United States Department of Labor
Employees' Compensation Appeals Board

J.G., Appellant	)	
	)	
and	)	**Docket No. 13-1466**
	)	**Issued: March 10, 2014**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, Kansas City, KS, 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
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 6, 2013 appellant filed a timely appeal from a December 11, 2012 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 to consider the merits of the case.

ISSUE

The issue is whether appellant has more than 55 percent permanent impairment of his lower extremities bilaterally, 45 percent impairment of the right upper extremity and 53 percent impairment of the left upper extremity for which he has received schedule awards.

On appeal, appellant again argued that his current schedule award improperly excluded impairment ratings for calf atrophy and limb length discrepancy and should have been calculated under the fifth edition of the American Medical Association, *Guides to the Evaluation of*

[1] 5 U.S.C. § 8101 *et seq.*

Permanent Impairment (A.M.A., *Guides*). He further argued that the statement of accepted facts dated May 26, 2006 and December 11, 2007 were insufficient and that any reports which relied on these reports must be excluded due to the "fruit of the poisonous tree doctrine." Appellant also alleged that OWCP and its selected physicians demonstrated bias against him.

FACTUAL HISTORY

This case has previously been before the Board.[2] On August 16, 1989 appellant strained his back lifting heavy boxes at work and his claim was accepted for paraspinal muscle strain and minimal disc herniation at L5-S1, depression and dysthymic disorder. Due to these injuries, in 1992, he received a schedule award for six percent impairment of each of his lower extremities on December 3, 1992. Appellant filed a second claim on March 13, 1995 due to an automobile accident which resulted in accepted conditions of subluxations of the cervical, lumbar and thoracic vertebra at L1, L3, T4 and T11 intervertebral disc disorder, keloid scar, dysfunction of the penis, abnormal involuntary movement, cervical spondylosis with myelopathy, recurrent major depression and dysthymic disorder. He underwent a magnetic resonance imaging (MRI) scan of the cervical spine on March 19, 1998 which demonstrated degenerative arthritic changes at C5-6 with a large spur and calcified disc fragment. On June 8, 1999 a nerve conduction velocity (NCV) test demonstrated slight to moderate L4, 5 and S1 radiculopathy on the right. Nerve conduction studies on December 7, 1999 demonstrated slight to moderate left C6 radiculopathy. In a September 27, 2000 MRI scan, appellant was determined to have a disc herniation at L5-S1 and disc degeneration at L5-S2.

On May 8, 2001 appellant underwent a posterior cervical partial laminectomy at C5 and C6 with foraminotomy at C5-6 and neurolysis of C6 nerve root. Due to these injuries on August 25, 2000 he received schedule awards for 49 percent impairment of the left upper extremity and 8 percent impairment of the right upper extremity. On September 27, 2001 OWCP granted appellant an additional schedule award for one percent impairment of his right lower extremity. By decision dated August 14, 2002,[3] the Board remanded his claim due to an unresolved conflict of medical opinion evidence between Dr. Robert Moore, a Board-certified neurologist, and Dr. Sanjay J. Chauhan, a Board-certified neurologist, regarding whether the 1995 accident resulted in any permanent impairment.

By decision dated September 3, 2003, OWCP denied appellant's claim for an additional schedule award based on the impartial medical examiner's report. The Branch of Hearings and Review vacated this decision on August 4, 2004 and remanded the case for further review.

In a decision dated March 24, 2006, OWCP granted appellant a schedule award for 17 percent partial loss of use of the penis. In a separate award of the same date, appellant received 33 percent additional impairment of his right lower extremity and an additional 13 percent

[2] On December 27, 1993 the Board dismissed the appeal docketed as No. 94-532 in accordance with appellant's request. *Order Dismissing Appeal,* Docket No. 94-532 (issued December 27, 1993). On January 7, 1997 the Board remanded appellant's appeal of a July 20, 1995 nonmerit decision for OWCP to review the merits of his schedule award claim. *Order Remanding Case,* Docket No. 96-195 (issued January 7, 1997).

[3] Docket No. 02-164 (issued August 14, 2002).

impairment to his left lower extremity resulting in a total of 40 percent impairment of the right lower extremity and 19 percent impairment of the left lower extremity.

