United States Department of Labor
Employees' Compensation Appeals Board

M.C., Appellant	)	
and	)	**Docket No. 15-1932**
	)	**Issued: March 7, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Indianapolis, IN, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 18, 2015 appellant filed a timely appeal from an April 6, 2015 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.[2]

ISSUE

The issue is whether appellant has more than 11 percent permanent impairment of the left lower extremity for which she has received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence following OWCP's April 6, 2015 decision. Since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c); *Sandra D. Pruitt*, 57 ECAB 126 (2005). Appellant may submit that evidence to OWCP along with a request for reconsideration, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606(b)(2).

FACTUAL HISTORY

On February 20, 2007 appellant, then a 53-year-old rural mail carrier, filed an occupational disease claim (Form CA-2) alleging that she experienced noticeable left hip discomfort beginning January 2006 due to repetitive twisting, bending, lifting, and reaching in order to process and deliver mail. She did not stop work. OWCP accepted appellant's claim for aggravation of herniated disc disease at L5-S1 and aggravation of disc protrusion.

On December 11, 2012 OWCP expanded appellant's claim to include right hip and thigh sprain, degeneration of lumbosacral intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, postlaminectomy syndrome, and thoracic or lumbosacral radiculitis.

On August 30, 2011 appellant underwent authorized L5 decompression and discectomy surgery. She stopped work and filed a recurrence claim. On November 7, 2011 OWCP accepted appellant's recurrence claim and paid compensation benefits. Appellant was placed on the periodic rolls as of May 16, 2012. On April 19, 2013 OWCP updated her claim to include postlaminectomy syndrome, lumbago, lumbar radiculopathy, and sciatica. Appellant continued to receive medical treatment for her employment injuries until October 31, 2014 when all wage-loss compensation and medical benefits were terminated.[3]

On December 15, 2014 OWCP received appellant's claim for a schedule award.

By letters dated December 5 and 17, 2014, OWCP informed appellant that she needed an impairment rating based on a current medical evaluation, which included an opinion regarding maximum medical improvement, a diagnosis on which the impairment rating was based, a detailed description of the permanent impairment, and a final rating of impairment based on the sixth edition of the A.M.A., *Guides.* Appellant was informed that she had 30 days to submit further evidence.

On December 12, 2014 and January 1, 2015 appellant requested an extension of the time period to submit her medical evidence.

On January 21, 2015 OWCP granted appellant a 30-day extension to submit the necessary medical evidence.

In a January 26, 2015 report, Dr. Amy D. Leland, Board-certified in physical medicine and rehabilitation, noted that she was conducting a follow-up examination of appellant for her continued complaints of low back pain and chronic lower left extremity radiculopathy. She related that she had not seen appellant for over two years since an October 12, 2012 examination when she had found that appellant had reached maximum medical improvement and recommended a permanent impairment rating of 15 percent for her left lower extremity. Dr. Leland reviewed appellant's history and medical records beginning on February 15, 2013. She related appellant's complaints of ongoing, near constant left lower extremity numbness, burning, and difficulty sensing where her foot was in space, which made her feel unsteady when

[3] Appellant filed an appeal to the Board regarding the termination of her compensation benefits on April 24, 2015. Docket No. 15-1141.

walking. Dr. Leland reported that appellant also complained of constant discomfort across her low back.

Upon examination of appellant's lumbar spine, Dr. Leland observed maximal tenderness in the left lower lumbar facet region and left proximal buttock. Straight leg raise testing demonstrated no back or leg pain. Dr. Leland noted that lumbar range of motion demonstrated lateral flexion to 35 degrees to the right and left, rotation to 90 degrees to the right and left, extension to 35 degrees, and flexion to 80 degrees. Neurovascular examination revealed intact lower extremity sensation to light touch and decreased sensation to light tough over the lateral left hip, lateral calf, and dorsum of the left foot. Dr. Leland indicated that strength testing of the lower extremity was 5/5 for bilateral hip abduction, bilateral flexion, and bilateral extension. Strength testing for the bilateral knee and ankle were also 5/5. Dr. Leland diagnosed lumbago, thoracic or lumbar radiculitis, and sciatica due to displacement of lumbar disc. She reported that she could not assign a permanent impairment rating without new diagnostic testing, specifically a nerve conduction study and electromyography (NCS/EMG) examination of the left lower extremity. Dr. Leland also advised appellant to undergo a new functional capacity evaluation (FCE) to assess functional abilities. Appellant completed a pain disability questionnaire, which Dr. Leland scored as 84 or 85.

Dr. Leland requested authorization for NCS/EMG examination of appellant's left lower extremity and an FCE.

