U. S. DEPARTMENT OF LABOR

# Employees' Compensation Appeals Board

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In the Matter of PAT JOSHUA and U.S. POSTAL SERVICE,
POST OFFICE, Carol Stream, IL

*Docket No. 01-1050; Submitted on the Record;*
*Issued December 6, 2001*

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DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether appellant has greater than a three percent permanent impairment of the left lower extremity for which she received a schedule award.

On March 11, 1998 appellant, then a 36-year-old letter carrier, was injured in the performance of duty when she slipped on ice, landing on her buttocks while delivering mail. The Office of Workers' Compensation Programs initially accepted the claim for low back contusion, lumbosacral strain and coccyx strain, but it was later expanded to include a herniated disc at L5-S1.[1] Appellant received appropriate compensation for wage loss from March 11, 1998 until she returned to full-time limited duty effective September 23, 2000.

Appellant has been under the care of Dr. Henry M. Kawanaga, a Board-certified orthopedic surgeon, for treatment of her work injury. He performed a laminectomy on September 23, 1998 with removal of the herniated disc and decompression of the nerve root. Dr. Kawanaga then released appellant to a gradual return to work with lifting restrictions.

On December 16, 1999 appellant filed a CA-7 claim for a schedule award.

In a report dated February 4, 2000, Dr. Kawanaga noted that appellant presented on February 1, 2000 with complaints of increased and more severe pain in the back and left leg. Dr. Kawanaga recommended that appellant undergo a MRI. On physical examination, he noted that "lumbar range of motion was limited in extension and lateral extension to the left." Dr. Kawanaga further reported straight leg raising being limited to 60 degrees and diminished left ankle reflex.

In a CA-17 duty status report dated February 8, 2000, Dr. Kawanaga diagnosed a herniated disc at L5-S1 due to appellant's March 1, 1998 work injury. He opined that appellant

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[1] A magnetic resonance imaging (MRI) on June 30, 1998 confirmed the presence of a herniated disc at L5-S1 and mild degenerative disc disease and articular facet disease at L4-5.

could work 8 hours a day with lifting restrictions of no more than 35 pounds on a continuous basis and 75 pounds on an intermittent basis.

On March 6, 2000 the Office asked Dr. Kawanaga to examine appellant for purposes of evaluating her permanent impairment of a work-related herniated disc under the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. The Office provided Dr. Kawanaga with a (CA-1303-09) form to fill out regarding appellant's impairment rating.

On March 14, 2000 Dr. Kawanaga completed the (CA-1303-09) form listing the date of maximum medical improvement as March 14, 2000. When asked what nerve root origin and specific nerve root branch was involved, Dr. Kawanaga listed "L5-S1." He concluded that appellant had a 30 percent impairment of the lower extremity due to loss of function from sensory deficit, pain or discomfort. Dr. Kawanaga also noted that appellant had 30 percent impairment of the left lower extremity due to loss of function from decreased strength.

In a report dated May 7, 2000, Dr. David M. Smink, an Office medical adviser, stated that he had reviewed the medical records and report of Dr. Kawanaga finding 30 percent permanent impairment of the left extremity. The Office medical adviser noted that Dr. Kawanaga's examination revealed a decreased ankle jerk reflex on the left compared to the right, but that the physician made no mention of particular dermatomal pain distribution, sensory deficits, or motor weakness in specific muscles. It was, therefore, recommended that the Office obtain a supplemental report from Dr. Kawanaga in order to better understand the basis of his impairment rating.

In an August 25, 2000 letter, the Office asked Dr. Kawanaga to submit a report of his detailed subjective and objective findings that led to his impairment rating and the rationale for his recommendation of March 14, 2000 as the date of maximum medical improvement.

In a September 22, 2000 report, Dr. Kawanaga reiterated that as of his last examination of appellant on March 14, 2000 she continued to be symptomatic with back and leg pain. He repeated his prior report that lumbar dynamics were limited in extension as well as lateral extension to the left. Straight leg raising was again noted as being limited to 60 degrees with mild decreased sensation over S1 dermatome and diminished left ankle reflex. Dr. Kawanaga recommended that appellant continue with her work restrictions. He stated in response to the Office inquiry: "The [rationale] for the recommendation of [appellant] having reached maximum medical improvement on March 14, 2000 was that [she] had plateaued in her response to treatment, which had included surgical intervention as well as conservative management and no additional improvement was expected." Dr. Kawanaga concluded that appellant had 30 percent permanent impairment for the left extremity due to loss of function form sensory deficit/pain/discomfort and decreased strength.[2]

[2] It was noted that the Office had mistakenly interpreted his prior report as finding 60 percent impairment when he only found 30 percent impairment of the left leg.

