United States Department of Labor
Employees' Compensation Appeals Board

K.H., Appellant	)	
and	)	**Docket No. 09-341**
	)	**Issued: December 30, 2009**
U.S. POSTAL SERVICE, PROCESSING & DELIVERY CENTER, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 17, 2008 appellant, through his attorney, filed a timely appeal from schedule award decisions of the Office of Workers' Compensation Programs dated January 17 and August 5, 2008. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this appeal.

ISSUE

The issue is whether appellant has more than one percent impairment to his right lower extremity and any impairment of his left lower extremity.

On appeal, counsel for appellant contends that the case should be remanded as the report of the second opinion physician was not based on an accurate statement of facts and he did not consider appellant's prior injuries to his left leg. In the alternative, counsel argues that at a conflict in medical opinion exists.

FACTUAL HISTORY

This is the second appeal before the Board.[1] In a July 14, 2006 decision, the Board affirmed decisions of the Office that terminated appellant's compensation benefits. The facts of the case as set forth in the Board's prior decision are incorporated by reference.

On March 2, 2007 appellant filed a claim for a schedule award. In a September 14, 2006 report, Dr. Nicholas Diamond, an osteopath, diagnosed post-traumatic anterior cruciate ligament tear with Grade 1 chondral erosion of lateral femoral condyle of left knee; status post left knee arthroscopy with debridement of the anterior cruciate ligament; post-traumatic right C5-6 herniated nucleus pulposus with radiculopathy; status post anterior cervical discectomy and fusion with bone graft and anterior plate fixation; post-traumatic L5-S1 herniated disc with bilateral S1 radiculopathy; and status post anterior lumbar interbody fusion at L5-S1. In reviewing appellant's history, he noted that appellant had an injury of left tibia and fibula fracture in 1982 for which multiple surgeries were performed. Dr. Diamond advised that he applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th edition 2001) (A.M.A., *Guides*) to find that appellant had 30 percent impairment to the left leg and 40 percent impairment to the right leg.

Dr. Diamond based his rating of impairment to the left leg on motor loss. Under Table 17-8, page 532, he found Grade 4 motor strength deficit involving knee extension to the left quadriceps for which 12 percent impairment was allowed. There was also Grade 4 motor loss involving ankle plantar flexion of the left gastrocnemius for which 17 percent impairment was allowed. Dr. Diamond combined the motor losses to find 27 percent impairment of the left leg and then added 3 percent impairment for pain, indicating that he applied Figure 18-1, page 574 to total 30 percent loss of the left leg. As to the right leg, Dr. Diamond based his impairment rating on both motor and sensory loss. He again applied Table 17-8 to find Grade 4 strength deficit of the right hip abductors for which 25 percent impairment was allowed and Grade 4 right quadriceps deficit of 12 percent. As to sensory loss, Dr. Diamond stated that he applied Tables 15-15 and 15-18, page 424, which rate impairment for unilateral spinal nerves. He identified Grade 2 sensory loss for which Table 15-15 allows up to an 80 percent deficit. Under Table 15-18, Dr. Diamond identified the affected nerves as the L5 and S1 nerve roots, for which the table allows a maximum of five percent loss to each impaired nerve root. He rated sensory

[1] Docket No. 06-214 (issued July 14, 2006). On March 30, 2002 appellant fell on a concrete floor. His claim was accepted for a herniated disc at L5-S1. The record indicates that, prior to the injury, appellant underwent anterior C5-6 cervical decompression and fusion surgery in 1997. He underwent an anterior lumbar interbody fusion of September 25, 2003. Appellant also has a history of nonemployment-related left leg injuries for which he underwent approximately 18 operations in the 1980s and 1990s.

impairment as four percent of both nerve roots. Dr. Diamond stated that he combined the motor and sensory ratings to total 40 percent impairment of the right leg.[2]

In a March 13, 2007 decision, the Office denied appellant's claim finding that he was not entitled to a schedule award for his back. However, in June 4, 2007 decision, an Office hearing representative set aside the schedule award denial and remanded the case for further development of the medical evidence on the extent of permanent impairment.

