed with a cardiac anomaly. She reported that her back and radiating left leg pain increased in intensity while standing, bending, lifting, and performing household chores. Appellant denied numbness, but reported a tingling sensation in the left lower extremity. Dr. DeSio found normal lower extremity strength, no areas of diminished sensation and positive straight leg raising on the left. He recommended additional epidural injections.

OWCP found a conflict of medical opinion between Drs. Becan and DeSio and referred appellant to Dr. Ian Blair Fries, a Board-certified orthopedic surgeon, for an impartial medical examination on November 10, 2010. In a report dated December 10, 2010, Dr. Fries provided an accurate history of injury and review of her medical history. He noted appellant's reports of pain and found on examination that she was able to walk on her toes and on her heels. Dr. Fries found mild percussion tenderness over the lower paralumbar area and left buttock. He found limited range of motion of the lumbar spine and positive straight leg raising on the left. Dr. Fries noted that appellant had decreased sensation in her left calf compared to the right and somewhat

[3] For impairment ratings calculated on and after May 1, 2009, OWCP should advise any physician evaluating permanent impairment to use the sixth edition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[4] A.M.A., *Guides* 535, Table 16-12.

[5] *Id*. at 516, Table 16-6.

[6] *Id*. at 519, Table 16-8.

[7] *Id*. at 535, Table 16-12.

[8] *Supra* note 5.

less involving the posterior distal left thigh. He noted that her sensory deficits gradually expanded during the examination such that she could not appreciate either a light touch or sharp pain anywhere in the left lower extremity including all toes, ankle, calf, knee, and thigh. Dr. Fries examined appellant's MRI scan and found a degenerated L5-S1 disc, nonphysiologic sensory findings in the left lower extremity and discrepant left straight leg raising. He found that she had normal strength in all left lower extremity muscle groups and symmetrical deep tendon reflexes. Dr. Fries noted that appellant's findings were inconsistent with radiculopathy. He diagnosed spondylosis with a markedly degenerated lumbosacral disc. Dr. Fries noted the MRI scan findings of a herniated disc were equivocal and not reliable as reflected in appellant's left lower extremity. He concluded that she did not have objective left lower extremity findings to support a permanent impairment under the A.M.A., *Guides*. Dr. Fries found that appellant reached maximum medical improvement on December 17, 2009.

Dr. Robert Y. Pick, a Board-certified orthopedic surgeon, and an OWCP medical adviser, reviewed the record on January 6, 2011. He found that appellant did not have objective left lower extremity findings to support permanent impairment to her leg. On February 8, 2011 Dr. DeSio found that she had normal lower extremity strength, normal sensory examination of the lower extremities, and negative straight leg raising bilaterally.

By decision dated April 21, 2011, OWCP denied appellant's claim for a schedule award. It found that she did not establish permanent impairment to her lower extremities.

Appellant requested an oral hearing on April 25, 2011. Following the hearing on August 10, 2011, she submitted an additional report from Dr. Becan, who contended that Dr. Fries did not adequately evaluate her impairment.

In a decision dated October 25, 2011, a hearing representative set aside the April 21, 2011 decision and remanded the case for additional development of the medical evidence. He found that there was no conflict of medical opinion at the time of Dr. Fries' examination. The hearing representative determined that neither Dr. Becan nor Dr. Fries applied the appropriate provision of the A.M.A., *Guides* to determine appellant's impairment of her lower extremity. He found that the district medical adviser's report should have been used as guidance for further medical development, and Dr. Fries' report would be considered an office-directed examination.

