United States Department of Labor
Employees' Compensation Appeals Board

G.R., Appellant	)	
and	)	**Docket No. 15-0725**
	)	**Issued: August 12, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Davison, MI, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 3, 2015 appellant, through counsel, filed a timely appeal from a December 23, 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 established permanent functional impairment in support of a schedule award for his accepted conditions.

On appeal, counsel asserts that the December 23, 2014 decision is contrary to fact and law.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On August 10, 2012 appellant, then a 60-year-old city carrier, filed an occupational disease claim alleging that employment duties caused bulging discs in his lower back and radiating back pain. He had stopped work on July 19, 2012. Appellant retired effective September 30, 2012.

On September 17, 2012 Dr. Carlos R. Padilla, an attending Board-certified physiatrist, diagnosed chronic low back pain secondary to lumbar spondylosis with degenerative disc disease and degenerative joint disease. On September 20, 2012 Dr. Bill Hukill, an osteopath, agreed with the degenerative disc disease and degenerative joint disease diagnoses.

On November 20, 2012 OWCP accepted the conditions of degeneration of lumbar or lumbosacral intervertebral disc and unspecified, osteoarthrosis, of the lower leg, as employment related.

Dr. Mokbel Chedid, a Board-certified neurosurgeon, performed lumbar decompression at L4-5 and L5-S1 with discectomy on February 18, 2013. In a May 15, 2013 report, Dr. Padilla advised that appellant was seen for follow-up after recent spinal fusion surgery. He advised that appellant was at maximum medical improvement. On June 26, 2013 Melissa Shonk, a physician assistant in Dr. Chedid's office, noted appellant's complaint of occasional leg pain and back pain with increased activity. She provided physical examination findings including normal motor strength in the lower extremities and intact sensation to light touch.

On July 12, 2013 appellant filed a schedule award claim. He submitted a July 25, 2013 impairment evaluation from Dr. John L. Dunne, an osteopath Board-certified in occupational and family medicine. Dr. Dunne noted appellant's employment history and his continued complaint of low back and bilateral ankle pain that prevented many activities of daily living and provided a history that appellant reported multiple ankle sprains while employed. He indicated that appellant walked with a normal gait. Sensory examination revealed a diminished pin wheel sensation in the right S1 distribution posterior lateral calf and lateral right foot compared to normal on the left and a diminished pin wheel sensation over the dorsum of the foot on the right compared to normal on the left. Motor testing demonstrated grade 4 weakness of the right extensor hallucis longus and right ankle dorsiflexors compared to 5/5 strength on the left. Sitting leg extension and straight-leg raising showed no evidence of radiculopathy and there was no atrophy of the legs. There was a mild persistent sensory radiculopathy at the right S1 and mixed sensory motor mild degree of radiculopathy at the right L5 level. Ankle range of motion was decreased. Dr. Dunne advised that a history of multiple ankle sprains limited standing, walking, and running. He advised that ankle range of motion was assessed on three trials *via* goniometer. Dr. Dunne stated that the maximum range recorded on the right was 35 degrees of flexion, 10 degrees of extension, 5 degrees of inversion, and 10 degrees of eversion, and that on the left the best flexion was 30 degrees, extension was 10 degrees, inversion was 5 degrees, and eversion was 10 degrees, with end point pain. He opined that it was assumed that the accepted osteoarthrosis, unspecified, lower leg referred to the bilateral ankle joints only.

Dr. Dunne assessed appellant's impairment in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter

A.M.A., *Guides*).[2] He found that, under Table 16-25, Range of Motion ICF Classification,[3] appellant had a class 1 impairment with no adjustment, for a final impairment of 11 percent for each ankle, based on range of motion deficits. Dr. Dunne stated that he utilized the range of motion model because there were no medical records describing radiologic findings available, and appellant's only impairment was due to pain and limited motion of the ankle joint.

On November 22, 2013 Dr. Morley Slutsky, an OWCP medical adviser who is Board-certified in occupational medicine, reviewed the medical evidence, including Dr. Dunne's report. He advised that additional information was needed. The medical adviser noted that both before and after appellant's spinal surgery, Dr. Chedid found no lower extremity sensory or motor deficits, which was in contrast to Dr. Dunne who found diminished right S1 sensory deficits and weakness in the right L5 distribution. Dr. Slutsky further noted that Dr. Dunne rated the claimant using the sixth edition of the A.M.A., *Guides* and not the July/August 2009 *The Guides Newsletter*. He requested that OWCP obtain all medical notes following the February 15, 2013 surgery date, concluding that if the notes were no longer available then the final impairment for each lower extremity was zero percent, using *The Guides Newsletter*, because appellant's best effort equaled no loss of sensation or motor function, both before and after his lumbar surgery.

