United States Department of Labor
Employees' Compensation Appeals Board

A.J., Appellant	)	
and	)	**Docket No. 13-109**
	)	**Issued: April 12, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Tuscaloosa, AL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 18, 2012 appellant filed a timely appeal from an August 20, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding her schedule award claim. 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 the claim.

ISSUE

The issue is whether appellant met her burden of proof to establish entitlement to schedule award compensation.

FACTUAL HISTORY

On August 17, 2006 appellant, then a 41-year-old part-time flexible (PTF) city carrier, filed a traumatic injury claim alleging that she hurt her low back and side on August 16, 2006 when she turned quickly to catch sliding tubs.

[1] 5 U.S.C. §§ 8101-8193.

In an August 17, 2006 report, Dr. Stephen A. Roberts, an osteopath and a Board-certified family practitioner, diagnosed back pain with thoracic spinal dysfunction with acute muscle spasm. In an August 17, 2006 duty status report, he opined that appellant's diagnoses were due to the work-related injury and she could work light duty. Appellant accepted a modified assignment on August 18, 2006, which involved casing and boxing.

On August 24, 2006 Dr. Roberts saw appellant for the complaint of low back pain that started a few days prior. Appellant stated that her supervisor told her to wear a lumbar back brace. Dr. Roberts stated that it was inappropriate and seemed to have provoked problems with her low back and left leg pain. He provided an impression of back pain with mid-back pain, thoracic spine stable; new complaint of low back pain and left leg pain with acute muscle strain; abnormal L5-S1 joint architecture as per x-ray; and new lumbar muscle strain with persistence of left leg pain, posterior thigh. Dr. Roberts advised that appellant was to stay out of the brace and undergo physical therapy. Appellant was restricted to sitting work only. In an August 28, 2006 report, Dr. Roberts stated that she returned asking for two weeks off work. Appellant noted that her work restrictions called for sitting, but she could only lean at work. Dr. Roberts clarified her restrictions and noted continued pain in the left buttock and back of left leg, which began after being placed in a back brace at work. The original injury to the thoracic spine was treated and currently stable. Dr. Roberts listed an impression of low back pain with an acute strain, exacerbated while at work; left leg pain secondary to the strain and a stable thoracic strain. He indicated that he would not hold appellant off work for two weeks.

On August 30, 2006 Dr. Jeffrey C. Laubenthal, a Board-certified family practitioner specializing in sports medicine, held appellant off work. In an August 31, 2006 letter, appellant noted that Dr. Laubenthal ordered magnetic resonance imaging (MRI) scans. In a September 8, 2006 report, Dr. Laubenthal held her off work for a week so she could recover from a herniated disc in her back. He advised that appellant had severe bilateral neuroforaminal narrowing in her back, which resulted in weakness to her legs with irritation. Dr. Laubenthal cleared her for light duty but noted that, when she returned to work, the stool on which she sat caused significant impingement on her lower back and weakness symptoms. In a September 15, 2006 report, he stated that appellant needed another week of extended rest and exercises. Appellant returned to full-duty work on September 22, 2006.

On January 3, 2007 OWCP accepted the claim for a lumbar strain. No additional medical evidence was submitted until September 2010.

In a September 30, 2010 report, Dr. Laubenthal advised that appellant returned with low back pain for five days. Appellant was evaluated on September 28, 2010 in an emergency room where she received medication and injections for pain. Dr. Laubenthal noted that she had plain x-rays and an MRI scan. He provided an assessment of low back pain, intervertebral disc disorder with myelopathy, lumbar region and muscle spasm.

In a September 30, 2010 report, Dr. Rick Thomason, a Board-certified anesthesiologist, noted that appellant was referred by Dr. Laubenthal for consideration of injection therapy. He obtained a history that her back pain had been present on and off for years and became severe one week earlier. Dr. Thomason diagnosed low back pain; bilateral degenerative facet hypertrophy at the lower three levels, especially at L5-S1; left lower extremity radiculitis and failure of conservative treatment. He administered L4, L5 and S1 lumbar epidural injections.