On November 22, 2011 OWCP referred appellant for an impartial medical examination with Dr. Michael Gordon, a Board-certified orthopedic surgeon. In his December 12, 2011 report, Dr. Gordon described her history of injury. He noted appellant's complaints of back pain radiating down the posterior aspect of her left leg to her foot as well as cramping in the left leg. Dr. Gordon found that her gait was normal and noted that she stated she was unable to heel walk, toe walk, deep squat, or do tandem gait. He found no lumbar spasm, negative seated straight leg raising, and positive supine leg raising on the left at 30 degrees. Appellant reported glove-like hypoesthesia over the left lower extremity. Dr. Gordon noted that she had voluntary release of the flexors and extensors of the left knee, but that motor strength was 5/5 bilaterally. He reviewed appellant's MRI scan and the accepted diagnoses of lumbar herniated disc, lumbosacral radiculopathy, lumbar spondylosis, and inguinal hernia without obstruction. Dr. Gordon stated that he reviewed the A.M.A., *Guides* and *The Guides Newsletter* July/August 2009 regarding rating of spinal nerve extremity impairment.

Dr. Gordon found that there was no impairment of the left lower extremity. He stated that appellant's complaints of glove-like sensory loss of the left lower extremity would not fit a typical peripheral nerve or radicular pattern and was a nonphysiologic finding. Dr. Gordon noted that, under the A.M.A., *Guides,* sensory examination results should conform to the cutaneous distribution of a peripheral nerve or branch of a peripheral nerve, which was not the case with complaints of a glove-like sensory loss. Appellant's motor deficits were based on the voluntary release of both flexor and extensors of the knee, a finding of symptom magnification. Dr. Gordon stated that if she had the extent of muscle weakness demonstrated she would have great difficulty standing up unsupported or walking. He further found that the lack of atrophy in the lower extremities was not compatible with significant muscle weakness in the left lower extremity. Dr. Gordon opined that the findings of muscular weakness in appellant'slower extremities were nonphysiologic. He concluded that there currently no objective evidence of ongoing radiculopathy involving the lower extremity.

Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed this report on February 7, 2012. He agreed with Dr. Gordon's conclusions based on the findings of his examination.

By decision dated February 21, 2012, OWCP denied appellant's claim for a schedule award.

Appellant requested an oral hearing on March 7, 2012.

Dr. Charles Cresanti-Daknis, a Board-certified anesthesiologist, examined appellant on February 1, March 7, and April 18, 2012. He noted that she fell in April 2011 and experienced increasing left leg and low back pain. Dr. Cresanti-Daknis found decreased sensation to touch in the L5-S1 dermatomal distribution, with spasm, and tenderness in the paravertebral muscles on the left and recommended an MRI scan. Appellant underwent an MRI scan on February 28, 2012 which demonstrated mild disc bulge with bilateral facet arthropathy at L3-4 and L4-5 as well as a mild disc-osteophyte complex at L5-S1 resulting in a diagnosis of multilevel mild degenerative changes of the lumbosacral spine. Dr. Cresanti-Daknis also recommended an electromyogram (EMG) and nerve conduction study (NCS). Dr. Bruce M. Coplin, a physician Board-certified in physical medicine and rehabilitation, examined appellant on May 3, 2012 found slight decrease in sensation along the lateral aspect of the left leg with mild weakness in plantar flexion at the left ankle. He noted that her straight leg raising examination was positive at 73 degrees on the left with some tenderness in the lower lumbar paraspinal muscles. Dr. Coplin diagnosed left S1 radiculopathy, underlying L5-S1 herniated disc and recommended electrodiagnostic studies. Appellant's representative appeared at the oral hearing on June 11, 2012.

Appellant's June 7, 2012 EMG and NCS demonstrated a left S1 radiculopathy. Dr. Cresanti-Daknis found on June 20 and May 3, 2012 that she had 4/5 weakness of the left great toe and foot with plantar and dorsiflexion and spasm of the paravertebral muscles.

An OWCP hearing representative issued a decision on August 7, 2012 and vacated the February 29, 2012 decision. He directed OWCP to refer the electrodiagnostic testing to Dr. Gordon for review and further opinion regarding permanent impairment.

