U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SHERRY W. REDD and U.S. POSTAL SERVICE,
POST OFFICE, Gulfport, MS

Docket No. 01-646; Submitted on the Record;
Issued April 5, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, COLLEEN DUFFY KIKO,
DAVID S. GERSON

The issues are: (1) whether appellant has more than a one percent permanent impairment of the left lower extremity for which she has received a schedule award; and (2) whether the Office of Workers' Compensation Programs properly denied appellant's request for a hearing before an Office hearing representative.

On October 23, 1992 appellant, then a 35-year-old postal worker, injured her lower back. The Office accepted the claim for lumbosacral strain and herniated nucleus pulposus; and authorized a lumbar laminectomy. Appellant stopped work on October 23, 1992 and returned to light duty, four hours per day in November 1993. Appropriate benefits were paid.

On June 1, 1998 appellant filed a claim for a schedule award. She submitted a July 19, 1994 treatment note from Dr. Michael Lowry, a specialist in orthopedics, who evaluated appellant for permanent impairment. Dr. Lowry noted that appellant had reached maximum medical improvement. He determined that appellant sustained a permanent impairment of 35 percent to the left leg.

Appellant also submitted treatment notes from Dr. Lowrey dated August 18, 1993 to October 2, 1995, noting a history of appellant's back injury on October 23, 1992 and indicating that appellant underwent a lumbar laminectomy on August 12, 1993 and was progressing post surgery.

The Office referred the case to Dr. Dave Roberts, a Board-certified neurologist, who noted, in a January 15, 1998 report, that an electomyographic (EMG) and nerve conduction velocity examination revealed only mild to equivocal evidence of a left perioneal neuropathy distally in the foot which was not felt to be clinically significant or symptomatic. Dr. Roberts noted that the EMG studies were compromised by limited effort secondary to pain. He diagnosed appellant with postoperative low back pain syndrome with no clinical or electrophysiologic evidence of residual lumbar or sacral radiculopathy.

The Office medical adviser, reviewed the record in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (4th ed. 1993) and determined, in his October 27, 1998 report, that appellant sustained a zero percent permanent impairment.

In a decision dated March 9, 1999, the Office denied appellant's request for a schedule award.

In a letter dated March 31, 1999, appellant requested a hearing before an Office hearing representative. The hearing was held on August 10, 1999. Appellant submitted July 28, 1998 and June 11, 1999 report's from Dr. Lowry and EMG testing performed on April 12, 1999. Dr. Lowry's reports noted that appellant continued to complain of pain in the back and neck. He noted that he believed Dr. Roberts testing to be incomplete. Dr. Lowry further noted that his disability rating had not changed from July 19, 1994. The EMG report revealed chronic L4 or L5 radiculopathy on the left; and nerve conduction study of the right revealed no abnormalities.

In a decision dated October 14, 1999, the Office set aside the decision dated March 9, 1999 and remanded the case to resolve the conflict of opinion between Dr. Lowry, appellant's treating physician, who indicated that appellant had a ratable impairment, and the medical adviser, who determined appellant had no ratable impairment.

On November 23, 1999 the Office referred appellant for a referee examination to Dr. Howard L. Smith, a Board-certified neurosurgeon. The Office provided Dr. Smith with appellant's medical records, a statement of accepted facts as well as a detailed description of appellant's employment duties. In a medical report dated December 16, 1999, Dr. Smith noted a history of appellant's condition. He noted upon physical examination gait was normal with no antalgia; there was no tenderness to palpation through the cervical and thoracic spine; and there was diffuse tenderness in the lumbosacral spine; strength was 5/5 and symmetric in the deltoids, biceps, triceps, wrist extensors, wrist flexors; light touch showed a decrease on the left medial foot; pin prick was intact throughout; and reflexes were two at the biceps, triceps, knees and ankles. Dr. Smith noted that appellant described pain frequently radiating down the left leg, with the severity ranging between 5 and 10 on a scale of 10. He further noted that appellant worked from 8:00 a.m. to 5:00 p.m. and then returned home to complete her regular household duties. Dr. Smith diagnosed appellant with chronic pain after left L5-6 discectomy, endometriosis and depression. He noted that appellant had reached maximum medical improvement. Dr. Smith indicated that appellant's impairment according to the A.M.A., *Guides* was 10 percent whole-person impairment, citing page 102, DRE Lumbosacral Category III: Radiculopathy.