A request for reconsideration was filed and by decision dated June 21, 2006 the reconsideration request was denied without reviewing the merits.

By decision dated August 15, 2006, OWCP denied appellant's claim for an additional schedule award due to his accepted bilateral upper extremities.

OWCP issued a decision on November 14, 2006 denying appellant's request for an additional lower extremity schedule award.

By decision dated March 20, 2007, OWCP found that appellant had not established an additional permanent impairment to a scheduled member entitling him to a schedule award.

By decision dated May 28, 2008, OWCP amended appellant's November 14, 2006 and March 20, 2007 schedule award decisions finding that he had 55 percent impairment of each of his lower extremities.

In a decision dated May 29, 2008 and finalized June 18, 2008, OWCP granted appellant additional schedule awards for 37 percent impairment of the right upper extremity and 4 percent impairment of the left upper extremity resulting in total schedule awards of 45 and 53 percent, respectively.

Appellant requested reconsideration of the May 28, 2008 lower extremity schedule award decision dated July 17 and October 19, 2008, stating that OWCP had not resolved the issues of his T1 nerve root impairment based on an electromyogram (EMG), his right lower extremity impairment due to gait derangement and impairment of his lungs.

On December 18, 2008 OWCP issued a decision denying modification of the May 28, 2008 decision.

On October 22, 2009 appellant requested reconsideration of the December 18, 2008 decision. He argued that OWCP failed to consider Dr. Chauhan's report regarding gait derangement and pelvic torsion. Appellant requested that his claim be evaluated in accordance with the fifth edition of the A.M.A., *Guides*. He stated that there were "substantial errors and abuses" in OWCP's prior decisions. Appellant also requested reconsideration of his cervical claim requesting maximum T1 and C8 impairments for sensory and motor loss to both arms.

OWCP referred appellant's claim to the medical adviser for evaluation. In a decision dated December 9, 2009, it denied modification of the December 18, 2008 decision. OWCP relied on the medical adviser's report finding no additional permanent impairment.

Appellant requested reconsideration on July 5, 2010 of the December 9, 2009 decision denying modification of his schedule awards for upper and lower extremities. He alleged that he had neurological impairment of T1 and C8 impacting in his upper extremities and 15 percent impairment for use of a cane for distance walking in the right lower extremity. Appellant argued that Dr. Chauhan was entitled to greater weight than the medical adviser. He argued that the

fifth edition of the A.M.A., *Guides* was appropriate as the appeal involved recalculating several prior awards based on OWCP's error.

The medical adviser reviewed the record on November 8, 2010. He noted that appellant's electrodiagnostic studies demonstrated findings consistent with right C8 and T1 radiculopathy, but found that there was no objective evidence on any physical examination supporting that he had either impaired sensation or weakness in the right C8-T1 distribution. In regard to appellant's right leg length discrepancy, the medical adviser found that OWCP had not accepted a pelvic injury as a result of his employment incidents. The medical adviser further stated that appellant would not have developed a leg length discrepancy as a result of his accepted work injury. He concluded that the sixth edition of the A.M.A., *Guides* did not provide any impairment for the use of a cane as this would be duplicative of impairment due to loss of sensation or motor weakness. The medical adviser opined that there was no increase in appellant's impairment to the upper or lower extremities and thus the impairment ratings should remain the same.

By decision dated November 19, 2010, OWCP denied modification of the December 9, 2009 decision based on the medical adviser's report.

