United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 13-1155**
	)	**Issued: September 16, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Perry, OK, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 12, 2013 appellant filed a timely appeal from a February 8, 2013 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 the case.

ISSUE

The issue is whether appellant has more than 17 percent impairment of her right leg for which she received a schedule award.

FACTUAL HISTORY

On February 10, 2006 appellant, then a 47-year-old city carrier, injured her low back when she was pulling a file cabinet down steps at work. OWCP accepted the claim for neck

[1] 5 U.S.C. §§ 8101-8193.

sprain, contusion of the face, scalp and neck and sprain of the back and lumbar region. It authorized surgery.

On January 23, 2008 appellant underwent an L4-5 decompressive laminectomy with bilateral foraminotomies and bilateral discectomies by Dr. Barry Pollard, a Board-certified neurosurgeon. She stopped work on February 11, 2006 and returned to work on February 13, 2006. In reports dated February 12 to August 13, 2008, Dr. Pollard noted that appellant did extremely well after the fusion surgery but noted some persistent numbness in the right foot and leg. A January 23, 2008 electromyogram (EMG) revealed stable neurophysiological functioning with no electrodiagnostic evidence of spinal cord, nerve root, lumbosacral plexus or peripheral nerve injury.

On June 26, 2012 appellant filed a claim for a schedule award. She submitted an April 25, 2012 EMG which showed evidence of chronic right L5 radiculopathy with evidence of reinnervation. A May 11, 2012 report from Dr. John Hughes, an osteopath, noted a stooped gait, restricted range of motion of the lumbar spine and no spinal deformity. He stated that appellant had no "clear-cut" neurological abnormalities but persistent numbness in her right leg and shooting symptoms. Dr. Hughes diagnosed status postoperative lumbosacral fusion at L4-5 and L5-S1. He opined that under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] appellant had 30 percent whole person impairment based on the lumbar spine regional grid, page 570.

In a July 14, 2012 report, Dr. R. Meador, an OWCP medical adviser, noted that Dr. Hughes' May 11, 2012 report used the lumbar spine regional grid to rate 30 percent whole person impairment. He noted that FECA did not permit schedule awards for impairment of the spine but that a spine condition may be considered for impairment only if it results in impairment to an extremity. The medical adviser further noted that an award may not be made for whole person impairment. He noted that the spinal nerve injury could be rated using the July/August 2009 "*The Guides Newsletter*." Dr. Meador recommended that OWCP refer appellant to another physician for an impairment rating.

On September 13, 2012 OWCP referred appellant to Dr. Shawn Smith, a Board-certified orthopedic surgeon, to determine if she had any permanent impairment. In a September 25, 2012 report, Dr. Smith reviewed the records provided and examined appellant. He noted findings of mild sensory deficits at L4 and S1, moderate sensory deficits at L5, weakness with dorsiflexion and planter flexion of the right lower extremity, 4/5 strength in the right leg, positive straight leg raises at 90 degrees on the right, limited flexion, extension and lateral bending in the lumbar spine, reflexes were decreased at the ankles bilaterally, knee flexion on the left is 5/5 and 4/5 on the right and quad strength was 4/5 on the right and 5/5 on the left. Dr. Smith diagnosed L4-5 sensory and motor deficits in the right lower extremity following spinal nerve impairment, right S1 sensory motor deficits and L4-5 disc disease with radiculopathy with residual symptoms. He

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

advised that OWCP recognized only extremity impairment resulting from spinal nerve root deficit as published in *The Guides Newsletter* July/August 2009.[3]

Dr. Smith utilized Table 2, Spinal Nerve Impairment, Lower Extremity found in *The Guides Newsletter*. In rating the L4 injury, appellant had a class 1 mild sensory impairment for one percent default impairment of the right leg. Dr. Smith noted a functional history grade modifier of one, clinical studies grade modifier of two which resulted in a net adjustment score of +1 for a grade D value of two percent impairment of the right leg. For the L5 injury, appellant had a class 1 moderate sensory impairment for three percent default impairment of the right leg. Dr. Smith noted a grade modifier for functional history of one, a grade modifier for clinical studies of two for a net grade modifier adjustment score of +1 for a grade D value of four percent impairment. For motor deficit for the L5 injury, appellant had a class 1 mild motor deficit for five percent default impairment of the right leg. Dr. Smith noted grade modifier for functional history of one, a grade modifier for clinical studies of two for a net grade modifier adjustment score of +1 for a grade D value of seven percent impairment of the right leg. For the S1 injury, appellant had a class 1 mild sensory impairment for one percent default impairment. Dr. Smith noted a grade modifier for functional history of one and a grade modifier of two for clinical studies for a net grade modifier adjustment score of +1 for a grade of D which also yielded one percent impairment for the right leg. For motor deficit due to the S1 injury, appellant had a class 1 mild motor impairment for three percent default impairment. Dr. Smith noted a grade modifier for functional history of one and a grade modifier for clinical studies of two for a net grade modifier adjustment score of +1 for a grade D that yielded four percent impairment of the right leg. He opined that combining the sensory impairment for all three levels resulted in 7 percent sensory impairment and 11 percent motor impairment for 18 percent right leg impairment.

