United States Department of Labor
Employees' Compensation Appeals Board

C.G., Appellant **and** **U.S. POSTAL SERVICE, POST OFFICE, Amarillo, TX, Employer**	))))))))	**Docket No. 18-0392** **Issued: August 14, 2018**

Appearances:
Appellant, *pro se*
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 19, 2017 appellant filed a timely appeal from a December 8, 2017 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.

ISSUE

The issue is whether appellant has established more than seven percent permanent impairment of the right lower extremity, for which he previously received a schedule award, or any permanent impairment of his left lower extremity.

FACTUAL HISTORY

On May 27, 2004 appellant, then a 45-year-old mail processor, filed a notice of traumatic injury (Form CA-1) alleging that on May 24, 2004 he reached up to place mail in a case slot and

[1] 5 U.S.C. § 8101 *et seq.*

experienced lumbar pain with right-sided radiculopathy and paresthesias.[2] OWCP accepted that the May 24, 2004 employment incident caused a lumbosacral strain, L5-S1 disc derangement, lumbar disc degeneration, and right-sided lumbar radiculopathy.

In a report dated June 15, 2006, Dr. John W. Ellis, an attending Board-certified family practitioner, provided a history of injury and treatment. He noted that appellant had alleged a second work-related lumbar injury on May 19, 2005 when he bent down to pick up a fallen clipboard.[3] On examination Dr. Ellis found decreased reflexes in the right foot, decreased range of lumbar motion, a positive right straight leg raising test, and bilateral paraspinal muscle spasms. He diagnosed a lumbosacral strain, L5-S1 disc derangement, and right lower extremity radiculopathy.

On September 6, 2006 appellant filed a claim for a schedule award (Form CA-7).

In a report dated September 21, 2006, an OWCP district medical adviser reviewed the medical record. He opined that appellant had attained maximum medical improvement (MMI) on June 1, 2005, one year following the May 24, 2004 employment injury. The medical adviser found that appellant had sustained seven percent permanent impairment of the right lower extremity according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides*) then in effect, three percent for diminished sensation, and four percent for atrophy or decreased strength.

By decision dated September 27, 2006, OWCP granted appellant a schedule award for seven percent permanent impairment of the right lower extremity. The period of the award ran from June 1 to October 20, 2005.

On May 10, 2007 appellant underwent right L2, L3, L4, and L5 lumbar facet medial branch neurotomies by radiofrequency ablation.

An August 27, 2007 lumbar MRI scan demonstrated disc desiccation and small diffuse disc protrusions with minimal central canal and bilateral neural foraminal stenosis at L2-3, L3-4, and L4-5.

Dr. Ellis provided a June 8, 2009 impairment rating, finding 24 percent permanent impairment of appellant's right lower extremity based on 13 percent impairment of the L5 nerve root, 13 percent impairment of the right S1 nerve root, and 9 percent permanent impairment of the left lower extremity due to S1 nerve root impairment. Subsequently, an OWCP district medical adviser reviewed Dr. Ellis' June 8, 2009 impairment rating on February 22, 2010. He opined that it did not conform to the appropriate rating methodologies of the A.M.A., *Guides*.

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[2] A lumbar magnetic resonance imaging (MRI) scan performed on May 27, 2004 demonstrated an L3-4 annular bulge, a mild diffuse bulge at L4-5, moderate bilateral foraminal narrowing at L4-5, and mild bilateral foraminal narrowing at L3-4.

[3] The record does not reflect that appellant filed a claim for a May 19, 2005 employment injury.

[4] A.M.A., *Guides* (5th ed. 2001).

A June 18, 2009 electromyography (EMG) and nerve conduction velocity (NCV) study was negative for lumbar radiculopathy. It indicated a possible peripheral polyneuropathy affecting both lower extremities.

On June 23, 2010 OWCP obtained a second opinion regarding the appropriate percentage of permanent impairment from Dr. John A. Sklar, a Board-certified physiatrist. Based on a review of the medical record, statement of accepted facts, and a clinical examination, Dr. Sklar opined that appellant had no impairment of either lower extremity due to lumbar nerve root impingement. An OWCP medical adviser reviewed Dr. Sklar's report on September 30, 2011 and concurred with his findings and impairment rating.