OWCP requested a supplemental report from Dr. Gordon on August 13, 2012. In a report dated September 7, 2012, Dr. Gordon reviewed the EMG of June 7, 2012 and noted that it supported left S1 nerve root "irritation." He stated that the information did not change his prior opinion and that he reviewed the A.M.A., *Guides* and *The Guides Newsletter*. Dr. Gordon stated that there was a lumbosacral radiculopathy, but that there was no objective sensory or motor deficit supported by "objective" neurologic findings.

On September 25, 2012 Dr. Bruce R. Rosenblum, a Board-certified neurosurgeon, noted appellant's history of injury. He found positive straight leg raising and tenderness at the L5 spinous process. Dr. Rosenblum diagnosed post-traumatic lumbar radiculopathy.

Dr. Magliato reviewed Dr. Gordon's supplemental report on October 17, 2012. He found no objective neurological findings in the left lower extremity, with no radiculopathy. Dr. Magliato agreed that appellant did not have a ratable impairment of the left lower extremity.

OWCP denied appellant's claim for a schedule award in a November 19, 2012 decision.

Appellant requested an oral hearing on November 28, 2012. Her representative objected to the application of *The Guides Newsletter*. He also contended that Dr. Gordon did not provide any explanation for his finding that there was no objective sensory deficit considering the positive NCS.

By decision dated April 30, 2013, the hearing representative affirmed the denial of a schedule award. He found that the medical evidence did not establish that appellant sustained permanent impairment of her lower extremities. The hearing representative found that the weight of the medical opinion evidence rested with Dr. Gordon.

LEGAL PRECEDENT

The schedule award provision of FECA[9] and its implementing regulations[10] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[11]

[9] 5 U.S.C. §§ 8101-8193, 8107.

[10] 20 C.F.R. § 10.404.

[11] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); *supra* note 3; Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[12] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[13] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[14] no claimant is entitled to such an award.[15]

Amendments to FECA, however, 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. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[16]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[17] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures provide that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) is to be applied as provided in section 3.700 of its procedures.[18] Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[19] and upper extremity impairment originating in the spine through Table 15-14.[20]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[21]

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[12] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).

[13] *W.D., id*. *William Edwin Muir*, 27 ECAB 579 (1976).

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

[15] *W.D., supra* note 12. *Timothy J. McGuire*, 34 ECAB 189 (1982).

[16] *W.D., id*. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[17] FECA Transmittal No. 10-04 (issued January 9, 2010); *supra* note 11 at Chapter 3.700 Exhibit 4 (January 2010).

[18] *Supra* note 11 at (Exhibits 1, 4).

[19] A.M.A., *Guides*, 533, Table 16-11.

[20] *Id*. at 425, Table 15-14.

[21] *Id*. at 521, Table 15-14. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

ANALYSIS

Dr. DeSio, a treating Board-certified anesthesiologist, examined appellant on April 8, 2010. He noted her complaints of low back and occasional left leg pain. OWCP accepted that appellant sustained lumbosacral spondylosis, lumbosacral radiculopathy, and lumbar herniated disc from her March 9, 2008 employment-related injury. Appellant submitted medical evidence of permanent impairment of her left leg as a result of this injury from Dr. Becan. OWCP originally referred her for an independent medical examination with Dr. Fries, who found no permanent impairment under the A.M.A., *Guides*. Later, the hearing representative found that no conflict was created between Drs. Becan and Fries and as such relegated Dr. Fries' opinion to that of an office-directed examination. As a result of the conflict of medical opinion evidence between Dr. Becan and Dr. Fries, it referred appellant for an impartial medical examination with Dr. Gordon.