The Office referred appellant, together with a statement of accepted facts, to Dr. Robert F. Draper, Jr., a Board-certified orthopedic surgeon, for a second opinion.[3] In a July 17, 2007 report, Dr. Draper reviewed appellant's history of injury and medical treatment, noting that successive diagnostic studies obtained following the March 31, 2002 injury revealed L5-S1 disc degeneration with mild right-side herniation. Following a course of conservative care, appellant underwent surgery on September 12, 2003 consisting of an interbody fusion with a prosthetic cage device and iliac crest bone graft. Dr. Draper noted that appellant had since returned to work performing modified duties. On examination he noted straight leg raising was negative bilaterally and provided findings on reflex testing of the patella and Achilles tendons. Dr. Draper noted that appellant had marked weakness of the left leg in foot and ankle motion, and excellent bilateral hip flexion, knee extension, knee flexors, inversion and eversion functions. He advised that appellant's left leg abnormalities were due to his prior injury in the 1980s and multiple surgeries and not to the accepted back injury. On sensory examination, Dr. Draper reported that there was normal sensation in the L2, L3, L4, L5 and S1 dermatomes of the right leg. As to the left leg, he noted normal sensation at L2 and L3 above the knee, with a stocking glove deficit in the left leg from the mid-calf to the tip of the toes. Dr. Draper noted that appellant attributed this to his prior leg injuries and stated that this was a finding unrelated to the accepted back injury. He listed his diagnoses, reiterating that the motor and sensory losses to the left leg were unrelated to the accepted employment injury but to the 18 operations on appellant's left lower extremity and previous fractures. As to the right leg, Dr. Draper described a very mild S1 radiculopathy and paresthesias which, under Table 16-10 at page 82, he characterized as a Grade 4 (20 percent) deficit for distorted superficial tactile sensibility with cutaneous manifestation. He noted that, under Table 17-37, page 552, the maximum impairment allowed for sensory loss to the sciatic nerve for dysthesia was five percent.[4] Dr. Draper multiplied the 20 percent deficit by 5 percent to find that appellant had 1 percent impairment of the right leg due to mild lumbar radiculopathy. He noted that there was no impairment to

[2] The Board notes that Dr. Diamond also found sensory impairment of six percent based on loss to the right C6 cervical nerve root and provided a rating for appellant's right arm. As appellant's 2002 injury was accepted by the Office only for a herniated disc at L5-S1, he bears the burden of proof to establish impairment for conditions not accepted by the Office. *See Noe L. Flores*, 49 ECAB 344 (1998). On causal relationship, Dr. Diamond noted generally that "the work[-]related injuries sustained during the course of the claimant's employment are the competent producing factor for the subjective and objective findings of today." He did not specifically address how appellant's accepted injury was competent to cause or contribute to any cervical condition or produce impairment as described.

[3] The statement of accepted facts noted appellant's accepted condition of herniated disc at L5-S1 sustained in a fall from the top of a metal shelving unit on March 30, 2002.

[4] The Board notes that under Table 17-37, five percent represents impairment to the whole person. The table provides that dysthesia of the sciatic nerve is 12 percent impairment of the lower extremity.

appellant's left leg as the findings on examination were not related to the accepted low back injury.

In an August 16, 2007 decision, the Office again denied appellant's claim for a schedule award. This decision was set aside by an Office hearing representative on November 13, 2007. The case was remanded for further development of the medical evidence.

On December 5, 2007 Dr. Arnold T. Berman, an Office medical adviser and Board-certified orthopedic surgeon, reviewed the medical evidence of record. He noted that the accepted condition was a herniated disc at L5-S1 and that appellant had a prior history of cervical fusion at C5-6 in December 1997. Dr. Berman discussed the medical evidence pertaining to appellant's lumbar surgery of September 25, 2003, noting that the postoperative records of the surgeon advised that appellant was neurologically intact with regard to strength, reflex and sensory testing. As to the impairment rating by Dr. Diamond, the medical adviser noted that the records from appellant's surgeon did not support the loss of strength or sensory deficits as reported. For this reason, he would not recommend that the assessment of loss at L5 and S1 by Dr. Diamond be accepted. Dr. Berman noted that Dr. Draper recommended one percent impairment for the right lower extremity and provided appropriate rationale for his conclusion. He found the date of maximum medical improvement to be July 17, 2007, the date of Dr. Draper's evaluation.

In a January 17, 2008 decision, the Office granted appellant a schedule award for one percent impairment to the right lower extremity. It found that he had no impairment to his left lower extremity related to the March 30, 2002 injury.

On January 22, 2008 appellant, through his attorney, requested a hearing which was held on April 22, 2008. Counsel contended that appellant's preexisting left leg injury was a factor to be considered in determining the extent of permanent impairment to that member. He also contended that a conflict in medical opinion existed between the ratings of Dr. Diamond and Dr. Draper.