Appellant retired from the employing establishment, effective April 28, 2011.

On January 13, 2015 appellant filed a claim for an increased schedule award (Form CA-7). He provided a report dated September 11, 2014 from Dr. Ellis in which he opined that the accepted lumbar injuries had disabled appellant from all work and continued to worsen. In a report dated October 20, 2014, Dr. Ellis noted findings on examination of decreased sensation in the L4, L5, and S1 dermatomes bilaterally, and an absent right ankle reflex. He diagnosed a thoracic sprain, displaced lumbar disc, and lumbosacral disc degeneration. Dr. Ellis opined that, according to Table 16-2 of the A.M.A., *Guides* and *The Guides Newsletter*, appellant had 18 percent permanent impairment of the right L5 nerve root, and 13 percent permanent impairment of the right S1 nerve root. He combined these values to equal 29 percent permanent impairment of the right lower extremity. On the left Dr. Ellis found three percent permanent impairment of the left L4 nerve root, three percent permanent impairment of the left L5 nerve root, and one percent impairment of the left S1 nerve root. He combined these values to find a total of seven percent permanent impairment of the left lower extremity. Dr. Ellis opined that appellant had attained MMI.[5]

On March 10, 2016 OWCP obtained another second opinion from Dr. Michael S. Brown, a Board-certified physiatrist. Dr. Brown reviewed the medical record and a statement of accepted facts (SOAF). On examination he found mildly limited lumbar motion, negative straight raising tests bilaterally, normal sensation throughout both legs, bilaterally present deep tendon reflexes, and no focal strength deficits in either lower extremity on manual muscle testing. Dr. Brown diagnosed lumbar degenerative disc disease. He opined that as appellant had a "normal neurologic examination including normal strength and normal sensation in the lower extremities with intact reflexes, no evidence of nerve injury is appreciated." Therefore, according to page 533 of the sixth edition of the A.M.A., *Guides*, appellant had no permanent impairment of either lower extremity.

[5] In a January 29, 2015 report, an OWCP district medical adviser recommended that OWCP obtain a second opinion as Dr. Ellis' October 20, 2014 impairment rating contained significant inconsistencies and did not conform to the A.M.A., *Guides*. He recommended that OWCP obtain a second opinion on the issue of permanent impairment. On September 2, 2015 OWCP obtained a second opinion report from Dr. Edward Brandecker, a Board-certified physiatrist and pain management specialist, who provided an impairment rating of the lumbar spine. In a September 14, 2015 report, an OWCP district medical adviser explained that Dr. Brandecker's evaluation erred by rating the spine itself as FECA did not allow for a schedule award for permanent impairment of the spine. OWCP's district medical adviser therefore recommended that OWCP obtain a new second opinion.

In a report dated March 21, 2016, an OWCP district medical adviser concurred with Dr. Brown that appellant had no permanent impairment of the lower extremities. He opined that appellant had attained MMI on March 10, 2016.

By decision dated March 23, 2016, OWCP denied appellant's claim for an additional schedule award, based on Dr. Brown's opinion as the weight of the medical evidence. It found that Dr. Brown provided a well-rationalized opinion, based on the appropriate portions of the A.M.A., *Guides*.

On June 14, 2016 appellant requested reconsideration and submitted additional medical evidence.

An April 18, 2016 EMG study demonstrated right L3 radiculopathy with no motor weakness, bilateral tarsal tunnel syndrome, and spinal stenosis superimposed on a history of diabetes.

In a report dated May 31, 2016, Dr. Ellis related appellant's subjective complaints of decreased sensation in his legs, feet, and bladder. He noted that appellant had been diagnosed with adult onset diabetes in 2007, treated with oral medication. Dr. Ellis opined that, according to Table 16-12 and *The Guides Newsletter,* appellant had 4 percent impairment of the right L3 spinal nerve root, 6 percent permanent impairment of the right L4 spinal nerve root, 6 percent permanent impairment of the right L5 spinal nerve root, and 10 percent permanent impairment of the right S1 spinal nerve root. Using the Combined Values Chart, he calculated a total of 23 percent permanent impairment of the right lower extremity. For the left lower extremity, he found 6 percent impairment of the left L5 spinal nerve root and 4 percent permanent impairment of the left S1 spinal nerve root, combined to equal a total of 10 percent permanent impairment of the left lower extremity.

