United States Department of Labor
Employees' Compensation Appeals Board

B.B., Appellant	)	
and	)	**Docket No. 13-1204**
	)	**Issued: June 2, 2014**
U.S. POSTAL SERVICE, POST OFFICE, West Sacramento, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Acting Chief Judge[1]
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On April 22, 2013 appellant, through his attorney, filed a timely appeal from an October 25, 2012 decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant is entitled to a schedule award greater than a one percent permanent impairment to his right lower extremity.

[1] Effective May 19, 2014, Patricia Howard Fitzgerald was appointed Acting Chief Judge.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 21, 1997 appellant, a 35-year-old distribution clerk, injured his back while pulling cages of mail. He filed a claim for benefits on December 22, 1997, which OWCP accepted for lumbar strain and herniated disc at L4-5.

In a September 16, 1998 report, Dr. Cully A. Cobb, a specialist in neurosurgery, stated that appellant had disc rupture with nerve compression, partial foot drop and numbness, consistent with his area of nerve compression. He opined that this caused disabling pain which progressed after his injury. Dr. Cobb indicated that these symptoms were causally related to his work-related injury and recommended surgery.

On December 16, 1998 appellant underwent back surgery, a discectomy to repair his herniated disc at L4-5.

In an August 17, 2009 report, Dr. Moola P. Reddy, Board-certified on physical medicine and rehabilitation and appellant's treating physician, reviewed the history of injury and found based on appellant's L4-5 disc herniation and 1998 discectomy that appellant had a 12 percent whole person impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed.) (A.M.A., *Guides*).

In an August 25, 2009 report, Dr. Reddy, utilizing an A.M.A., *Guides* impairment worksheet, determined that the findings from his August 17, 2009 report would produce a 30 percent left lower extremity impairment under the A.M.A., *Guides*.

In a September 5, 2009 report, Dr. Leonard A. Simpson, a specialist in orthopedic surgery and an OWCP medical adviser, stated his disagreement with Dr. Reddy's impairment rating. He advised that lower extremity electrodiagnostic studies dated August 17, 2009 were normal and showed no evidence of radiculopathy, lumbosacral plexopathy or peripheral neuropathy. Dr. Simpson stated that a back condition can yield a lower extremity impairment rating with findings of either pain and/or loss of sensation or altered sensation; with clinical findings, an award may be rendered based on permanent functional loss of either lower extremity. He stated that while no specific nerve root compression diagnosis is listed in Chapter 16 to calculate an award for the permanent functional loss of the left lower extremity, the A.M.A., *Guides* indicate that when a specific diagnosis is not listed an equivalent one can be utilized. Dr. Simpson recommended using Table 16-12, utilizing the equivalent of a sciatic nerve diagnosis. As appellant's medical history did not reveal any objective sensory or motor deficits, Dr. Simpson recommended a zero percent impairment of each lower extremity or leg based on a class zero for sciatic nerve at Table 16-12, page 535 of A.M.A., *Guides*.[3]

In a Form CA-7 dated October 23, 2009, appellant requested a schedule award based on a partial loss of use of his left and right lower extremities.

By decision dated October 23, 2009, OWCP found that appellant had no ratable impairment causally related to an accepted condition and therefore was not entitled to a schedule

[3] A.M.A., *Guides* 535.

award. By letter dated October 30, 2009, appellant requested an oral hearing, which was held on February 22, 2010.

In a November 10, 2009 report, Dr. Reddy reiterated his 12 percent impairment rating and expressed his disagreement with Dr. Simpson's report. He stated that appellant's impairment should be based on his L4-5 discectomy, that he had no evidence of lumbar radiculopathy and no neurological deficits.

In a March 14, 2010 report, Dr. William N. Grant, Board-certified in internal medicine, found that appellant had a nine percent right lower extremity impairment under the A.M.A., *Guides*.

By decision dated April 14, 2010, an OWCP hearing representative set aside the October 23, 2009 decision, indicating that Dr. Grant's opinion was not well rationalized. He advised that Dr. Grant's impairment rating was lacking in probative value because he did not conduct an examination of appellant, did not state which leg was impaired and did not indicate if he was referring to both of appellant's legs. The hearing representative also found that Dr. Grant's report lacked probative value because he relied on Dr. Cobb's September 16, 1998 report, which did not provide measurement findings consistent with the A.M.A., *Guides* and was completed prior to appellant's December 1998 discectomy. He further noted that Dr. Grant did not reference Dr. Simpson's or Dr. Reddy's findings that appellant had radiculopathy. The hearing representative, found, however, that Dr. Grant had provided new medical evidence and new calculations which should be reviewed by OWCP's medical adviser to determine whether a different application of the A.M.A., *Guides* should be utilized.