In an August 5, 2008 decision, an Office hearing representative affirmed the January 17, 2008 schedule award.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[5] and its implementing regulations[6] 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, the Office has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] The

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8]

A schedule award is not payable for a member, function or organ of the body not specified in the Act or in the implementing regulations. The Act and federal regulations do not provide for the payment of a schedule award for the permanent loss of use of the back or spine.[9] However, as the Act provides for the lower extremities, a claimant may be entitled to a schedule award for permanent impairment to his or her legs even though the cause of the impairment originates in the spine.[10]

ANALYSIS

The Office accepted appellant's claim for a herniated lumbar disc at L5-S1 for which he underwent surgery. Appellant claims a schedule award for impairment to his lower extremities due to his accepted lumbar condition. In finding that he had one percent impairment to his right leg and no impairment to his left leg, the Office accepted the opinion of Dr. Draper as constituting the weight of medical opinion. The Board finds, however, that the case is not in posture for decision due to an unresolved conflict of medical opinion between Dr. Diamond and Dr. Draper as to the extent of sensory loss to appellant's right leg. As to the left leg, the Board finds that appellant has not established that he sustained any permanent impairment to the member due to his accepted back condition.[11]

Dr. Draper applied Table 16-10 of the A.M.A., *Guides* to rate appellant's right leg sensory deficit (pain) as Grade 4 or 20 percent. He stated that the maximum lower extremity impairment allowed for dysthesia of the sciatic nerve under Table 17-37 was five percent. However, the Board notes that five percent is the amount allowed for "whole person" impairment under Table 17-37. Rather, 12 percent is the maximum allowed for impairment to the lower extremity for dysthesia of the sciatic nerve. The schedule award for one percent impairment as found by Dr. Draper and adopted by the Office medical adviser was in error.[12] In the alternative, in rating sensory deficit to the right leg, Dr. Diamond identified the L5 and S1 nerve roots under Table 15-18 as those impaired due to the accepted injury. This table allows a maximum five percent for sensory loss to both these nerves. Dr. Diamond classified the extent of sensory impairment as Grade 2 under Table 15-15, for which he allowed 80 percent sensory deficit. He concluded that there was 4 percent impairment of both the L5 and S1 nerve roots (80 percent x 5 percent), and a total 8 percent loss. Loss of right leg strength is an impairment factor noted by both examining physicians. They disagree as to the extent of deficit loss by which the

[8] *Id.*

[9] *George E. Williams*, 44 ECAB 530 (1993).

[10] *Id.*

[11] On appeal, counsel did not raise any argument pertaining to impairment of appellant's right arm. As the Office has not issued a final decision on this aspect of the claim, it is not an issue before the Board in the present appeal. *See* 20 C.F.R. § 501.2(c).

[12] 20 percent deficit of the maximum 12 percent allowed would result in 2.4 percent impairment.

impairment should be graded. The Office medical adviser did not explain why this determination of sensory loss to the right leg due to the accepted back condition was in error.[13] Therefore, the Board finds a conflict in medical opinion between Dr. Diamond and Dr. Draper as to the extent of sensory loss affecting appellant's right leg.

As to right leg motor loss, Dr. Draper found that appellant exhibited full strength of the right leg and had no functional impairment. The Office medical adviser noted that this finding was supported by appellant's surgeon in the months following surgery.[14] As noted, Dr. Diamond described motor deficit utilizing Table 17-8 for determining impairment due to muscle weakness. In this regard, however, the Board must find that the impairment rating of Dr. Draper is more probative. The textual material at 17.2e at page 531 pertaining to manual muscle testing advises that this method of rating impairment is subject to the conscious control of the individual being examined. It states:

> "Measurements can be made by one or two observers. If the measurements are made by one examiner, they should be consistent on different occasions. If made by two, they should be consistent between examiners. Even in a fully cooperative individual, strength may vary from one examination to another, but not by more than one grade. *If they vary by more than one grade between observers, or by the same examiner on separate occasions, the measurements should be considered invalid*."[15] (Emphasis added.)

The evidence of record reflects that the absence of loss of strength as reported by appellant's surgeon is consistent with the findings made by Dr. Draper. Two separate examiners made consistent findings over several years. As the loss of strength impairment values for both lower extremities reported by Dr. Diamond vary by more than one grade from these observers, such measurements are to be considered invalid under the A.M.A., *Guides*.[16] Moreover, the Board notes that the cross-usage chart at Table 17-2, page 526 specifically precludes the

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[13] As to the application of Figure 18-1, Dr. Diamond allowed an additional three percent for pain. However, he did not explain why his sensory loss ratings under Tables 15-15 and 15-18 were not adequate. The textual material at page 570 of the A.M.A., *Guides* state that an explanation should be provided in writing whenever the organ and body rating systems of the other chapters are not adequate to rate actual impairment. Without such explanation, an additional rating under Chapter 18 appears arbitrary.

[14] By letters dated December 15, 2003 and April 29, 2004 to appellant's counsel, Dr. Todd J. Albert, a Board-certified orthopedic surgeon, addressed his treatment of appellant. On October 15, 2002 appellant complained of pain in his low back, right buttock and lateral calf with weakness. He had no complaints with regard to his left leg. On September 14, 2004 Dr. Albert examined appellant a year following surgery and found full and equal strength throughout both lower extremities and normal reflexes. He advised that sensation was intact.