In his initial report dated December 12, 2011, Dr. Gordon provided an accurate history of injury and reviewed the medical records. He provided findings on physical examination noting that appellant's gait was normal although she stated that she was unable to heel walk, toe walk, deep squat, or do tandem gait. Dr. Gordon found no lumbar spasm, negative seated straight leg raising and positive supine leg raising on the left at 30 degrees. Appellant reported glove-like hypoesthesia of the left lower extremity. Dr. Gordon noted that she had voluntary release of the flexors and extensors of the left knee, but that motor strength was 5/5 bilaterally. He diagnosed lumbar herniated disc, lumbosacral radiculopathy, lumbar spondylosis and inguinal hernia without obstruction. Dr. Gordon stated that he reviewed the A.M.A., *Guides* and *The Guides Newsletter* July/August 2009 regarding rating of spinal nerve extremity impairment and found no impairment of the left lower extremity. He discussed appellant's complaints of glove-like sensory loss of the left lower extremity. Dr. Gordon noted that these would not fit a typical peripheral nerve or radicular pattern and were a nonphysiologic finding which did not conform to the cutaneous distribution of a peripheral nerve or branch of a peripheral nerve as required by the A.M.A., *Guides.*

Dr. Gordon discussed appellant's symptoms of muscle weakness and indicated that her motor deficits were based on the voluntary release of both flexor and extensors of the knee, a finding of symptom magnification. He opined that if she had the extent of muscle weakness demonstrated, she would have great difficulty standing up unsupported or walking and would demonstrate atrophy in the lower extremities. Dr. Gordon opined that the findings of muscular weakness in appellant's lower extremities were nonphysiologic. He concluded that there currently was no objective evidence of ongoing radiculopathy involving the lower extremity.

In his supplemental report dated September 7, 2012, Dr. Gordon reviewed the EMG of June 7, 2012 and noted that this report supported left S1 nerve root "irritation." He stated that this information did not change his opinions based on his review of the A.M.A., *Guides* and *The Guides Newsletter*. Dr. Gordon stated that there was a lumbosacral radiculopathy, but that there was no objective sensory or motor deficit as there were no "objective" neurologic findings.

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving

the conflict, the opinion of such specialist, if sufficiently well rationalized, and based on a proper factual background, must be given special weight.[22]

The Board finds that Dr. Gordon's reports are entitled to the weight of the medical evidence. Dr. Gordon provided an accurate history of injury, review of the medical evidence and detailed finding on physical examination. He explained the nonphysiological aspect of appellant's sensory and motor deficits. Dr. Gordon noted that lumbosacral radiculopathy found on electrodiagnostic testing was not confirmed by objective neurological findings on physical examination. Without findings of impairment of the lower extremity based on physical examination, the electrodiagnostic results alone are not sufficient to establish impairment under the A.M.A., *Guides*.[23] Dr. Gordon's reports are entitled to the special weight of an impartial medical examiner and do not support appellant's claim for permanent impairment of a scheduled member.

Following Dr. Gordon's initial report, appellant submitted additional medical evidence from Drs. Cresanti-Daknis, Rosenblum and Coplin. These physicians did not address her permanent impairment and these reports are not sufficiently detailed to establish appellant's entitlement to a schedule award or to create a conflict with Dr. Gordon's detailed and well-reasoned reports.

The Board finds that Dr. Gordon's reports are entitled to the special weight of the medical evidence and resolve the conflict of medical opinion between Dr. Becan and Dr. Fries. These reports do not establish a permanent impairment of the left lower extremity entitling appellant to a schedule award.

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 does not have a permanent impairment of a scheduled member entitling her to a schedule award.

[22] *Nathan L. Harrell,* 41 ECAB 401, 407 (1990).

[23] *B.T.*, Docket No. 13-2128 (issued March 10, 2014).

ORDER

IT IS HEREBY ORDERED THAT the April 30, 2013 decision of the Office of Workers' Compensation Programs is affirmed.[24]

Issued: September 28, 2015
Washington, DC

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

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

[24] Michael E. Groom, Alternate Judge, participated in the preparation of this decision, but was no longer a member of the Board effective December 27, 2014.