In an April 18, 2010 report, Dr. Simpson reviewed Dr. Grant's March 14, 2010 report and found that appellant had a six percent impairment of the right lower extremity. He noted findings of occasional tingling and numbness involving the right lower extremity and stated that Dr. Grant's report identified weakness of the L5 nerve root, which produced a partial foot drop and numbness. Relying on *The Guides Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009), Dr. Simpson rated a class 1, one percent default rating for mild sensory deficit involving L5 and an additional five percent impairment for mild motor deficit based on his partial foot drop. He found that a class 1 impairment yielded a grade modifier of 1 for functional history, or a net adjustment of zero; he stated that the physical examination adjustment was not utilized and clinical studies adjustment was not applicable. Dr. Simpson found that, under this method, total net adjustment was zero and a six percent default impairment rating, based on one for mild sensory deficit and five for mild motor deficit, would become the rating. Accordingly, he recommended a six percent impairment of the right lower extremity or leg, and a zero percent impairment of the left lower extremity or leg.

By decision dated April 28, 2010, OWCP granted appellant a schedule award for a six percent permanent impairment of the right lower extremity for the period December 16, 2000 to April 15, 2001, for a total of 17.28 weeks of compensation.

On May 18, 2010 appellant requested an oral hearing, which was held on September 13, 2010.

By decision dated November 18, 2010, an OWCP hearing representative set aside the April 28, 2010 decision. He stated that, as Dr. Simpson based his impairment rating on findings made by Dr. Grant, a report completed prior to appellant's December 16, 1998 discectomy and the date of maximum medical improvement, the rating was of little probative value and would not constitute a sufficient basis for a schedule award. The hearing representative directed the district Office on remand to refer the case file back to Dr. Simpson to review the current, postsurgery medical reports and evaluate whether these reports contained findings sufficient to issue an impairment rating under the sixth edition of the A.M.A., *Guides*. Dr. Simpson should be instructed to identify the findings of impairment and explain how he applied such findings to the A.M.A., *Guides*.

In a November 27, 2010 report, Dr. Simpson stated that, in light of the findings and instructions issued by the hearing representative in his November 18, 2010 decision, he no longer considered his rating of a six percent right lower extremity impairment to be valid. He then reviewed Dr. Reddy's August 17, 2009 report, which contained a 12 percent whole person rating impairment rating for the lower extremities. Dr. Simpson advised that the report did not indicate any lower extremity radicular symptomatology or findings, noting that Dr. Reddy measured muscle strength of 5/5 of all muscle groups of both lower extremities, normal lower extremity reflexes and a normal Babinski's sign with no lower extremity atrophy or weakness. Dr. Simpson stated that the report showed some decreased sensation of the right leg "diffusely below the knee," which did not conform to any particular dermatonal pattern. He related that electrodiagnostic studies relied on by Dr. Reddy did not reveal evidence of right or left lumbosacral radiculopathy, plexopathy or lower extremity peripheral neuropathy. Dr. Simpson further stated that, while Dr. Reddy rated a 12 percent whole person impairment based on a class 1 impairment, a whole person impairment did not translate to a specific lower extremity impairment under the A.M.A., *Guides*. He therefore concluded that his review of Dr. Reddy's August 17, 2009 report and the medical evidence of record supported a zero percent impairment of the right and left lower extremities, with no evidence of ongoing lower extremity radiculopathy. Dr. Simpson recommended a date of maximum medical improvement two years after the December 16, 1998 right L4-5 discectomy.

In a December 19, 2010 report, Dr. Simpson clarified that he no longer considered his prior rating of a six percent impairment of the right lower extremity to be valid because it did not reflect appellant's sensory and clinical findings postoperatively. He stated that his subsequently calculated zero percent impairment of each lower extremity, as indicated in his November 27, 2010 report, should be considered the valid lower extremity impairment.

By decision dated February 3, 2011, OWCP rescinded the prior schedule award based on Dr. Simpson's December 19, 2010 report.