On July 15, 2016 an OWCP district medical adviser opined that Dr. Ellis' May 31, 2016 impairment rating differed significantly from that of Dr. Brown. The district medical adviser noted that OWCP should clarify whether there was a conflict of medical opinion which required resolution by an impartial medical specialist.

In a report dated May 30, 2017, Dr. Ellis provided an American Academy of Orthopedic Surgeons (AAOS) lower limb questionnaire with a score of 22 on the right and 14 on the left, and a pain disability questionnaire (PDQ) score of 138. He repeated the impairment rating set forth in his May 31, 2016 opinion of 23 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity.

OWCP found a conflict of medical opinion between Dr. Ellis, for appellant, and Dr. Brown, for the government, regarding the appropriate percentage of permanent impairment. To resolve the conflict, OWCP selected Dr. Sami R. Framjee, a Board-certified orthopedic surgeon.[6] In a June 8, 2017 report, Dr. Framjee reviewed the medical record and a SOAF. On

[6] OWCP had originally selected Dr. Stephen Ringel, a Board-certified orthopedic surgeon, but the examination did not take place as Dr. Ringel did not perform schedule award evaluations using the sixth edition of the A.M.A., *Guides*. Dr. Andrew Parkinson, a Board-certified orthopedic surgeon, as impartial medical examiner. However, OWCP cancelled the appointment due to a conflict of interest.

examination he observed bilateral paraspinal tenderness, restricted lumbar motion, negative straight leg raising tests bilaterally, a normal sensory examination throughout both lower extremities, and 4+ motor strength in each leg. Dr. Framjee obtained lumbar x-rays demonstrative anterior osteophytes from L3 to L5, and a mild L3-4 retrolisthesis. He opined that appellant had no objective evidence of focal neurologic deficits in either lower extremity secondary to any lumbar pathology. Dr. Framjee found that appellant therefore had no ratable impairment of the right or left leg due to nerve root involvement according to the A.M.A., *Guides*.

By decision dated July 10, 2017, OWCP denied modification of its prior decision, finding that appellant had not submitted probative medical evidence establishing greater than seven percent permanent impairment of the right lower extremity or any ratable impairment of the left lower extremity. It accorded the weight of the medical evidence to Dr. Framjee, who provided a thorough, well-rationalized opinion explaining that appellant had no impairment of either lower extremity attributable to nerve root involvement.

On September 8, 2017 appellant requested reconsideration. He contended that Dr. Ellis' opinion should be controlling as he was appellant's attending physician. Appellant submitted additional evidence.

In a report dated November 14, 2017, Dr. Ellis opined that appellant's occupational lumbar conditions had reached MMI as of May 30, 2017.[7]

By decision dated December 8, 2017, OWCP denied modification of its prior decision, finding that the evidence submitted on reconsideration did not establish that appellant sustained more than a seven percent permanent impairment of the right lower extremity or any permanent impairment of the left lower extremity. It found that Dr. Ellis' November 14, 2017 report did not address the issue of permanent impairment.

LEGAL PRECEDENT

The schedule award provisions 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the

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[7] Appellant also provided copies of medical evidence previously of record, and his August and September 2017 correspondence to OWCP regarding contact information and mileage reimbursement.

[8] *Supra* note 1.

[9] 20 C.F.R. § 10.404.

specified edition of the A.M.A., *Guides*.[10] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[11]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the implementing regulations.[12] Neither FECA nor its implementing federal regulations provide for payment of a schedule award for the permanent loss of use of the back, the spine, or the body as a whole; a claimant is not entitled to such a schedule award.[13] The Board notes that section 8101(19) specifically excludes the back from the definition of organ.[14] A claimant may receive a schedule award for any permanent impairment to the upper or lower extremities even though the cause of the impairment originated in the spine.[15]

The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve impairment, set forth in the July/August 2009 *The Guides Newsletter*.[16] 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.[17] 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.[18]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with an OWCP medical adviser providing rationale for the percentage of impairment specified.[19]

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[10] *Id*. 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 2.808.5.a (March 2017).