[15] The A.M.A., *Guides* also state that individuals whose performance is inhibited by pain or fear of pain are not good candidates for manual muscle testing and other methods for rating impairment should be considered. Dr. Diamond did not address why he rated impairment using this method in light of the ratings for pain he also provided.

[16] This would also pertain to the motor strength loss reported by Dr. Diamond as to appellant's left leg as Dr. Albert found full and equal strength throughout both of appellant's lower extremities on October 21, 2003 and September 14, 2004. Dr. Draper reported excellent motor function bilaterally in hip flexion, knee extension and knee flexors. The marked weakness of the left foot and ankle was attributed to the nonemployment-related injuries.

combination of muscle strength loss with pain due to nerve injury. This further diminishes the probative value of the total 40 percent right leg rating provided by Dr. Diamond as he erroneously combined invalid muscle strength impairment with the sensory nerve loss identified at L5 and S1. Appellant has not established the motor strength deficits as reported by Dr. Diamond to be valid.

Appellant contends on appeal that the opinion of Dr. Draper is deficient in that the statement of accepted facts did not provide a description of his September 25, 2003 surgery or note the prior left knee injury. The Board notes, however, that the report of Dr. Draper reviewed the medical evidence of record and specifically addressed the surgery appellant underwent of his lumbar spine and the prior injuries and surgeries of his left knee, the left leg fractures, and cervical spine. The Board finds that Dr. Draper provided a thorough discussion of appellant's history of injuries, employment and nonemployment related, various surgeries and medical treatment.

The weight of medical opinion establishes that appellant has no impairment to his left leg casually related to his accepted lumbar condition. As noted, the motor strength impairment values reported by Dr. Diamond cannot be considered as valid as they were not consistent with the findings reported by Dr. Draper or appellant's surgeon. Moreover, there is no evidence that the accepted L5-S1 disc herniation is causing sensory loss into the left leg. Appellant's surgeon did not report any such loss following surgery, noting that appellant's complaints were only to his right lower extremity. Dr. Draper found no radiculopathy affecting the left leg due to the accepted condition. Moreover, the pain rating of Dr. Diamond was made under Figure 18-1. He did not identify or describe any sensory loss originating in the L5 or S1 nerve root of the spine impairing the left leg. The 30 percent impairment rating of Dr. Diamond is of diminished probative value for these reasons.

On appeal, appellant contends that the Office failed to consider his preexisting left knee condition and lower extremity fractures. While the record supports that appellant had extensive preexisting injury to his left leg for which he underwent multiple surgeries, there is no evidence of any impairment caused by his lumbar condition affecting his left leg. It is well established that, in determining the amount of a schedule award for a given member of the body that sustained an employment-related permanent impairment, preexisting impairments of that scheduled member of the body are to be included.[17] The injury sustained in this case was to the back or spine, for which a schedule award is not allowed. Appellant may have preexisting impairment of his left foot, ankle and knee but it must first be established that his spine contributes to permanent impairment to the leg, either by motor or sensory loss, before they may be taken into consideration. None of the medical evidence of record provides any opinion addressing how the accepted lumbar injury causes or contributes to his left foot and ankle or

[17] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.b. (June 1993). This portion of the Office procedure provides that the impairment rating of a given scheduled member should include "any existing permanent impairment of the same member or function."

knee conditions.[18] As noted, the loss of strength values reported by Dr. Diamond cannot be accepted as valid in this case. Moreover, Dr. Draper advised that the loss of strength in the area of appellant's left foot and ankle was solely due to the prior injuries and fractures without any contribution by the accepted L5-S1 disc herniation. Appellant was found to have excellent motor function in his hips and knees. As appellant has not established impairment extending into his left leg due to residuals of his accepted back condition, it is premature to consider any preexisting impairment of the member.

CONCLUSION

The Board finds that appellant has not established that he sustained impairment to his left lower extremity. As to the extent of right leg impairment, the Board finds a conflict in medical opinion as to the extent of sensory loss.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 5 and January 17, 2008 are affirmed, in part, and set aside, in part. The case is remanded for further action in conformance with this decision.

Issued: December 30, 2009
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[18] *See Thomas P. Lavin*, 57 ECAB 353 at 358 (2006). As noted in *Michael C. Milner*, 53 ECAB 446 at 450 (2002) there is a causal element as described by Professor Larson in his treatise on workers' compensation: that the industrial injury must first precipitate disability from a latent prior condition. *See also Tammy L. Meehan*, 53 ECAB 229 (2001).