By letter dated February 8, 2011, appellant, through his attorney, requested an oral hearing, which was held on May 25, 2011. At the hearing appellant's attorney questioned whether the February 3, 2011 decision actually rescinded the prior schedule award; he opined that this issue needed to be remanded for clarification. He contended that the February 3, 2011 decision was inherently contradictory and illogical. Counsel argued that it was inconsistent to find that Dr. Grant's report was of diminished probative value because he spoke to appellant on the telephone and did not do a physical examination, given that OWCP's medical advisers do not

perform examinations and always rely on reports from other physicians. Counsel further contended that there was no basis for OWCP to rescind appellant's schedule award.

Appellant submitted a June 1, 2011 report containing results of an electrodiagnostic testing, including electromyelogram (EMG) nerve conduction velocity tests. The results of these tests showed electrodiagnostic evidence for right L5 radiculopathy, with no electrodiagnostic evidence for peripheral neuropathy.

By decision dated July 19, 2011, an OWCP hearing representative set aside the February 3, 2011 decision. She found that appellant had submitted new medical evidence; *i.e.*, the June 1, 2011 electrodiagnostic study, which warranted further development of the medical evidence. The hearing representative directed the district Office on remand to refer appellant for a new second opinion examination and impairment evaluation with a specialist under the A.M.A., *Guides*. She instructed the district Office to have the examiner determine whether appellant had permanent impairment of either lower extremity by using the A.M.A., *Guides* July/August issue of *The Guides Newsletter* for rating spinal nerve impairment, and to consider the June 1, 2011 electrodiagnostic study in rendering his impairment rating.

In an August 26, 2011 report, Dr. Reddy had appellant undergo electrodiagnostic studies to determine whether he had any peripheral nerve injuries in his lower extremities. He advised that the studies showed evidence of chronic mild right L5 radiculopathy with no electrodiagnostic evidence of acute radiculopathy in the right lower extremity; no acute or chronic left lumbosacral radiculopathy; no peripheral neuropathy in the bilateral lower extremities; and no evidence of peroneal, tibial, sural or superficial neuropathy in the right or left lower extremities. Dr. Reddy reiterated that appellant had a 12 percent impairment of the whole person for intervertebral disc herniation at the single L4-5 level, a spinal condition under the A.M.A., *Guides*, noting that he underwent an L4-5 discectomy and had evidence of residual right lower extremity radiculopathy. He stated that there was no change in his opinion from his August 17, 2009 evaluation. Dr. Reddy concluded that it was not appropriate to rate appellant's condition in terms of peripheral nerve injury because he had a spinal injury and did not sustain any peripheral nerve injuries in his lower extremities.

OWCP resubmitted the case file to Dr. Simpson, OWCP's medical adviser. In a September 30, 2011 report, he reviewed the June 1, 2011 electrodiagnostic study and Dr. Reddy's August 26, 2011 report and electrodiagnostic study and found that appellant had a one percent impairment of the right lower extremity and a zero percent impairment of the left lower extremity. Dr. Simpson reviewed the June 1, 2011 electrodiagnostic study and found that it showed extensor hallucis longus muscles of the right lower extremity suggestive of right L5 radiculopathy but demonstrated no evidence of peripheral neuropathy. With regard to Dr. Reddy's August 26, 2011 electrodiagnostic study report, he stated that evaluation of the right peroneal motor, right tibial motor, left peroneal motor, left tibial motor, left sural sensory, right sural sensory, left superior peroneal sensory and right superior peroneal sensory were unremarkable. Dr. Simpson found that the study provided no electrodiagnostic evidence of peripheral neuropathy involving the lower extremities and no electrodiagnostic evidence of acute or chronic left lumbosacral radiculopathy.

Utilizing using the A.M.A., *Guides* July/August issue of *The Guides Newsletter* for rating spinal nerve impairment, in conjunction with the corresponding tables at Chapter 16 of the A.M.A., *Guides*, Dr. Simpson rated a class 1, one percent impairment. He noted that the documentation of mild chronic right L5 radiculopathy, noted electrodiagnostically, with occasional pain in the right lower extremity and tingling and numbness in the right lower extremity below the knee yielded a class 1 default rating for mild sensory deficit involving the L5 nerve root on the right. Dr. Simpson rated a functional history grade modifier of 1 or a zero net adjustment; no utilization of the physical examination grade modifier; and a clinical studies grade modifier of 1 or a zero net adjustment based on mild pathology. Based on the above findings OWCP's medical adviser compared the net adjustments from functional history and clinical studies at the net adjustment formula at page 521 of the A.M.A., *Guides*. Dr. Simpson calculated a total net adjustment of zero, which would leave in place the class 1, one percent default rating and a one percent right lower extremity impairment of the right lower extremity, with a zero percent left lower extremity impairment. He reiterated that the electrodiagnostic studies, particularly the June 1, 2011 EMG results, supported a right lower extremity impairment based on mild sensory deficit involving the right L5 nerve root.