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

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

[13] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[14] 5 U.S.C. § 8101(9).

[15] *W.D.*, Docket No. 10-0274 (issued September 3, 2016).

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

[17] *See supra* note 10 at Part 3 -- Medical, *Schedule Awards,* Chapter 3.700, Exhibit 4 (January 2010).

[18] *D.S.*, Docket No. 14-0012 (issued March 18, 2014).

[19] *See supra* note 10 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims,* Chapter 2.808.6(f) (March 2017).

ANALYSIS

The Board finds that appellant has not established greater than seven percent permanent impairment of his right lower extremity for which he previously received a schedule award, or any permanent impairment of the left lower extremity.

On September 27, 2006 OWCP granted appellant a schedule award for seven percent permanent impairment of the right lower extremity.

On January 13, 2015 appellant claimed an increased schedule award based on Dr. Ellis' October 20, 2014 impairment rating, which found 29 percent permanent impairment of the right lower extremity and 7 percent permanent impairment of the left lower extremity according to Table 16-2 of the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*. On March 10, 2016 Dr. Brown, a Board-certified physiatrist and second opinion examiner, opined that appellant had no appreciable nerve injury affecting either of his lower extremities. OWCP denied appellant's claim for an increased schedule award on March 23, 2016 based on Dr. Brown's opinion as the weight of the medical evidence.

Pursuant to appellant's June 14, 2016 request for reconsideration, OWCP found a conflict of medical opinion between Dr. Brown and Dr. Ellis, and selected Dr. Framjee, a Board-certified orthopedic surgeon, to resolve the conflict. Dr. Framjee provided a June 8, 2017 report, setting forth detailed clinical findings of a normal motor and sensory examination throughout both lower extremities. He therefore opined that appellant had no permanent impairment of either leg due to nerve root impairment. By decision dated July 10, 2017, OWCP denied modification based on Dr. Framjee's opinion as the weight of the medical evidence.

Appellant requested reconsideration on September 8, 2017 and submitted a November 14, 2017 report from Dr. Ellis, which did not address the issue of permanent impairment. OWCP denied modification by decision dated December 8, 2017.

The Board finds that OWCP properly accorded the special weight of the medical evidence in the case to Dr. Framjee, who provided a detailed, well-rationalized report based on his clinical examination, a review of the medical record, and SOAF. Dr. Framjee explained that there was no evidence of focal neurologic deficit impairing either lower extremity. As noted, an appellant may receive a schedule award for permanent impairment to the extremities even though the cause of the impairment originated in the spine.[20] In this case, however, Dr. Framjee explained that the medical record and objective findings on examination failed to document any sensory or motor deficit of either lower extremity attributable to nerve root impairment. As appellant has no evidence of lumbar radiculopathy affecting the lower extremities he was not entitled to an increased schedule award based on impairment to his lower extremities which originated in the

[20] *Francesco Veneziani*, 48 ECAB 572 (1997). A schedule award is payable for a permanent impairment of the extremities that is due to a work-related back condition; *see also Denise D. Cason*, 48 ECAB 530 (1997); *J.S.*, Docket No. 13-2129 (issued June 6, 2014).

spine.[21] Therefore, he has not established greater than the seven percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

On appeal appellant contends that OWCP should have accorded the weight of the medical evidence to Dr. Ellis as his reports were more accurate and complete than those of the second opinion physician and impartial medical specialist. However, for the reasons set forth above, there is no evidence which establishes that appellant sustained more than seven percent permanent impairment of the right lower extremity or any impairment of the left lower extremity causally related to the accepted lumbar spine conditions.

Appellant may request a schedule award or increased schedule award at any time 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 greater than a seven percent permanent impairment of the right lower extremity, for which he previously received a schedule award, or any permanent impairment of his left lower extremity.

[21] *Supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 8, 2017 is affirmed.

Issued: August 14, 2018
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board