Dr. Smith's report and the case record were referred to the Office's medical adviser, who, in a report dated January 14, 2000, used Dr. Smith's findings and determined that appellant sustained one percent permanent impairment.[1] The Office medical adviser utilized Dr. Smith's findings upon examination to determine the impairment rating.

In a decision dated March 14, 2000, the Office granted appellant a schedule award for one percent impairment of the left leg.

[1] *See* Table 11, page 48; Table 83, page 130 of the A.M.A., *Guides.*

In a letter dated March 16, 2000, appellant requested a hearing before an Office hearing representative. The hearing occurred on July 24, 2000 and appellant testified that she continued to experience pain in her leg and loss of sensation. The record was held open so that appellant could submit additional medical evidence in support of her claim. Thereafter, appellant submitted a report from Dr. J. Stephen Beam, a specialist in rehabilitative medicine, dated July 26, 2000, who indicated that gross examination of the lower extremities revealed no muscle atrophy; there was decreased sensation to the lateral lower leg and lateral foot to the left; Babinski's test was negative bilaterally; toe walk was normal bilaterally; heel walk was abnormal; straight leg raises were negative bilaterally; and there was minimal tenderness of palpation in the lower back. He noted that the EMG test performed April 12, 1999 revealed abnormalities of the left common perioneal, left anterior tibilalis; and left vastis lateralis. Dr. Beam determined that appellant had a 17 percent whole person impairment rating and a 47 percent left lower extremity impairment rating based on motor changes of the common peroneal on the EMG.[2]

Dr. Beam's report dated July 26, 2000 was referred to the Office's medical adviser who determined that appellant sustained a one percent impairment of the left leg.

In a decision dated August 31, 2000, the Office affirmed the decision dated March 14, 2000.

In a letter dated October 9, 2000, appellant requested an oral hearing before an Office hearing representative.

In a decision dated November 15, 2000, the Office denied appellant's request for an oral hearing on the grounds that appellant had already received a hearing on the issue of the percentage of permanent partial impairment of the left lower extremity and was not entitled to another review on the same issue. Appellant was informed that her case had been considered in relation to the issues involved and that the request was further denied for the reason that the issues in this case could be addressed by requesting reconsideration from the district Office and submitting evidence not previously considered.

The Board finds that appellant has no more than a one percent impairment of the left leg.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] 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, the Act 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 regulation as the appropriate standard for evaluating schedule losses.

[2] *See* Table 68, page 89 of the A.M.A., *Guides.*

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

On appeal appellant alleges that she is entitled to more than a one percent impairment of the left leg.

In a medical report dated December 16, 1999, Dr. Smith, the Office referee physician, noted an essentially normal physical examination. He indicated that appellant described pain frequently radiating down the left leg, with the severity ranging between 5 and 10 on a scale of 10. Dr. Smith further noted that appellant worked from 8:00 a.m. to 5:00 p.m. and then returned home to complete her regular household duties. He diagnosed appellant with chronic pain after left L5-6 discectomy, endometriosis and depression. Dr. Smith noted that appellant had reached maximum medical improvement. He indicated that appellant's impairment according to the A.M.A., *Guides* was 10 percent whole-person impairment; however, the Act does not provide whole person impairment.

The medical adviser properly utilized the findings in Dr. Smith's report, and correlated them to specific provisions in the A.M.A., *Guides.* The Office medical adviser determined, based on these findings, that appellant's pain was Grade 2, decreased sensibility with or without abnormal sensation or pain, which was forgotten during activity and provided a 25 percent sensory deficit.[5] He further noted that the affected nerve was S1, and according to Table 83, page 120 of the A.M.A., *Guides,* the maximum rating for pain was five percent. The medical adviser then determined, using the formula designated in Table 11(b), page 48, (25 percent sensory deficit multiplied by the maximum rating for pain of 5 percent) that appellant sustained a one percent permanent impairment of the left leg. The medical adviser properly utilized the findings in Dr. Smith's report to determine that appellant sustained a one percent impairment of the left leg.

