United States Department of Labor
Employees' Compensation Appeals Board

CHESTER W. TORRES, Appellant	)	
and	)	**Docket No. 05-659**
	)	**Issued: September 23, 2005**
U.S. POSTAL SERVICE, CHICO POST OFFICE, Chico, CA, Employer	)	

Appearances:
Chester W. Torres, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
WILLIE T.C. THOMAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 24, 2004 appellant timely filed an appeal from a January 12, 2005 decision by the Office of Workers' Compensation Programs which found 50 percent impairment of each leg for which he received a schedule award. The Board has jurisdiction over the merits of this case pursuant to 20 C.F.R. §§ 501.2(c) and 501.3.

ISSUE

The issue is whether appellant had an impairment of his legs greater that a 50 percent impairment of each lower extremity.

FACTUAL HISTORY

On September 6, 1972 appellant, then a 32-year-old substitute clerk, was lifting boxes from a postal truck when he developed pain in his lower back on the right side. On August 1, 1974 he had a recurrence of back pain while unloading boxes of books and heavy parcels from a postal truck. On June 15, 1979 appellant was dumping a sack of small parcels into a tub when he developed pain in the left side of his low back. On July 12, 1979 he was bending down into a

postal tub to get parcels when he again had pain in his back on the left side. On September 8, 1982 appellant was getting off a stool and bending down to pick up mail when he felt pain in his lower back.

On December 13, 1988 appellant underwent back surgery, consisting of a laminectomy and disc excision at L4-5 on the left side and an L5-S1 posterior lateral fusion with iliac crest allograft. In a March 14, 1989 report, Dr. Bechard stated that appellant had a long-standing history of intermittent back injuries beginning in September 1972. He commented that the cumulative trauma to appellant's spine resulting from these injuries had resulted in aggravating a probable preexisting Grade I spondylolisthesis at L5-S1 and also resulted in a herniated L4-5 disc which ultimately required surgery for relief of nerve root pressure.

On July 15, 1996 Dr. Bechard performed a bilateral laminectomy at L3-4 with excision of the L3-4 disc. In a July 25, 1996 report, Dr. Bechard stated that the L3-4 herniated disc surgery was partially attributed to appellant's previous L4-5 fusion surgery.

The Office referred appellant to Dr. Douglas W. Benson, a Board-certified orthopedic surgeon, for a second opinion examination. In an October 7, 1996 report, he noted that after appellant's pain had diminished following the surgery he continued to experience weakness in both legs. Dr. Benson noted that appellant had pain in his lower back if he stood too long. On examination he found an ankle-foot arthrosis on the left. Dr. Benson noted that the left thigh was one inch larger in circumference than the right, but the calves were equal in circumference. Dr. Benson diagnosed status post laminectomy and discectomy at L4-5, L5-S1 disc with fusion from L4 to the sacrum, status post L3-4 laminectomy and discectomy and partial cauda equina syndrome with significant quadriceps, anterior tibialis and extensor hallices weakness on the right and anterior tibialis, extensor hallices longus and gastrocsoleus weakness on the left.

The Office referred the case record to an Office medical adviser for his review and opinion on the degree of permanent impairment to appellant's lower extremity. In a November 7, 1996 memorandum, the Office medical adviser used two separate methods to calculate the impairment to the legs. For the first method, the medical adviser stated that with the cauda equina syndrome, the sciatic nerve was involved with a maximum 17 percent impairment for pain and 75 percent for motor deficit. He indicated that appellant had an 80 percent grade for pain which equaled a 14 percent impairment of the legs due to pain. The Office medical adviser estimated that appellant had a 50 percent grade weakness of the sciatic nerve, which equaled an impairment of 38 percent for each leg. He indicated that by combining the measures of impairment, appellant had a 47 percent impairment of each leg. The Office medical adviser also noted that a person with cauda equina syndrome without bowel or bladder involvement had a 40 percent impairment of the whole man. By extrapolating the 40 percent whole person impairment, the medical adviser noted a 20 percent whole person impairment of each leg which would equal a 50 percent impairment to each leg. The medical adviser recommended that the second higher impairment rating for the legs be used with a maximal improvement no earlier than October 7, 1996, three months after appellant's most recent surgery.

In a November 22, 1996 decision, the Office issued a schedule award for a 50 percent impairment to each leg, to run from October 7, 1996 to April 14, 2002.

On January 20, 1998 appellant underwent surgery to treat paralysis of the tibial compartment of the left leg with left leg foot drop. Dr. Bechard performed a tibialis anterior tenodesis of the left ankle.

In a July 30, 2003 report, Dr. Stephen D. Landaker, a Board-certified orthopedic surgeon, stated that in the left foot appellant had a well-healed surgical scar anteriorly. He indicated that with dorsiflexion he had active eversion and no active inversion. Dr. Landaker found decreased sensation over the dorsum of the foot. He noted that appellant was tender to palpation over the plantar medial heel pad anteriorly. Dr. Landaker detected no pain with passive toe dorsiflexion. He indicated that appellant had no pain with palpation over the plantar medial arch. Dr. Landaker diagnosed status post left leg neurapraxia with foot drop and a painful left heel. Appellant subsequently claimed an additional schedule award for greater impairment of both lower extremities.

