United States Department of Labor
Employees' Compensation Appeals Board

NATHAN SLEMOVITCH, Appellant	)	
and	)	**Docket No. 04-1619**
	)	**Issued: March 24, 2005**
U. S. POSTAL SERVICE, POST OFFICE, East Hartford, CT, Employer	)	

Appearances:
William E. Shanahan, Esq., for the appellant
Office of Solicitor, for the Director,

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On June 9, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' schedule award decision dated April 6, 2004. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award determination.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained more than an eight percent permanent impairment of his right lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On December 27, 1966 appellant then a 43-year-old letter carrier, was exiting his postal vehicle when he lost his footing and slipped on a wet step and twisted but did not fall, sustaining

a ruptured disc at L4-5 and L5-S1.[1] The Office accepted the claim for low back sprain. The Office accepted the additional condition of nerve root compression secondary to ruptured disc at L4-5 on the right. Appellant stopped work on October 13, 1971.[2] Appellant retired on November 13, 1978; however, his claim remained open for medical benefits.

Appellant, through his attorney submitted a claim for a schedule award on December 21, 1999.

In a February 29, 2000 report, Dr. David Kruger, a Board-certified orthopedic surgeon, noted appellant's history of injury.[3] He related that the vast majority of appellant's spinal disability was not related to his discectomy and subsequent redo discectomy, but rather his extensive degenerative spondylosis and scoliosis and opined that appellant had a permanent impairment of 45 percent of his lumbosacral spine, of which one third was related to his work injury, discectomy and subsequent redo surgery.

In a December 11, 2000 report, Dr. Paul Murray, an orthopedic surgeon and second opinion physician, noted appellant's history of injury and treatment and opined that appellant had reached maximum medical improvement with regard to his back and was totally disabled from any gainful employment. On January 4, 2001 the Office placed appellant on the periodic rolls.

In a January 23, 2002 decision, the Office found that appellant had no lower extremity impairment due to his accepted back injury.

By decision dated June 27, 2002, the Office hearing representative set aside the January 23, 2002 decision and remanded the claim for referral of appellant to a neurologist for a second opinion examination and a *de novo* decision concerning appellant's entitlement to a schedule award.

[1] Appellant had several conditions that were not work related including tuberculosis, for which he received a 30 percent impairment through the Veteran's Administration. He also underwent a nonwork-related radical mastectomy and heart bypass surgery.

[2] The record reflects that appellant had several accepted work injuries in the course of his federal employment. They included injuries on October 23, 1957, March 14, 1958 and December 3, 1962, which the Office accepted for back sprain. Furthermore, on December 27, 1966 appellant sustained a ruptured disc at L4-5 and L5-S1. The December 27, 1966 injury was also accepted for herniated lumbar disc. On March 14, 1967 appellant underwent a hemilaminectomy at L4-5 and L5-S1 with removal of ruptured intervertebral discs, which was authorized by the Office. Appellant subsequently returned to work on June 14, 1967 in a light-duty position. On March 6, 1969 appellant underwent a second surgery with excision of a disc at L4-5 on the right. The Office accepted the additional condition of nerve root compression secondary to ruptured disc at L4-5 on the right. Appellant subsequently returned to work in a light-duty position on April 21, 1969. Appellant experienced a recurrence of symptoms and was totally disabled from October 13 to 24, 1971 and after undergoing x-rays and a repeat myelogram on October 16, 1971; appellant was discharged on October 19, 1971. Appellant retired on November 13, 1978.

[3] He also noted appellant's assertion that the statement of accepted facts was incorrect with regard to his return to work on June 14, 1967 indicating that he only returned to part-time limited-duty work.

By letters dated July 11 and 15, 2002, the Office referred appellant for a second opinion examination with Dr. Robert Berland, a Board-certified neurologist.