On February 6, 2014 OWCP requested that appellant provide the additional medical information as requested. In a January 25, 2014 treatment note, Elizabeth Dale, a nurse practitioner indicated that he had fallen from a ladder at home and sprained his ankle. She provided physical examination findings including full strength in all extremities and intact sensation to light touch/pinprick in all distributions. Gait and station were normal.

By decision dated March 19, 2014, OWCP denied appellant's claim for a schedule award because the medical evidence submitted by appellant was not in accordance with *The Guides Newsletter*, used for evaluating impairment of the spine. Appellant, through counsel, timely requested a hearing.

In a May 15, 2014 treatment note, Jamie Scalia, a physician's assistant in Dr. Chedid's office, noted that appellant returned for routine follow up visit. She noted that appellant reported occasional low back pain radiating into the right buttock, and that he was active in swimming and at the gym and no longer had stabbing sharp low back or leg pain. Ms. Scalia advised that he had full strength in all extremities and intact sensation to light touch/pinprick in all distributions and advised that he could continue normal activity as tolerated.

On May 22, 2014 Dr. Chedid noted a history that appellant experienced severe back pain since an approximately eight foot fall and that lumbar spine imaging demonstrated a broken S1 screw. Physical examination demonstrated full strength in all extremities and intact sensation to light touch/pinprick in all distributions. Gait and station were normal. Appellant was scheduled for lumbar exploration and revision of bilateral S1 screws. Dr. Chedid performed surgery on June 17, 2014 including removal of the broken S1 screw and augmentation of the spinal fusion. Appellant was discharged from the hospital on June 19, 2014 with diagnoses of back pain, status

[2] A.M.A., *Guides* (6th ed. 2008).

[3] ICF refers to the International Classification of Functioning, Disability and Health. *Id*. at 3, § 1.3.

post lumbar exploration with revision of bilateral S1 screws, and spinal stenosis, lumbar region, without neurogenic claudication.

Appellant did not testify at the hearing which was held on October 9, 2014. However counsel provided arguments on behalf of his client generally criticizing the use of and reliance upon *The Guides Newsletter* and perceived bias practices of Dr. Slutsky as a district medical adviser. More specifically he asserts that Dr. Slutsky goes beyond his defined role in the case to overrule the medical findings of lower extremity impairment, of weakness, of numbness, and of loss of sensation of impairment of the lower extremities as reported by Dr. Dunne and then interjects his own findings to create a conflict with the treating doctor. Counsel argues the role of Dr. Slutsky is limited to reading the medical report of the treating physician and making sure that the evaluating physician correctly followed *The Guides Newsletter* when assigning permanent functional impairment. He suggested that in this case the evaluation findings between the treating physician and Dr. Dunne are disparate, thus creating a conflict necessitating a referee opinion. Counsel notes that instead Dr. Slutsky's actions, in accord with his common practice, rejected the evaluation findings favorable to the worker, without conducting any medical evaluation, and confirming physical evaluation findings of the other doctor in the conflict and then resolving the conflict by weighing the facts and making findings that support a lower rating of impairment. Finally, counsel argues that appellant had a very serious injury with invasive surgical treatment and residuals and it is therefore unreasonable to bypass the evaluation and impairment findings of a well-respected Eastern Ohio physician, Dr. Dunne, to reject an award based upon the conduct and practices of Dr. Slutsky.

In a December 23, 2014 decision, an OWCP hearing representative affirmed the March 19, 2014 decision. The hearing representative noted that there was no explanation as to why the claim had been accepted for unspecified osteoarthrosis of the lower leg since there were no medical reports of file that diagnosed the condition. She found that *The Guides Newsletter*, which had been incorporated into OWCP procedures, provided the proper methodology for an impairment to an extremity based on an impairment that originated in the spine and dismissed counsel's argument concerning his disfavor with use of *The Guides Newsletter*. The hearing representative found that the record did not establish impairment based on a spinal nerve root disruption. She further found that Dr. Dunne's impairment rating, based on bilateral ankle conditions, was not supported by the record, specifically stating that "even if such a diagnosis was provided, there is no medical evidence that establishes a causal relationship between that condition and the factors of employment in the current claim. Dr. Dunne stated that the claimant has had ongoing treatment and injections for bilateral ankle arthritis, but there are no medical reports that document any right ankle treatment." The hearing representative continued that there were no ankle x-rays in the record and that Dr. Dunne did not take any ankle x-rays. She concluded that the physician's diagnosis of ankle osteoarthritis was speculative.

LEGAL PRECEDENT

The schedule award provision of FECA,[4] and its implementing federal regulations,[5] set forth the number of weeks of compensation payable to employees sustaining permanent

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is to be used.[7]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[8] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[9] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[10] The sixth edition of the A.M.A., *Guides* also provides that under certain circumstances, range of motion may be selected as an alternative approach in rating impairment. An impairment rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[11]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, under FECA a schedule award is not payable for injury to the spine.[12] In 1960, amendments to FECA 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. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[13]

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* for decades has offered an alternative approach to rating spinal nerve impairments.[14] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in

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[6] *Id*. at § 10.404(a).