In an August 11, 2004 report, Dr. Landaker indicated that appellant had a new onset of back pain radiating into the buttock and then down the thigh to the knee. He reported that his motor examination was 5/5 with the exception of the extensor digitorium longus and the extensor hallucis longus muscles which were 0/5. Dr. Landaker noted that sensation with a pinwheel was normal and equal bilaterally. He reported that the deep tendon reflexes were 0 for the right knee jerk, 2+ for the left knee jerk, 2+ for the right ankle jerk and 0 for the left ankle jerk. Dr. Landaker indicated that appellant's gait was smooth and nonantagic. He stated that x-rays showed his previous surgical changes of the L5-S1 fusion and L3-4 laminectomy. Dr. Landaker diagnosed chronic low back pain with a possible new herniated nucleus pulposus.

In an August 30, 2004 report, Dr. Stuart May, a Board-certified radiologist, stated that a magnetic resonance imaging (MRI) scan that the L1-2 disc showed a mild multifactorial central canal and lateral recess narrowing bilaterally. The L2-3 disc showed mild to moderate central canal and moderate right lateral recess stenosis. The L3-4 disc showed moderate lateral recess narrowing on the left and moderate to severe narrowing on the right secondary to disc encroachment and spondylosis. Dr. May detected moderate right foraminal narrowing impinging on the existing L3 nerve rootlet. He indicated that at L5-S1 appellant had bilateral foraminal stenosis slightly greater on the left, contacting the exiting L5 nerve rootlet. Dr. May saw no recurrent central canal stenosis following the wide decompression laminectomy and fusion at that level.

The Office referred appellant to Dr. John R. Chu, a Board-certified orthopedic surgeon, for an examination and second opinion. In a December 8, 2004 report, he indicated that appellant had a normal range of motion in the hips, knees and feet. Dr. Chu reported that he had a well-healed surgical incision over his anterior left ankle. He noted that, with active dorsiflexion of the left side, appellant's foot deviated to the lateral side. Dr. Chu stated that he had normal muscle strength in all major muscle groups except for the right quadriceps function and right ankle dorsiflexion, both rated as 4/5 in strength. He found right thigh atrophy with the right thigh measuring 48 centimeters and the left thigh measuring 52 centimeters. Dr. Chu indicated that sensation was intact to light touch throughout both legs. He reported patellar reflexes as absent on the right and 2+ on the left with ankle reflexes 1+ on both sides. He diagnosed chronic right leg weakness, status post L3-4 and L4-5 discectomies and fusion of L5-S1.

The Office referred the case record to the Office medical adviser for review. In a December 21, 2004 memorandum, he noted that the medical records documented a 4 centimeter difference between the left and right thighs which constituted atrophy equal to a 13 percent impairment of the right leg. The Office medical adviser commented that the 4/5 weakness of quadriceps strength would be assessed at a 12 percent impairment. He noted that Dr. Chu's report did not indicate any right leg pain or subjective complaints. The Office medical adviser stated that, in the left leg, appellant had no ongoing pain. He indicated that left ankle dorsiflexion strength was listed as 4/5 and, therefore, would be a 12 percent impairment of the left leg. The Office medical adviser stated that appellant's records did not document any loss of motion in the hips, knees, ankle, subtalar or toe range on either foot. He commented that the final award would be a 13 percent impairment on the right leg and a 12 percent impairment of the left leg. The Office medical adviser pointed out that these impairment ratings were lower than the previously awarded 50 percent impairment to each leg.

In a January 12, 2005 decision, the Office denied appellant's claim for an increased schedule award, finding that the medical evidence of record did not establish an increased impairment due to his accepted injuries.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[1] and its implementing regulations[2] sets 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, 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[3]

ANALYSIS

The Office medical adviser, using the fourth edition of the A.M.A., *Guides*, found that appellant had a 50 percent impairment of each leg due to weakness and pain. He was granted a schedule award on November 22, 1996 for 50 percent impairment of each leg. Following payment of this award, the record indicates that appellant underwent additional surgery to the left leg.

In a review of the record, conducted appropriately under the fifth edition of the A.M.A., *Guides*, the Office medical adviser found on December 21, 2004 that appellant had a 13 percent

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.404 (1999).

[3] 5th ed. (2001)

impairment of the right leg and a 12 percent impairment of the left leg.[4] He properly found that he had a 13 percent impairment of the leg due to atrophy greater than three centimeters.[5] Although appellant had a 12 percent impairment due to weakness in the quadriceps muscle, under the A.M.A., *Guides*, impairment due to atrophy cannot be combined with impairment due to muscle weakness since both essentially measure the same impairment.[6] In the left leg, the medical adviser properly found that he had a 12 percent impairment due to weakness in the left dorsiflexion of the ankle.[7]

The record establishes that at the time appellant requested an additional schedule award his impairment to the lower extremities was rated less than the 50 percent impairment for which he had previously been awarded. The medical evidence is not sufficient to establish greater impairment than that for which he has been awaded.

CONCLUSION

The Board finds that appellant is not entitled to an increased schedule award beyond the 50 percent he has received for each leg.

[4] Under the Office's procedures, if a claimant is seeking a greater schedule award than that already awarded employing establishment, the Office is to use the current edition of the A.M.A., *Guides* in use at the time of the reevaluation of the claimant's impairment. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.7(b)(4) (September 1995).

[5] A.M.A., *Guides*, page 530, Table 17-6.

[6] *Id.* at page 526, Table 17-2.

[7] *Id.* at page 532, Table 17-8.

ORDER

IT IS HEREBY ORDERED THAT the January 12, 2005 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: September 23, 2005
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Willie T.C. Thomas, Alternate Judge
Employees' Compensation Appeals Board

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