In a July 29, 2002 report, Dr. Berland noted appellant's history of injury and treatment and utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*) (5th ed. 2001). Dr. Berland indicated that appellant walked with a cane and favored the right lower extremity. He noted marked scoliosis of the thoracic spine to the right and advised that appellant had no clear-cut weakness, although he had decreased resistance to right lower extremity muscle testing. He indicated that appellant was absent ankle reflexes bilaterally and had a scar on his leg secondary to the bypass surgery and the venous graft. Dr. Berland noted that there were no pathological reflexes and diminished pin sensation in the right foot. He advised that appellant had impaired vibration of both lower extremities to the mid thighs, straight-leg raising was positive on the right at 20 degrees and there was significant limited movement of the lumbar spine in all directions, flexion, extension and lateral rotation. Dr. Berland opined that he was barely able to move the spine in any of these directions with the superimposed pain, limited movement and severe scoliosis. He advised that appellant had pain and difficulty getting on and off the examination table. Dr. Berland opined that appellant was severely impaired for any form of activity due to the limited movement of the lumbar spine, right leg pain impaired gait and persistent foot pain and sensory changes. He also contended that the surgery did cause secondary nerve root compression and nerve root pain noting that appellant had definite findings of sensory changes, impaired straight leg raising and absent ankle jerk "all suggesting there is nerve root impairment involving the L5-S1 root at least on the right." Dr. Berland further noted that appellant had an impaired gait favoring the right lower extremity and did use a cane. He opined that appellant had a 13 percent permanent impairment of the whole person due to his spine condition, referring to Table 15-7[4] and opined that appellant reached maximum medical improvement in 1971.

On August 21, 2002 an Office medical adviser reviewed the July 29, 2002 report of Dr. Berland and noted that he found no clear cut lower extremity weakness on examination but did report limited lumbar spine motion and diminished sensation in the right foot. He noted that Table 15-18[5] provided a maximum of 5 percent lower extremity impairment rating due to sensory deficit or pain involving either the L5 or S1 nerve root. Citing Table 15-15,[6] he graded appellant's pain as Grade 2 or pain that may prevent some activities or 80 percent and advised that multiplying 80 percent by 5 percent resulted in a 4 percent impairment rating due to pain involving both the L5 and the S1 nerve roots. The Office medical adviser combined these ratings, using the Combined Values Chart[7] and concluded that appellant had an 8 percent impairment of the right lower extremity due to sensory deficit or pain and that the date of maximum medical improvement was October 1971.

[4] A.M.A., *Guides* at 404, Table 15-7.

[5] *Id*. at 424, Table 15-18.

[6] *Id*. at 424, Table 15-15.

[7] *Id*. at 604.

By decision dated October 4, 2002, the Office granted appellant a schedule award for eight percent permanent impairment of his right lower extremity. The award covered a period of 23.04 weeks from July 29, 2002 to January 6, 2003.[8]

On October 10, 2002 appellant, through his attorney requested a hearing.[9]

By letters dated December 5, 2002 and May 13, 2003 and January 5, 2004, appellant through his attorney contended that the claim was not in posture for a hearing and contended that the Office should have requested that Dr. Berland provide an opinion concerning the percentage of impairment and whether any impairment should be assigned due to gait disorder. He also alleged that the Office failed to make a finding that appellant was totally and permanently disabled.

In a decision dated April 6, 2004, an Office hearing representative affirmed the October 4, 2002 decision.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[10] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[11] The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[12] The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[13]

The schedule award provision of the Act[14] and its implementing federal regulation[15] provide for payment of compensation for the permanent loss or loss of use of specified members, functions and organs of the body. No schedule award is payable for a member, function, or organ of the body not specified in the Act or in the regulations.[16] Because neither the Act nor the

[8] Compensation for total wage loss was resumed at the expiration of the award.

[9] A review of the written record was subsequently requested in lieu of an oral hearing.

[10] 5 U.S.C. §§ 8101-8193.

[11] 5 U.S.C. § 8107.

[12] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[13] 20 C.F.R. § 10.404.

[14] 5 U.S.C. § 8107(a).

[15] 20 C.F.R. § 10.404.