In a November 12, 2010 report, Dr. Laubenthal reevaluated appellant's back pain, which was located over the entire low back. Appellant did not remember a particular event that caused the pain. She indicated that working on the mail truck increased pain. Dr. Laubenthal listed an assessment of low back pain, intervertebral disc disorder with myelopathy, lumbar region, muscle spasm and hypertension.

In a February 8, 2011 report, Dr. Thomason stated that appellant was seen for low back and bilateral leg pain that was present for years and was 80 percent better after the previous lumbar radiofrequency neural lesioning. Appellant reported a recent increase in pain that she attributed to returning to work on a mail truck. Dr. Thomason noted that she had to take off and rest over the prior weekend. He reiterated an impression of low back pain, bilateral degenerative facet hypertrophy at the lower three lumbar levels, especially at L5-S1, left lower extremity radiculitis, resolved and the failure of conservative treatment.

On July 6, 2011 appellant underwent a left L5-S1 hemilaminectomy with medial facetectomy and lateral recess decompression followed by L5-S1 discectomy. She returned to full duty on August 24, 2011. OWCP did not authorize the surgery.

On October 20, 2011 appellant filed a Form CA-7 requesting a schedule award. In an October 18, 2011 note, Dr. Bryan S. Givhan, a Board-certified neurosurgeon, stated that, based on her functional capacity evaluation, appellant could perform jobs in the medium work category and it was reasonable to permanently restrict her to such work level. Based on the fact that appellant had a one level lumbar discectomy with some mild residual radicular symptoms, she had 10 percent whole body impairment. Dr. Givhan did not refer to a specific edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*) or to any tables in rating impairment.

In an October 28, 2011 letter, OWCP advised appellant that the claim had been accepted for a lumbar strain. Appellant was advised that schedule award claims for spinal injuries were only payable for impairment to an extremity while Dr. Givhan provided a 10 percent whole person rating. She was requested to provide supporting medical evidence to establish an impairment to a scheduled member under the sixth edition of the A.M.A., *Guides*.

In a November 11, 2011 note, Dr. Givhan stated that maximum medical improvement was reached on October 28, 2011 with a mild degree of numbness in the left S1 distribution, a mild weakness in the left gastrocnemius muscle and loss of an ankle reflex, consistent with a mild radiculopathy in the left leg. He advised that these findings had prompted her surgery. Dr. Givhan reiterated the 10 percent whole person rating due to continued radicular findings.

In a February 9, 2012 report, Dr. James W. Dyer, an OWCP medical adviser, reviewed Dr. Givhan's reports. He noted that a whole person rating was not compensable under FECA. The medical adviser stated that appellant did well postoperatively with mild numbness and weakness and that only the L5-S1 mild motor and sensory deficit could be considered for lower extremity impairment. He calculated four percent left leg impairment based on one percent impairment for a mild sensory deficit and three percent impairment for mild motor deficit at the left L5-S1 nerve root.

In a February 23, 2012 decision, OWCP denied the claim for a schedule award. It explained that, while its medical adviser found four percent impairment of the left leg, the record indicated that her July 6, 2011 surgery at L5-S1 was not authorized by OWCP. OWCP found that there was no work-related condition other than the accepted lumbar strain and a schedule award was not warranted based on this condition.

On February 29, 2012 appellant, through her attorney, requested an oral hearing, which was held on June 7, 2012. She submitted duplicative copies of evidence and included medical records, diagnostic testing and surgical reports. Progress reports from Dr. Givhan prior to the July 6, 2011 surgery revealed that appellant had a significant disc protrusion with lateral recessed stenosis from ligamentous hypertrophy at L5-S1 on the left.