On March 22, 2011 Dr. Chauhan completed EMG studies of both upper extremities. He found moderate C5-8 and T1 cervical radiculopathy bilaterally. Dr. Chauhan completed a report on March 25, 2011 addressing appellant's permanent impairment. He diagnosed hyperreflexia of the right lower extremity associated with cervical myelopathy due to spinal cord compression at C5-7. Dr. Chauhan opined that this condition explained appellant's bowel, bladder and sexual dysfunction. He also suggested that appellant's tinnitus was related to his cervical myelopathy. Dr. Chauhan reviewed appellant's electrodiagnostic studies and opined that his cervical radiculopathy had worsened. He provided an impairment rating based on the fifth edition of the A.M.A., *Guides* and noted that this was at appellant's request. Dr. Chauhan stated that, under the sixth edition of the A.M.A., *Guides*, he would rate appellant in the severe disability category. Under the fifth edition of the A.M.A., *Guides*, he found that appellant had 66 percent motor deficit and 28 percent sensory deficit of the left upper extremity for a total of 76 percent impairment of the left upper extremity. For the right upper extremity, Dr. Chauhan found 51 percent motor deficit and 28 percent sensory deficit or 65 percent impairment of that upper extremity. In regard to appellant's lower extremities, he found gait derangement on the right with abnormal bilateral reflex in both lower extremities more problematic on the right. Dr. Chauhan also noted that appellant required a cane. He opined that appellant had an additional 49 percent impairment of the right lower extremity due to these conditions. Dr. Chauhan argued that appellant was entitled to additional compensation for gait derangement on March 24, 2006. He provided an EMG and NCV study dated March 22, 2011.

On June 6, 2011 appellant requested reconsideration of the November 19, 2010 decision denying modification of his schedule award entitlement. In a letter dated August 17, 2011, he stated that the 2006 and 2008 schedule award decisions were improperly calculated under the fifth edition of the A.M.A., *Guides*. Appellant submitted additional legal arguments in support of his June 6, 2011 request for reconsideration on August 19, 2011. He alleged that he was not requesting an increase in a prior schedule award, but that his prior schedule award was not calculated correctly under the fifth edition of the A.M.A., *Guides*. Appellant submitted a

corrected version of his reconsideration request on June 8, 2011. He submitted a supplemental request for reconsideration on August 19, 2011. Appellant argued that he was entitled to schedule awards for gait derangement and calf atrophy, which were not included in the 2006 and 2008 schedule awards.

On August 2, 2011 OWCP referred appellant's claim to Dr. Christopher R. Brigham, a physician Board-certified in occupational medicine and an OWCP medical adviser, who completed a report dated September 6, 2011 reviewing the findings in Dr. Chauhan's March 25, 2011 report and applying the sixth edition of the A.M.A., *Guides*. Dr. Brigham provided a summation of Dr. Chauhan's impairments ratings under the fifth edition of the A.M.A., *Guides* and noted that appellant's claims were largely subjective in nature including his incontinence and penile impairments. He stated that other medical evaluations were not available but that Dr. Chauhan noted a wide range of findings by those physicians. Dr. Brigham recommended additional examination and impairment by a Board-certified neurologist.

Dr. Brigham applied the sixth edition of the A.M.A., *Guides* to Dr. Chauhan's motor and sensory findings in the upper extremities and noted that radiology reports were not available. He noted that Dr. Chauhan's reports lacked specificity as to the muscles tested and that there were no reports of atrophy or other clinical findings to be reasonably expected with muscle grading of 3/5. Dr. Brigham also found that Dr. Chauhan's findings regarding sensation were without explanation of how the sensation loss was determined and with no indication of the extensive involvement as would reasonably be expected from cervical MRI scan to correlate with the functional findings reported. He determined that appellant had mild C5 motor abnormality with grade 2 clinical studies modifier and grade 4 functional history modifier which differed by 2 values and must be excluded from the final net adjustment as was physical examination. Dr. Brigham reached six percent impairment of the upper extremities due to C5 motor abnormality. He also found mild C5-6 sensory deficit with a default rating of 1. Dr. Brigham found a clinical studies modifier 2 and excluded physical examination and functional history to reach one percent upper extremity impairment for the C5 sensory abnormality. He found a similar impairment for C6 bilaterally, reaching six percent for motor deficit and one percent for sensory deficit. Dr. Brigham reached 14 percent impairment for each of the upper extremities.