[16] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

regulations provide for the payment of a schedule award for the permanent loss of use of the back,[17] no claimant is entitled to such an award.[18]

However, in 1966, amendments to the Act modified the schedule award provision 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. As the schedule award provision of the Act includes 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.[19]

ANALYSIS

In a July 29, 2002 report, Dr. Berland, the second opinion physician, noted appellant's history of injury and treatment and noted findings including that appellant walked with a cane and favored the right lower extremity. He also contended that appellant had secondary nerve root compression and nerve root pain noting that appellant had nerve root impairment involving the L5-S1 root on the right. Dr. Berland opined that appellant reached maximum medical improvement in 1971 and that he had a 13 percent permanent impairment of the whole person due to his spine condition and referred to Table 15-7.[20] However, a schedule award is not payable for an impairment of the whole person.[21] Furthermore, schedule awards are not payable for the spine.[22] Therefore, as Dr. Berland used the tables and pages of the A.M.A., *Guides* relevant to spinal impairments in determining appellant's right lower extremity impairment, his report is of little probative value. Consequently, Dr. Berland's report is of diminished probative value on the extent of appellant's impairment as he did not provide an opinion that appellant had an impairment to a scheduled member that would be ratable under the Act.[23]

On August 21, 2002 the Office medical adviser reviewed the July 29, 2002 report of Dr. Berland and utilized his findings. He noted that Table 15-18[24] provided a maximum of five percent lower extremity impairment rating due to sensory deficit or pain involving either the L5 or S1 nerve root. He also referred to Table 15-15[25] and graded appellant's pain as a Grade 2 or pain that may prevent some activities or 80 percent and advised that multiplying 80 percent by

[17] The Act itself specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

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

[19] *Id*. *See also, Rozella L. Skinner*, 37 ECAB 398, 402 (1986).

[20] A.M.A., *Guides* at 404.

[21] *Phyllis F. Cundiff*, 52 ECAB 439 (2001).

[22] *See* footnote 17.

[23] *See* footnote 11.

[24] *See supra* note 5.

[25] *See supra* note 6.

5 percent resulted in a 4 percent impairment rating due to pain involving both the L5 and the S1 nerve roots. The Office medical adviser combined these ratings, using the Combined Values Chart[26] and concluded that appellant had an eight percent impairment of the right lower extremity due to sensory deficit or pain and that the date of maximum medical improvement was October 1971. The Board finds that the Office medical adviser properly calculated the right leg impairment pursuant to the A.M.A., *Guides* and properly found that there was no more than an eight percent impairment in the right lower extremity.

The Board also notes that appellant, through his attorney, contended that the Office should have requested additional information from the second opinion physician, including gait disorders. The Board notes that section 17.2c of the A.M.A., *Guides* provides as follows:

> "Gait derangement is present with many different types of lower extremity impairments and is always secondary to another condition. An impairment rating due to a gait derangement should be supported by pathologic findings, such as x-rays. Except as otherwise noted, the percentages given in Table 17-5 are for full-time gait derangements of persons who are dependent on assistive devices. Whenever possible, the evaluator should use a more specific method. When the gait method is used, a written rationale should be included in the report. The lower limb impairment percents shown in Table 17-5 stand alone and are not combined with any other impairment evaluation method."[27]

Furthermore, section 17.2c does not apply to abnormalities based only on subjective factors, such as pain or sudden giving-way, as with, for example, an individual with low back discomfort who chooses to use a cane to assist in walking. Therefore, contrary to appellant's opinion that the Office should have requested additional information regarding a gait disorder, section 17.2c of the fifth edition of the A.M.A., *Guides* precludes the use of gait derangement to calculate appellant's impairment if a more specific method is available to assess the impairment. It does not appear that appellant met the requirements to be rated under these provisions. The Board finds that the Office medical adviser properly determined that appellant had no more than an eight percent impairment of the right lower extremity under Tables 15-18 and 15-15 of the A.M.A., *Guides*.[28]

There is no other rationalized medical evidence properly documenting a ratable impairment in a scheduled member of the body pursuant to the A.M.A., *Guides*.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained more than an eight percent permanent impairment of his right lower extremity, for which he received a schedule award.

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[26] *See supra* note 7.

[27] A.M.A., *Guides* at 529.

[28] *Id.* at Table 15-18 and Table 15-15.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 6, 2004 is affirmed.

Issued: March 24, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member