The Board has carefully reviewed Dr. Beam's report dated February 4, 2000, which determined appellant's left lower extremity impairment and notes that Dr. Beam did not properly utilize the relevant standards of the A.M.A., *Guides*.[6] Dr. Beam determined appellant had a 17 percent whole person impairment rating and a 47 percent left lower extremity which comprised a 15 percent whole person impairment and a 42 percent left lower extremity impairment based on motor changes of the common peroneal on the EMG; and a 2 percent whole person and 5 percent left lower extremity rating based on dysesthesia of the left common peroneal nerve.[7] He noted that he based his findings on the EMG test performed April 12, 1999 which revealed abnormalities of the left common peroneal, left anterior tibialis; and left vastis lateralis. Dr. Beam indicated that appellant's lower extremities did not reveal atrophy and her gait was essentially normal. The medical adviser determined that Dr. Beam had no objective medical evidence which indicated that appellant had motor weakness due to peripheral nerve involvement. Dr. Beam determined appellant sustained a 42 percent impairment of the left lower extremity on the basis of an abnormal EMG/nerve conduction velocity study and not on the basis of physical findings. The A.M.A., *Guides* do not provide that EMG/nerve conduction velocity studies are to be used to establish and rate motor deficits due to peripheral nerve injuries without

[5] *See* Table 11, page 48; Table 83, page 130 of the A.M.A., *Guides.*

[6] *See Tonya R. Bell,* 43 ECAB 845, 849 (1992).

[7] *See* Table 68, page 89 of the A.M.A., *Guides.*

objective physical findings. In this case, the physical findings were essentially normal. Additionally, the medical adviser determined that Dr. Beam incorrectly assigned a five percent permanent impairment on the basis of sensory changes of appellant's peroneal nerve; however, he did not modify the maximum level of sensory deficit or pain as required in the A.M.A., *Guides.*[8] Dr. Beam did not provide a numerical impairment rating in conformance with the A.M.A., *Guides.*

The Board finds that Dr. Beam did not properly follow the procedures as set forth in the A.M.A., *Guides.*[9] The medical adviser properly applied the A.M.A., *Guides* to the information provided in Dr. Smith's report and reached an impairment rating of one percent. This evaluation conforms to the A.M.A., *Guides* and establishes that appellant has no more than a one percent permanent impairment of the left leg.

The Board further finds that the Office properly denied appellant's request for a hearing.

Section 8124(b)(1) of the Act provides that a claimant not satisfied with a decision of the Office is entitled, upon timely request, to a hearing before a representative of the Office. Pursuant to 20 C.F.R. § 10.615, a claimant may choose to exercise this statutory right by requesting either an "oral hearing" or a "review of the written record." However, once an Office hearing representative has issued a decision after conducting a review of the written record, a claimant is not entitled to a subsequent oral hearing.[10]

The evidence of record indicates that on March 16, 2000 appellant disagreed with the March 14, 2000 decision and made a timely request for an oral hearing before an Office hearing representative. The hearing was held on July 24, 2000 and the Office issued an August 31, 2000 decision. By letter dated October 9, 2000, appellant disagreed with the decision and subsequently requested an oral hearing before an Office hearing representative. The Board finds that because the Office provided an oral hearing on her claim under section 8124(b), appellant is not entitled, by right, to a subsequent oral hearing on the same issue.[11] The Office noted that the issue in question could be equally well addressed by submitting a request for reconsideration to the Office and by providing evidence not previously considered, which establishes a schedule award for greater than one percent permanent impairment. The Board finds that the Office properly exercised its discretionary authority under the circumstances of this case.

[8] *See* Table 11, page 48; Table 83, page 130 of the A.M.A., *Guides.*

[9] *See Paul R. Evans, Jr.,* 44 ECAB 646 (1993) (an attending physician's report is of little probative value where the A.M.A., *Guides* were not properly followed); *John Constantin,* 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[10] *See Richard F. Hines,* 39 ECAB 1431 (1988); *Patricia A. Morris,* Docket No. 97-907 (issued June 3, 1998).

[11] *Id.*

The decision of the Office of Workers' Compensation Programs dated November 15 and August 31, 2000 are hereby affirmed.

Dated, Washington, DC
April 5, 2002

Alec J. Koromilas
Member

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member