In regard to appellant's lower extremities, Dr. Brigham noted the distinction between chiropractic and medical subluxations and found that there was no evidence of segmental instability of the lumbar spine. He did find evidence of radiculopathy L5-S1. Dr. Brigham stated, "There is no evidence, other than a recent report of hyperreflexia that would appear to support that the lower extremity findings are a result of cervical cord compression." He opined that there was little by way of objective testing to relate the lower extremity problems to cord compression in the neck. Dr. Brigham rated appellant's right lower extremity based on S1 motor abnormality and excluded the physical examination modifier as it was used to determine the class. He found that clinical studies including an EMG and MRI scan revealed a mild S1 radiculopathy for grade 1. Dr. Brigham determined functional history modifier 2 based on appellant's significant Trendelenberg's sign as supported by his functional leg length difference and used a cane due to chronic low back pain. He found four percent lower extremity rating for S1 motor involvement. In regard to S1 sensory abnormality, Dr. Brigham stated, "Again physical examination is excluded as it is used to determine the class. Clinical studies support a mild S1 involvement. Functional history was used with motor assessment so is excluded to

avoid duplication. This offers a net adjustment of zero for a final [one] percent lower extremity rating for S1 sensory deficit." He found no sensory or motor deficits in the left lower extremity resulting in no ratable impairment to that member.

Dr. Brigham noted that Dr. Chauhan assigned an additional 49 percent lower extremity impairment for gait abnormality. He opined that gait was only to be used in cases in which no other methodology applied. Dr. Brigham found that the appropriate method for rating the lower extremities was through spinal nerve root dysfunction rather than gait. He noted the dearth of description of appellant's "spasticity." Finally, Dr. Brigham noted appellant's leg length discrepancy of two centimeters, but found no indication that he suffered from an anatomically short leg that would support consideration for additional permanent impairment. He concluded, "It is more probable that the aforementioned leg discrepancy, if confirmed, is secondary to antalgia and postural abnormalities secondary to his pain." Dr. Brigham found that appellant had 14 percent impairment of each upper extremity and 5 percent impairment of his right lower extremity. He noted that appellant had previously received schedule awards exceeding these amounts and was not entitled to additional compensation for these members.

On September 21, 2011 appellant completed a second reconsideration request addendum and alleged due process errors in the development of his schedule award claim. In a letter dated September 23, 2010, he added additional legal argument in support of his reconsideration request, that the May 29, 2008 schedule award did not include calf atrophy or gait disorder. On September 27, 2011 appellant submitted a reconsideration request addendum. He requested that OWCP ensure that his entitlements previously granted for calf atrophy and gait were restored and alleged that these impairments were subjected to improper rescission under the fifth edition of the A.M.A., *Guides*. Appellant alleged that Dr. Brigham was biased and lacked understanding of the A.M.A., *Guides* and that Dr. Chauhan was entitled to the weight of the medical evidence.

In a letter dated October 4, 2011, appellant submitted additional arguments in support of his request for reconsideration. He alleged that an improper rescission occurred when his conditions of calf atrophy, limb length and gait disorders were not included in his 2008 schedule award.

OWCP requested a supplemental report on October 19, 2011 from Dr. Brigham noting that it was providing all the medical reports including March 19, 1998 and November 16, 2006 MRI scans.

In a report dated November 2, 2011, Dr. Brigham submitted a supplemental report noting that Dr. Chauhan had applied the fifth edition rather than the sixth edition, that he would apply the sixth edition to these findings and that he would determine if any additional impairment was appropriate. He stated that he had reviewed all the medical records and determined that there was no additional impairment to the lower extremities as a result of the accepted spinal conditions. Dr. Brigham stated that, as other physicians were unable to substantiate Dr. Chauhan's sensory or motor deficits in the extremities, Dr. Chauhan's findings were deemed unreliable for rating purposes. He reviewed reports from Dr. Jordan and Dr. Sophon, which he found listed normal sensory and motor findings. Dr. Brigham reviewed the diagnostic testing and noted that Dr. Chauhan's findings were significant for bilateral multilevel radiculopathy, but showed no evidence of lumbar nerve root compromise. He concluded that there was no ratable

impairment to the upper or lower extremities as a result of the spinal conditions. Dr. Brigham reaffirmed that Dr. Chauhan's findings were deemed unreliable for rating purposes.

Dr. Chauhan completed a report on December 21, 2011. He conducted NCV studies on December 20, 2011 which demonstrated moderate chronic L3-5 and S1-2 lumbar radiculopathy bilaterally. The study was negative for polyneuropathy.