By letter dated February 13, 2015, appellant requested additional time to submit a detailed medical report in support of her claim for a schedule award. She explained that due to the fact that she had not received authorization for an FCE and NCS/EMG she had to cancel her appointments and reschedule them for February 20 and 26, 2015.

In a decision dated February 24, 2015, OWCP denied appellant's claim for a schedule award. It found that the medical evidence failed to establish that she sustained a permanent impairment to her left lower extremity as a result of her accepted lumbar conditions.

By letter dated February 26, 2015, appellant requested a copy of all her medical records and all written and verbal correspondence between OWCP and Dr. Leland. She also noted that she had a recent examination which OWCP required for consideration of her claim for a schedule award.

On February 26, 2015 appellant underwent an NCS/EMG examination by Dr. Leland who related appellant's complaints of chronic left L5 radiculopathy from a 2006 work injury. She reported that needle examination of the muscles of the left lower extremity and of the left mid and low lumbar paraspinal showed normal resting activity throughout. Dr. Leland indicated that motor units were decreased in number and increased in size in the anterior tibula, peroneous longus, and biceps femoris. She opined that appellant had an abnormal NCS/EMG study of the left lower extremity and concluded that findings were consistent with an old, chronic left L5 radiculopathy.

In her narrative report of that same date, Dr. Leland reviewed appellant's medical history and treatment for chronic left lower extremity radiculopathy and chronic low back pain. She

related that appellant continued to complain of ongoing left lower extremity numbness and associated stabbing and burning. Dr. Leland indicated that appellant still experienced difficulty sensing where her foot was in space and felt unsteady when walking. She noted that appellant experienced constant discomfort and tenderness across her low back. Upon examination of appellant's lumbar spine, Dr. Leland observed tenderness in the left lumbosacral junction into the left proximal buttock. Appellant exhibited pain with motion, worse with end range right rotation and end range extension. Straight leg raise testing demonstrated no pain bilaterally. Dr. Leland provided lumbar range of motion findings. Neurovascular examination of the left lower extremity demonstrated decreased sensation to light touch over the lateral left hip. Reflexes of the bilateral patella and Achilles were 2/4. Dr. Leland reported that strength examination of the bilateral hip, knee, and ankle were also 5/5 except for left ankle dorsiflexion and plantar flexion which were 4/5.

Dr. Leland diagnosed chronic lumbar radiculopathy and lumbago in class 3. Utilizing Table 17-4: Lumbar Regional Grid of the A.M.A., *Guides,* she determined that appellant had a default impairment of 19 percent. Dr. Leland also reported that appellant could work with restrictions of a medium physical demand level and provided work restrictions.

On March 20, 2015 OWCP referred appellant's case, along with a statement of accepted facts, to an OWCP medical adviser. In a March 22, 2015 report, Dr. Morley Slutsky, Board-certified in occupational medicine and an OWCP medical adviser, reviewed appellant's medical records. He related that a lumbar MRI scan revealed right lateral L3 nerve root involvement and EMG/NCV testing demonstrated chronic left L5 radiculopathy. Dr. Slutsky explained that because there was no evidence of left L3 or L4 nerve root involvement, he would use the left L5 nerve root. Utilizing Table 16-11 for sensory deficits of *The Guides Newsletter,* July/August 2009 (*The Guides Newsletter*), he determined that appellant was a default three percent impairment for class 1, grade C because of sensibility touching by light touch and sharp/dull discrimination. Dr. Slutsky next addressed motor deficits and found that appellant was a default five percent impairment for class 1, grade C due to mild left L5 motor deficits. He assigned a Functional History (GMFH) grade modifier of 1 because appellant had an antalgic gait that did not require using a single gait aid device and there was no evidence of a positive Trendelenburg. Dr. Slutsky also reported that Physical Examination (GMPE) was not relevant and that Clinical Studies (GMCS) grade modifier was 2 because an EMG examination showed evidence of left L5 nerve root involvement. He applied the net adjustment formula for a total adjustment of +1. Dr. Slutsky then calculated that appellant had 4 percent impairment for sensory deficits and 7 percent impairment for motor deficits, which totaled 11 percent total impairment for the left lower extremity. He explained that his impairment differed from Dr. Leland because Dr. Leland used the Spine Chapter 17 from the A.M.A., *Guides* instead of the appropriate July/August 2009 *The Guides Newsletter*. Dr. Slutsky concluded that appellant had 11 percent permanent impairment for the left upper extremity and noted a date of maximum medical improvement of February 26, 2015.