In a November 6, 2000 report, Dr. David H. Garelick, an Office medical adviser, discussed Dr. Kawanaga's September 22, 2000 report and prior physical findings on examination. The Office medical adviser stated as follows:

> "Dr. Kawanaga's detailed analysis of [appellant's] complicated situation is very helpful. However, it relates [permanent partial impairment] to his belief that [appellant's] left leg is functioning at 70 [percent] of the normal right leg. However, he does not support this with objective measurements or weakness, limited range of motion or the extremity, or significant sensory abnormalities. The only lower extremity impairment which could be derived from current medical narratives is the residual left S1 radicular pain and diminished sensation. Table 83, [page] 130 of the [A.M.A., *Guides*], combined with [T]able 11, [page] 3/48 allows for [three percent impairment] of the left lower extremity for Grade 3 radicular pain/sensory deficit in the distribution of the S1 nerve root."

The Office medical adviser listed the date of maximum medical improvement as March 14, 2000 and concluded that appellant had three percent impairment of the left lower extremity under the A.M.A., *Guides*.

On December 20, 2000 the Office issued appellant a schedule award for three percent permanent impairment of the left lower extremity. The period of the award was from March 14 to May 13, 2000.

The Board finds that appellant is not entitled to greater than a three percent permanent impairment of the left lower extremity for which she received a schedule award.

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing federal regulation,[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of specified members, functions or organs of the body. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[5] 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.[6]

The A.M.A., *Guides* were prepared to establish reference tables and evaluation protocols which, if followed, may allow the clinical findings of the physician to be compared directly with the impairment criteria and related to impairment percentages. While the medical opinion of the

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[3] 5 U.C.S. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] 5 U.S.C. § 8107(c)(19).

[6] *See* 20 C.F.R. § 10.404 (1999).

treating physician may be accorded some weight, his or her clinical data can be readily extrapolated and evaluated within the tables and guidelines presented.[7]

In the present case, the Office on two occasions has tried to procure from Dr. Kawanaga a medical report explaining with specific reference to the A.M.A., *Guides* the basis of his calculation of 30 percent permanent impairment for appellant's left leg. In both reports, Dr. Kawanaga listed minimal physical findings and did not refer to the appropriate Tables of the A.M.A., *Guides*, which were provided to him by the Office for calculating appellant's degree of permanent impairment due to his work injury. Because Dr. Kawanaga did not explain his impairment rating with reference to the uniform standards set forth in the Office regulations, it was proper for an Office medical adviser to apply the A.M.A., *Guides* to the findings reported by Dr. Kawanaga on examination.[8] The Board has duly reviewed the Office medical adviser's November 6, 2000 report and finds that he supports his three percent impairment rating with reference to Table 83, page 130 and Table 11, page 48 of the A.M.A., *Guides* pertaining to Grade three radicular pain and sensory deficit of the S1 nerve root.[9] As the Office medical adviser's report provides the only evaluation that conforms with the A.M.A., *Guides*, it constitutes the weight of the medical evidence.[10]

The decision of the Office of Workers' Compensation Programs dated December 20, 2000 is hereby affirmed.

Dated, Washington, DC
December 6, 2001

David S. Gerson
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member

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[7] *Michael D. Nielsen*, 49 ECAB 453 (1998).

[8] *Lena P. Huntley*, 46 ECAB 643 (1995); *Roel Santos*, 41 ECAB 1001 (1990).

[9] The Office medical adviser correctly made specific reference to Dr. Kawanaga's physical finding of diminished sensation of the S1 dermatome. The Board has stated that an Office medical adviser cannot select a percentage of impairment without reference to physical findings of an examining physician; *see John Keller*, 39 ECAB 543 (1988).

[10] *Lena P. Huntley, supra* note 8.