OWCP requested a review of the medical record by the district medical adviser on February 8, 2012.

In a report dated March 6, 2012, Dr. Chauhan provided appellant's history of injury including appellant's employment injuries on March 3, 1989 and March 3, 1995. He listed appellant's subjective complaints involving his back, gait, neck, tinnitus, incontinence, breathing gastrointestinal issues, depression and insomnia. Dr. Chauhan noted that appellant was diagnosed with diverticulitis in 1999. He related appellant's surgeries including partial laminectomy of C5, vertebrectomy of C4, foramintomy of C5-6, neurolysis of C6 nerve on May 8, 2001. Dr. Chauhan provided findings on neurological examination including diminished sensation bilaterally at C5-7 and T1 dermatomes. He also found sensation reduced at L3-5 and S1 bilaterally. Dr. Chauhan stated that appellant's gait was antalgic due to neck and low back conditions causing motor and sensory deficits in both arms and legs as well as hyperreflexia in the right lower extremity. He reported loss of motor strength in all four limbs with slight spasticity in the right lower extremity. Dr. Chauhan found moderate tenderness and spasm of the bilateral paracervical muscles worse on the right than the left. He noted appellant's accepted conditions of chronic airway obstruction,[4] major depression, dysthymic disorder, morbid obesity, hypertension, obstructive sleep apnea, thoracic or lumbosacral neuritis or radiculitis, displacement of lumbar intervertebral disc dislocation lumbar vertebra, dislocation of C5, dislocation of thoracic vertebra, cervical disc disorder with myelopathy, cervical spondylosis with myelopathy, abnormality of gait, keloid scar and disorders of the penis and bladder. Dr. Chauhan added additional diagnoses of chronic allergic rhinitis and tinnitus as consequences of appellant's pulmonary claim, diverticulitis aggravated due to daily anti-inflammatory use as a consequence of his lumbar claim and dysphagia as a complication of his 2001 cervical surgery. He recommended additional therapy and cervical surgery.

Dr. Chauhan addressed Dr. Brigham's report and noted that he personally conducted all electrodiagnostic studies of appellant. He further asserted that appellant did not have diabetes or other abnormalities found through blood studies. Dr. Chauhan stated that monofilament testing was not required during a neurological sensory examination. He provided an impairment rating in accordance with the fifth edition of the A.M.A., *Guides* and opined that appellant demonstrated hyperreflexia as well as ankle clonus due to his chronic cervical myelopathy. Dr. Chauhan also attributed appellant's symptomatology of the urinary and reproductive system to cervical myelopathy and stated that these conditions should be rated under the A.M.A., *Guides*.

In a report dated March 25, 2011, Dr. Chauhan opined that appellant had 28 percent impairment of the right upper extremity due to sensory deficit and 51 percent impairment of the

[4] Claim No. xxxxxx314.

right upper extremity due to motor deficit or 65 percent impairment of the right upper extremity under the A.M.A., *Guides*. He further found that appellant had 28 percent impairment of the left upper extremity due to sensory deficit and 66 percent impairment due to motor deficits for 76 percent impairment of the left upper extremity under the fifth edition of the A.M.A., *Guides*.

Dr. Chauhan evaluated appellant's lower extremities and found on the right spastic gait disorder with abnormal bilateral reflex in both lower extremities. He stated that frequent jerking in the right leg was a typical neurologic symptom of intervertebral disc disorder with myelopathy at C5-7. Dr. Chauhan applied the fifth edition of the A.M.A., *Guides* whole person impairment and converted to right lower extremity impairment of 49 percent. He stated that Dr. M. Michael Mahdad attributed appellant's gait derangement to cervical myelopathy on May 22, 2003.

In a letter dated April 19, 2012, appellant submitted reconsideration argument. He described his right lower extremity gait disorder resulting from the March 3, 1995 cervical cord injury and prior lifting injury. Appellant cited to the fifth edition of the A.M.A., *Guides* as entitling him to an impairment rating due to cane use in 2003. He argued that FECA Bulletin 09-03 provided that recalculations resulting from reconsiderations did not require recalculation under the sixth edition of the A.M.A., *Guides* as OWCP had discretionary authority. Appellant stated that OWCP could not justify rescission of the award six percent for calf atrophy and limb length discrepancy. He stated that OWCP could apply either the fifth or sixth edition, but that the percentages must remain the same to make him whole.