In an October 15, 2012 report, Dr. H. Mobley, an OWCP medical adviser, reviewed the medical evidence. He opined that appellant reached maximum medical improvement on September 25, 2012. Using Dr. Smith's examination findings, the medical adviser applied *The Guides Newsletter* July/August 2009, using Table 2, Spinal Nerve Impairment, Lower Extremity. He noted that Dr. Smith found right L4, L5 and S1 motor and sensory deficits from radiculopathies, right leg numbness and weakness and strength was 4/5 on the right lower extremity. Dr. Mobley concurred in Dr. Smith's findings,[4] but noted that he incorrectly combined the values. He noted that appellant had a 17 percent impairment of the right lower extremity. Appellant had 2 percent impairment for L4 sensory deficit, 11 percent for the L5 sensory and motor deficit (4 percent impairment for L5 sensory deficit and 7 percent impairment for L5 motor deficit) and a 5 percent impairment for S1 sensory and motor deficit (1 percent impairment for S1 sensory deficit and 4 percent impairment for S1 motor impairment) for a combined total impairment of 17 percent for the right leg.

[3] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[4] In addressing grade modifiers, the medical adviser explained that a physical examination modifier was excluded because it was used to define the impairment.

In a decision dated February 8, 2013, OWCP granted appellant a schedule award for 17 percent impairment of the right leg. The period of the award was from September 25, 2012 to September 2, 2013.

LEGAL PRECEDENT

Section 8107 of FECA[5] and its implementing federal 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, 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.[7] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[8]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[9] 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.[10]

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.[11] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in the July/August 2009 *The Guides Newsletter*.[12]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

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

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

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

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

[12] *See supra* note 3.

(GMFH) and if electrodiagnostic testing were done, Clinical Studies (GMCS).[13] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[14]

ANALYSIS

Appellant's claim was accepted by OWCP for neck sprain, contusion of the face, scalp and neck and sprain of the back and lumbar region. OWCP authorized surgery and on January 23, 2008 she underwent an L4 and L5 decompressive laminectomy, bilateral foraminotomies and bilateral discectomies. On June 26, 2012 appellant filed a claim for a schedule award. The Board finds that the medical evidence of record establishes 17 percent impairment to her right lower extremity. The Board finds that the weight of the medical evidence rests with the opinion of the medical adviser's interpretation of Dr. Smith's physical findings.

Appellant initially submitted a May 11, 2012 report from Dr. Hughes who rated 30 percent whole person impairment; however, FECA does not authorize schedule awards for permanent impairment of the whole person or the spine.[15] As Dr. Hughes did not otherwise address whether she sustained permanent impairment of a lower extremity due to her work injury, his report is insufficient to establish permanent impairment of a scheduled body member.

OWCP referred appellant for a second opinion to Dr. Smith who properly noted that spinal nerve lower extremity impairments to the extremities were to be rated as provided in the July/August 2009 *The Guides Newsletter*. Dr. Smith used the proposed Table 2.[16] In rating the L4 injury, as explained, he determined that appellant had a mild sensory impairment which, after applying grade modifiers, resulted in two percent impairment of the right lower extremity. For the L5 injury, appellant had a moderate sensory impairment which merited four percent impairment. The L5 injury also involved a mild motor deficit which warranted seven percent impairment of the right leg. For the S1 injury, appellant had mild sensory impairment for one percent impairment. For the S1 motor deficit, Dr. Smith explained that she had a class 1 mild motor impairment which warranted four percent impairment of the right lower extremity. OWCP's medical adviser, in his October 15, 2012 report, concurred with these findings of Dr. Smith who opined that using the Combined Values Chart on page 604 of the A.M.A., *Guides*, appellant had 18 percent right leg impairment. However, as properly explained by OWCP's medical adviser, the 11 percent impairment due to motor deficit must be combined with

[13] *Supra* note 2 at 533.

[14] *Id.* at 521.

[15] *N.D.*, 59 ECAB 344 (2008).

[16] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

the 7 percent impairment due to sensory deficit.[17] Using the Combined Values Chart, it yielded 17 percent for the right lower extremity.[18]

The Board finds that Dr. Mobley properly reviewed the medical record and evaluated appellant's right lower extremity impairment in accordance with OWCP procedures found at Exhibit 4 of section 3.700. There is no medical evidence in conformance with the A.M.A., *Guides* showing a greater impairment. The Board finds that, as the medical adviser properly applied the A.M.A., *Guides* to Dr. Smith's clinical findings, his opinion represents the weight of the medical evidence in this case.[19]

On appeal appellant argues that she is entitled to a greater schedule. As explained, the sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment as was the case in prior editions. Instead, OWCP procedures provide that such lower extremity impairments are to be rated as provided in Exhibit 4 of section 3.700 of OWCP's procedures. This identifies proposed Table 2 of the July/August 2009 *The Guides Newsletter*, which is to be used in rating lower extremity impairments caused by spinal nerve injury.[20] Dr. Smith examined appellant and explained how he determined lower extremity impairment at each affected level. OWCP's medical adviser concurred in Dr. Smith's findings and noted that the motor and sensory deficits must be combined. There is no medical evidence in conformance with the A.M.A., *Guides* or *The Guides Newsletter* showing a greater impairment.

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 has no more than 17 percent impairment of the right lower extremity for which she received a schedule award.

[17] *See id.* at page 3 of Exhibit 4.

[18] *See* A.M.A., *Guides* 604.

[19] *See Bobby L. Jackson*, 40 ECAB 593, 601 (1989).

[20] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

ORDER

IT IS HEREBY ORDERED THAT the February 8, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 16, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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