[7] FECA Bulletin No. 09-03 (issued March 15, 2009).

[8] A.M.A., *Guides*, *supra* note 2 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[9] *Id*. at 385-419.

[10] *Id*. at 411.

[11] *Id*. at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

[12] *Pamela J. Darling*, 49 ECAB 286 (1998).

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

[14] *Rozella L. Skinner*, 37 ECAB 398 (1986).

section 3.700 of its procedures, which memorializes proposed tables outlined in a July/August 2009, *The Guides Newsletter*.[15]

OWCP 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 the medical adviser providing rationale for the percentage of impairment specified.[16] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[17]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish that he has a ratable impairment of either lower extremity. OWCP accepted that he sustained degeneration of lumbar or lumbosacral intervertebral disc and unspecified osteoarthrosis, of the lower leg, as employment related. Appellant filed a schedule award claim and submitted a July 25, 2013 impairment evaluation from Dr. Dunne.

Regarding the accepted lumbar conditions, as noted above, the approach for rating impairment of the upper or lower extremities caused by a spinal injury is provided in section 3.700 of OWCP procedures, which memorializes proposed tables outlined in a July/August 2009 *The Guides Newsletter*.[18] Dr. Dunne did not provide any analysis in accordance with the July/August 2009 *The Guides Newsletter*, and the record contains no other impairment evaluation. Appellant bore the burden to prove permanent impairment for a schedule award based upon the proper rating practices. The Board further notes that his back condition in May 2014 and subsequently, including the June 17, 2014 surgery, was apparently due to an eight foot fall from a ladder that occurred after appellant's retirement in September 2012. Dr. Dunne did not evaluate appellant's spinal condition or mention section 3.700 or the July/August 2009 *The Guides Newsletter*. Appellant therefore did not establish that he is entitled to a schedule award for the accepted degeneration of lumbar or lumbosacral intervertebral disc.

In his impairment analysis, Dr. Dunne reported a history of multiple ankle sprains and assumed that the accepted osteoarthrosis referred to the bilateral ankle joints. He advised that he utilized Table 16-25[19] because there were no medical records describing radiologic findings, and appellant's only impairment was due to pain and limited motion of the ankle joint. Dr. Dunne concluded that appellant had 11 percent impairment of each ankle.

[15] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, Chapter 3.700, Exhibit 1, note 5 (January 2010); *The Guides Newsletter* is included as Exhibit 4.

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[17] *Peter C. Belkind*, 56 ECAB 580 (2005).

[18] *See supra* note 15.

[19] A.M.A., *Guides*, *supra* note 2 at 550.

As noted by the hearing representative, the record contains no explanation as to why the claim was accepted for osteoarthrosis, unspecified, lower leg. None of the medical reports of record at the time the claim was accepted on November 20, 2012 diagnosed any arthritic or specific lower extremity condition. Moreover, section 16.7 provides that diagnosis-based impairment is the method of choice for calculating impairment and that range of motion is used principally as a factor in the physical examination adjustment grid.[20]

As a specific ankle condition has not been accepted as employment related, appellant has not established entitlement to a schedule award for the accepted osteoarthrosis, unspecified, lower leg.

The remainder of counsel's arguments relating to the procedures and practices of Dr. Slutsky are moot as appellant has not presented sufficient medical evidence of impairment to establish a schedule award as he failed to offer any evidence of permanent impairment through the use of *The Guides Newsletter*.

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 did not meet his burden of proof to establish entitlement to a schedule award for the accepted degeneration of lumbar or lumbosacral intervertebral disc and osteoarthrosis, unspecified, lower leg, as employment related.[21]

[20] *Id*. at 543. Table 16-2 (Foot and Ankle Regional Grid), Table 16-3 (Knee Regional Grid), and Table 16-4 (Hip Regional Grid) provide the diagnoses to be used in analyzing a lower extremity impairment. *Id*. at 501-15. These include specific arthritis diagnoses. *Id*. at 507, 511, 514.

[21] At the hearing counsel maintained that *The Guides Newsletter* was junk science and that Dr. Slutsky was biased. As noted above, the A.M.A., *Guides* have been adopted as the uniform standard applicable to all claimants for the determination of permanent impairment under FECA. 20 C.F.R. § 10.404(a). Section 3.700 of OWCP procedures memorializes the proposed tables outlined in a July/August 2009 *The Guides Newsletter*. *Supra* note 15. Moreover, mere allegations are not sufficient to establish bias. There must be some evidence of actual bias or unfairness by the physician. *See J.C*., Docket No. 08-1833 (issued March 23, 2009). Appellant submitted no such evidence in this case.

ORDER

IT IS HEREBY ORDERED THAT the December 23, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 12, 2015
Washington, DC

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

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

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