By decision dated June 6, 2012, OWCP reviewed the merits of appellant's claims noting his argument that his schedule awards should be developed under the fifth edition of the A.M.A., *Guides* and should include 6 percent for right lower leg atrophy and limb length discrepancy as well as 49 percent for right lower leg impairment due to gait derangement as a result of cervical myelopathy and 43 percent impairment to the upper extremities bilaterally due to C8 and T1 nerve root impairments. It found that the sixth edition of the A.M.A., *Guides* was appropriate for evaluating appellant's impairment for schedule award purposes. OWCP further found that as Dr. Chauhan utilized the fifth edition of the A.M.A., *Guides* his impairment rating was not appropriate. It had referred his report to the medical adviser who found deficiencies under the sixth edition of the A.M.A., *Guides*. OWCP determined that appellant had not established grounds to modify its prior decision.

On August 23, 2012 appellant requested reconsideration of the June 6, 2012 decision. In support of his reconsideration request, he referenced a report dated March 6, 2012 from Dr. Chauhan and alleged error in OWCP's decision. Appellant requested schedule award compensation for right lower extremity impairment due to cervical myelopathy based on medical reports from Dr. Moore dated 2001, Dr. Mahdad dated 2003 and Dr. Lama dated 2004. He alleged that there were inaccurate statements of accepted facts that must be excluded and alleged that compensation for calf atrophy and limb length discrepancy was improperly rejected by the medical adviser. Appellant argued that OWCP was not required to apply the sixth edition of the A.M.A., *Guides* in the June 6, 2012 decision.

Dr. Chauhan completed reports on August 28, September 11 and 20, 2012. On August 28, 2012 his report repeated the history, findings and diagnoses of his March 6, 2012 report. In his September 11, 2012 report, Dr. Chauhan repeated appellant's history of injury and

reported a two-centimeter limb length discrepancy on the right with right-sided gait derangement due to pelvic torsion from the automobile accident.

In a letter dated September 19, 2012, appellant argued that he was entitled to 51 percent impairment of the right lower extremity due to his cervical condition under the fifth edition of the A.M.A., *Guides*. In a letter dated September 28, 2012, he requested that his claim be expanded to include diverticulitis as a result of pain medication to treat his accepted low back condition.

In a decision dated December 11, 2012, OWCP denied modification of its prior decisions. It found that any new decision on appellant's entitlement to a schedule award must be based on the sixth edition of the A.M.A., *Guides*. OWCP noted that he had not alleged a worsening of his employment-related conditions, but instead argued that there were errors in the previous schedule award decisions made under the fifth edition, which require revision under the fifth edition of the A.M.A., *Guides*.

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 for loss of loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the 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. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[7]

In *Harry D. Butler*,[8] the Board noted that Congress delegated authority to the Director of OWCP regarding the specific methods by which permanent impairment is to be rated. Pursuant to this authority, the Director adopted the A.M.A., *Guides* as a uniform standard applicable to all claimants and the Board has concurred in the adoption.[9] On March 15, 2009 the Director exercised authority to advise that as of May 1, 2009 all schedule award decisions of OWCP should reflect use of the sixth edition of the A.M.A., *Guides*.[10] The applicable date of the sixth

[5] 5 U.S.C. §§ 8101-8193, 8107.

[6] 20 C.F.R. § 10.404.

[7] For new decisions issued after May 1, 2009, OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[8] 43 ECAB 859 (1992).

[9] *Id.* at 866.

[10] FECA Bulletin No. 09-03 (March 15, 2009). FECA Bulletin was incorporated in *supra* note 7 at Chapter 2.808.6(a) (January 2010).

edition is as of the schedule award decision reached. It is not determined by either the date of maximum medical improvement or when the claim for such award was filed.