On April 6, 2015 OWCP granted a schedule award decision for 11 percent permanent impairment of the left lower extremity. The award ran for a total of 34.32 weeks from February 26 to October 24, 2015.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and its implementing regulations 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. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized 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 OWCP as the appropriate standards for evaluating schedule losses.[5]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. The A.M.A., *Guides* has developed an approach to rating such impairment in *The Guides Newsletter* (July/August 2009). OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[6]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[7]

ANALYSIS

OWCP accepted that appellant sustained multiple conditions of her lumbar spine as a result of her employment duties. Its procedures provide that a schedule award is not payable for injury to the spine.[8] However, 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.[9] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that the July/August 2009 *The Guides Newsletter* of the sixth edition of the A.M.A., *Guides* is to be applied.[10]

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[4] 5 U.S.C. §§ 8101-8193.

[5] 20 C.F.R. § 10.404 (1999); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010). *See also G.N.*, Docket No. 10-850 (issued November 12, 2010).

[7] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[8] *Pamela J. Darling*, 49 ECAB 286 n.7 (1998).

[9] *Thomas J. Engelhart*, 50 ECAB 319 n. 8 (1999).

[10] *Supra* note 6.

Appellant submitted an impairment rating dated October 13, 2012 by Dr. Leland, appellant's treating physician who is Board-certified in physical medicine and rehabilitation. She determined that under Table 17-4, Lumbar Spine Regional Grid, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) appellant was placed in class 3 for intervertebral disc herniations and/or AOSM at multiple levels, with documented findings with or without surgery and with or without documented radiculopathy at a single clinically appropriate level present at the time of examination for a default value of 19 percent. Appellant applied the net adjustment formula and calculated an adjustment of -4, which resulted in 15 percent impairment of the lumbar spine.

In a March 22, 2015 report, Dr. Slutsky, an OWCP medical adviser, reviewed appellant's medical records and noted that EMG/NCV testing demonstrated chronic left L5 radiculopathy. Referencing Table 16-11 of the July/August 2009 edition of *The Guides Newsletter* for sensory deficits, he determined that appellant had a default value of three percent impairment for a class 1, grade C rating due to sensibility touching by light touch and sharp/dull discrimination. Dr. Slutsky next addressed motor deficits under Table 16-11 and found that appellant had default five percent impairment for class 1, grade C due to mild left L5 motor deficits. He assigned a GMFH of 1 and GMCS of 2. Dr. Slutsky reported that GMPE was not relevant. After applying the net adjustment formula for a total adjustment of +1, he calculated that appellant had four percent impairment for sensory deficits and seven percent impairment for motor deficits. Dr. Slutsky concluded that appellant had a total 11 percent impairment of the left lower extremity and a date of maximum medical improvement of February 26, 2015. He explained that his impairment differed from Dr. Leland because Dr. Leland used the Spine Chapter 17 from the A.M.A., *Guides* instead of the appropriate July/August 2009 *The Guides Newsletter*.

The Board finds that the medical adviser, Dr. Slutsky, properly reviewed the medical record and evaluated appellant's condition in accordance with OWCP procedures found in July/August 2009 *The Guides Newsletter*.[11] 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 provided the only rating which properly applied the A.M.A., *Guides*, his medical opinion represents the weight of the medical evidence in this case.[12]

On appeal, appellant requested an impartial medical neurologic or orthopedic referee physician to solve the discrepancies between Dr. Leland, her treating physician, and Dr. Slutsky, the OWCP medical adviser. The Board has found, however, that a referee medical examiner is required only when there exists opposing medical reports of virtually equal weight and rationale.[13] Dr. Leland's report, however, does not stand in equal weight to Dr. Slutsky's report as Dr. Leland's report does not comport with the standards of the A.M.A., *Guides.* Dr. Leland based her impairment rating on Chapter 17 of the A.M.A., *Guides* as opposed to the July/August 2009 *The Guides Newsletter*, which is the only appropriate table to use when

[11] The Board notes that Dr. Slutsky's reference to a left upper extremity impairment is harmless error as he refers to appellant's left lower extremity throughout the rest of his report.

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

[13] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

calculating impairment to the upper or lower extremities caused by a spinal injury.[14] The Board has held that an attending physician's report is of diminished probative value where the A.M.A., *Guides* are not properly followed.[15] Because Dr. Leland's February 26, 2015 impairment rating is of diminished probative value, it fails to establish appellant's request for an increased schedule or to create a conflict in medical opinion evidence.

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 failed to establish more than 11 percent permanent impairment to the left lower extremity, for which she received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 6, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 7, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[14] *Supra* note 6.

[15] *J.G.*, Docket No. 09-1128 (issued December 7, 2009).