In an August 7, 2008 report, Dr. Laubenthal noted that appellant had back pain for approximately two years. When appellant was evaluated, she was diagnosed as having a herniated disc, treated with pain medications and sent home. Copies of Dr. Laubenthal's earlier progress reports from September 2006 were attached.

In a November 12, 2010 letter to the employing establishment, Dr. Laubenthal stated that he had treated appellant for four and one-half years with a number of differing methods for her degenerative back disease. He stated that her condition had progressively worsened to the point where any type of bending or lifting caused significant discomfort and disability. Dr. Laubenthal requested that she be moved to a position with less lifting and bending as any lifting over 10 pounds caused significant pain, as exacerbated upon returning to work within the postal truck.

Appellant's attorney argued that no diagnostic testing was performed at the time of appellant's initial injury, but within a month of the injury, an MRI scan showed problems at the L5-S1 level. Appellant testified about her initial injury, her light-duty assignments and the course of her medical care. She stated that her surgery was in the same area she previously injured in 2006 and that her supervisors were aware of her medical treatments. No new medical evidence was submitted.

By decision dated August 20, 2012, an OWCP hearing representative affirmed the February 23, 2012 decision denying appellant's claim for a schedule award. The hearing representative noted that appellant could file a new claim if she felt that other work factors contributed to her back conditions.

LEGAL PRECEDENT

The schedule award provision of FECA[2] and its implementing regulations[3] 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, FECA does not specify the manner in which the percentage of loss shall be determined. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

schedule losses.[4] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides*.[5]

A schedule award can be paid only for a condition related to an employment injury. The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[6]

The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between appellant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of appellant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by appellant.[7]

ANALYSIS

OWCP accepted that on August 16, 2006 appellant sustained a lumbar strain during the performance of her duties. In February 23 and August 20, 2012 decisions, it denied her schedule award claim finding that the medical evidence did not establish that she had any permanent impairment related to her accepted lumbar strain.

The evidence of record contains no medical opinion clearly explaining how appellant sustained any permanent impairment of either lower extremity due to the August 16, 2006 lumbar strain. The record reflects that appellant was diagnosed with a lumbar disc bulge, radiculopathy, stenosis, or herniation and underwent surgery on the L5-S1 area. These additional conditions and the surgery were not accepted by OWCP as employment related and there is no medical report of record which provides a reasoned opinion that addresses how such conditions or the need for surgery were causally related to the August 16, 2006 employment injury caused when she turned quickly to catch mail tubs. No report addresses how the accepted incident caused an aggravation of her degenerative back disease.[8]

An OWCP medical adviser, reviewing Dr. Givhan's findings, rated impairment to the left leg based on sensory and motor deficits of the L5-S1 nerve root. As noted, the medical evidence does not support that appellant's need for surgery or the postsurgical sensory and motor deficits

[4] *Id*.

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (January 2010).

[6] *Veronica Williams*, 56 ECAB 367 (2005).

[7] *Victor J. Woodhams*, 41 ECAB 345, 351-52 (1989).

[8] *See Jaja K. Asaramo*, 55 ECAB 200 (2004) (for conditions not accepted or approved by OWCP as being due to an employment injury, the claimant bears the burden of proof to establish that the conditions are causally related to the employment injury).

are causally related to the accepted lumbar strain. The medical evidence does not establish that appellant's permanent impairment is causally related to her accepted injury. Consequently, appellant has not established entitlement to a schedule award.

Appellant submitted new evidence on appeal, but the Board lacks jurisdiction to review such evidence for the first time on appeal.[9]

Appellant may request a schedule award or an increased schedule award based on evidence of a new exposure or medical evidence showing a progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she was entitled to schedule award compensation for permanent impairment.

ORDER

IT IS HEREBY ORDERED THAT the August 20, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 12, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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

[9] *See* 20 C.F.R. § 501.2(c)(1); *Sandra D. Pruitt*, 57 ECAB 126 (2005).