If a claimant who has received a schedule award calculated under a previous edition of the A.M.A., *Guides* is entitled to additional benefits, the increased award will be calculated according to the sixth edition. Should the subsequent calculation result in a percentage of impairment lower than the original award (as sometimes occurs), a finding should be made that the claimant has no more than the percentage of impairment originally awarded, that the evidence does not establish an increased impairment and that OWCP has no basis for declaring an overpayment. Similarly, awards made prior to May 1, 2009 (the effective date for use of the sixth edition) should not be reconsidered merely on the basis that the A.M.A., *Guides* have changed. All permanent partial impairment calculations made on or after May 1, 2009 must be based on the sixth edition.[11]

No schedule award is payable for a member, function or organ of the body that is not specified in FECA or in the implementing regulations.[12] The list of scheduled members includes the eye, arm, hand, fingers, leg, foot and toes.[13] Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.[14] By authority granted under FECA, the Secretary of Labor expanded the list of scheduled members to include the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina and skin.[15]

Neither, FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[16] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[17] The sixth edition of the A.M.A., *Guides* (2009) does not provide a specific methodology for rating spinal nerve extremity impairment.[18] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the FECA procedure manual.[19] Specifically, it will

[11] *Supra* note 7, *Schedule Awards*, Chapter 2.808.7(b)(4) (January 2010).

[12] *C.B.*, Docket No. 13-1516 (issued December 6, 2013); *Anna V. Burke*, 57 ECAB 521 (2006).

[13] 5 U.S.C. § 8107(c).

[14] *Id.*

[15] *Id.*; 20 C.F.R. § 10.404(b).

[16] *Id.*; *see Jay K Tomokiyo*, 51 ECAB 361 (2000).

[17] *Supra* note 7, *Schedule Awards*, Chapter 2.808.6a (January 2010).

[18] The methodology and applicable tables were published in the July/August 2009 edition of *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment* using the sixth edition.

[19] *Supra* note 7, Chapter 3.700 (January 2010).

address lower extremity impairments originating in the spine through Table 16-11 and upper extremity impairment originating in the spine through Table 15-14.[20]

ANALYSIS

Appellant has received several schedule awards from OWCP resulting in total impairment ratings of 55 percent impairment of his lower extremities bilaterally, 45 percent impairment of the right upper extremity and 53 percent impairment of the left upper extremity. These impairment ratings are based on his accepted spinal conditions of paraspinal muscle strain and minimal disc herniation at L5-S1 as well as subluxations of the cervical, lumbar and thoracic vertebra at L1, L3, T4 and T11, interverbral disc disorder and cervical spondylosis with myelopathy.

As noted above, for decisions after May 1, 2009, the sixth edition of the A.M.A., *Guides* are applicable. Appellant has made several repeated arguments that this edition of the A.M.A., *Guides* is not applicable to his claim. The Board finds that these arguments are without merit. The Board has adopted the application of FECA Bulletin No. 09-03[21] which clarifies that any recalculations of previous awards which result from reconsiderations decisions issued on or after May 1, 2009 should be based on the sixth edition of the A.M.A., *Guides*.[22] Appellant is attempting to increase the amount of his compensation by receiving an increased schedule award. He does not, therefore, fall within the exception of FECA Bulletin No. 09-03 allowing application of a previous edition of the A.M.A., *Guides*.[23]

Appellant submitted arguments regarding the weight of the medical evidence. He proposed discounting several of the physicians used by OWCP based on allegations of bias and allegations that certain of the statements of accepted facts relied upon are not correct. While the Board reviewed the extensive factual record including the reports mentioned by appellant, the Board is not persuaded of the relevance of his arguments. The legal status of his claim is that after May 1, 2009 he must establish by the weight of the medical evidence that he has more than 55 percent impairment of his lower extremities bilaterally, 45 percent impairment of the right upper extremity and 53 percent impairment of the left upper extremity under the sixth edition of the A.M.A., *Guides* if he wishes to receive additional compensation benefits for permanent impairment. As appellant has not submitted medical evidence complying with the sixth edition of the A.M.A., *Guides*, the remainder of his arguments are not relevant to his current claim.