By decision dated April 27, 2012, OWCP, relying on Dr. Simpson's September 30, 2011 report, granted appellant a schedule award for a one percent permanent impairment of the right lower extremity for the period December 16, 2000 to January 5, 2001, for a total of 2.88 weeks of compensation.

By decision dated October 25, 2012, an OWCP hearing representative affirmed the April 27, 2012 decision.[4]

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing 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 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 A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] 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.[8]

[4] OWCP also found that an overpayment had occurred as a result of the reduction in appellant's schedule award.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[7] *Id.*

[8] *Veronica Williams*, 56 ECAB 367, 370 (2005).

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. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP procedures indicate that *The Guides Newsletter* "Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[11]

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 (GMFH) and if electrodiagnostic testing were done, Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[13]

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 of impairment in accordance with the A.M.A., *Guides*, with OWCP's medical adviser providing rationale for the percentage of impairment specified.[14]

ANALYSIS

The Board finds that the case is not in posture for decision.

OWCP's hearing representative, in his July 19, 2011 decision, directed OWCP on remand to have the district Office refer appellant to a new specialist. On remand, however, the district Office disregarded the hearing representative's instructions and referred the case file back to Dr. Simpson, OWCP's medical adviser, for an additional impairment evaluation. OWCP

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

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

[11] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- *Medical, Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[12] A.M.A., *Guides* 533

[13] *Id.* at 521.

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

relied on Dr. Simpson's opinion and granted appellant an award for a one percent right lower extremity impairment.in its April 27, 2012 decision. This constituted error, as OWCP ignored the hearing representative's explicit instructions.

OWCP's procedures address the actions that should be taken following a decision by the Branch of Hearings and Review, including specifically how OWCP should proceed if the district Office does not agree with the hearing representative's decision.[15] These procedures provide that any case requiring further action based on a decision issued by the Branch of Hearings and Review should be promptly assigned to a claims examiner for the required action. The procedures further explain how the claim should be handled if the claims examiner believes that the required action is incorrect:

> "c. *Review of the Remand Decision*. If the [d]istrict Office, upon careful review, believes the remand decision issued by the Branch of Hearings and Review contains a serious error of fact or law, the District Director should contact the Hearings and Review Branch Chief (or Assistant Branch Chief) within 15 days of receipt of the decision outlining the basis for the disagreement. This review process, rarely employed, should be reserved for cases where there is a material factual error or a misinterpretation of the statute, regulations or procedures that is critical to the decision. If, upon review of the decision, the Hearings and Review Branch Chief determines that the decision issued was in error, the decision may be vacated through 5 U.S.C. § 8128, which provides for review of a decision allowing or denying compensation 'at any time.' If, upon review of the decision, the Hearings and Review Branch Chief determines that the decision issued was appropriate, no action will be taken. This process does not apply to Employing Agencies."

These procedures were not followed in this case. The Board thus finds that to allow OWCP to unilaterally dismiss specific instructions by the Branch of Hearings and Review, for further development of the case record, would negate and eviscerate the review authority granted to the Branch of Hearings and Review.

As the October 25, 2012 decision did not correct these errors and make the required findings, its affirmance of the April 27, 2012 OWCP decision was in error. Accordingly, the October 25, 2012 decision is vacated and the case is remanded for referral to a new second opinion examination with an impairment specialist.

The Board directs OWCP on remand to instruct the second opinion examiner to issue findings and conclusions based on the A.M.A., *Guides* July/August issue of *The Guides Newsletter* for rating spinal nerve impairment and to consider the June 1 and August 26, 2011 electrodiagnostic studies in rendering his impairment rating, pursuant to the standards set out in section 8128(a). After such further development of the record as it deems necessary, OWCP shall issue a *de novo* decision.

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Hearings and Review of the Written Record*, Chapter 2.1601.9 (October 2011).

CONCLUSION

The Board finds that the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the October 25, 2012 decision of the Office of Workers' Compensation Programs be set aside and the case is remanded to OWCP for further action consistent with this decision of the Board.[16]

Issued: June 2, 2014
Washington, DC

Patricia Howard Fitzgerald, Acting Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[16] Richard J. Daschbach participated in the preparation of the decision but was no longer a member of the Board after May 16, 2014.