The only medical evidence applying the sixth edition of the A.M.A., *Guides* to the findings in appellant's claim are the reports from Dr. Brigham dated September 6 and November 2, 2011. Dr. Brigham applied the appropriate provisions of the A.M.A., *Guides* for

[20] A.M.A., *Guides* 533, 425.

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

[22] *C.K.*, Docket No. 09-2371 (issued August 18, 2010).

[23] *Id.* The Bulletin provides that if the percentage of the award is affirmed but the case remanded for further development of some other issue, such as pay rate, then recalculation of the award under the sixth edition is not required.

spinal impairments and determined that appellant had mild C5 motor abnormality with grade 2 clinical studies modifier and reached six percent impairment of the upper extremities due to C5 motor abnormality. He also found mild C5-6 sensory deficit with a default rating of 1, clinical studies modifier 2 to reach one percent upper extremity impairment for the C5 sensory abnormality. Dr. Brigham found a similar impairment for C6 bilaterally, reaching six percent for motor deficit and one percent for sensory deficit. He reached 14 percent impairment for each of the upper extremities.

Dr. Brigham rated appellant's right lower extremity based on S1 motor abnormality and found that clinical studies including an EMG and MRI scan revealed a mild S1 radiculopathy for grade 1. He determined functional history modifier 2 and found four percent lower extremity rating for S1 motor involvement. In regard to S1 sensory abnormality, Dr. Brigham determined that clinical studies supported a mild S1 involvement and a net adjustment of zero for a final one percent lower extremity rating for S1 sensory deficit. He found no sensory or motor deficits in the left lower extremity resulting in no ratable impairment to that member. Dr. Brigham determined that appellant had 14 percent impairment of each upper extremity and 5 percent impairment of his right lower extremity. He noted that appellant had previously received schedule awards exceeding these amounts and was not entitled to additional compensation for these members.

Dr. Chauhan completed reports with greater impairment ratings based on the fifth edition of the A.M.A., *Guides*. He opined that appellant had 28 percent impairment of the right upper extremity due to sensory deficit and 51 percent impairment of the right upper extremity due to motor deficit or 65 percent impairment of the right upper extremity under the A.M.A., *Guides*. Dr. Chauhan also found that appellant had 28 percent impairment of the left upper extremity due to sensory deficit and 66 percent impairment due to motor deficits for 76 percent impairment of the left upper extremity under the fifth edition of the A.M.A., *Guides*. He evaluated appellant's lower extremities and found on the right spastic gait disorder with abnormal bilateral reflex in both lower extremities. Dr. Chauhan stated that frequent jerking in the right leg was a typical neurologic symptom of intervertebral disc disorder with myelopathy at C5-7. He applied the fifth edition of the A.M.A., *Guides* whole person impairment and converted to right lower extremity impairment of 49 percent.

Unlike Dr. Chauhan, Dr. Brigham referenced the appropriate provisions for rating spinal nerve extremity impairment under the sixth edition of the A.M.A., *Guides,* which have been incorporated in the FECA Procedure Manual. Dr. Brigham properly indicated that to evaluate the peripheral nerve impairments in appellant's upper and lower extremities resulting from spinal injuries, he was applying the standards contained in the procedure manual. He concluded that appellant had a 14 percent impairment of each upper extremity and 5 percent impairment of his right lower extremity and a 0 percent permanent impairment of his left leg. In reaching this conclusion, Dr. Brigham chose default values for peripheral spinal nerve impairments based on the findings of record. He modified these values based on the appropriate grade modifiers. Futhermore, in reaching these determinations, Dr. Brigham extensively discussed the medical findings of record.

The Board finds that Dr. Brigham's impairment rating is consistent with FECA and the A.M.A., *Guides* and thus, represents the weight of the medical evidence regarding the extent of

appellant's impairment. The record does not include any credible evidence demonstrating that appellant has greater than impairment ratings of 14 percent impairment of each upper extremity and 5 percent impairment of his right lower extremity under the sixth edition of the A.M.A., *Guides*.

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 55 percent impairment of his lower extremities bilaterally, 45 percent impairment of the right upper extremity and 53 percent impairment of the left upper extremity for which he has received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the December 11, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 10, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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