

FACTUAL HISTORY

OWCP accepted that on December 21, 1999 appellant, then a 48-year-old marketing and logistics specialist, sustained a lumbosacral sprain, herniated L5-S1 disc, lumbar radiculopathy, lumbosacral neuritis, lumbago and adhesive arachnoiditis when she slipped and fell on a wet floor. It later accepted a consequential cervical sprain. OWCP authorized a November 9, 2000 L5-S1 left-sided microdiscectomy. It later expanded the claim to accept major depressive disorder and adjustment reaction with anxiety and depression. Following intermittent absences, appellant stopped work on December 3, 2001 and did not return.² She received compensation on the periodic rolls.

Appellant remained under medical treatment for lumbar radiculitis through 2001. Dr. Barbara A. McQuinn, an attending Board-certified neurologist, treated appellant for discogenic low back pain through 2002.

In an October 31, 2002 report, Dr. Thomas R. Stephenson, an attending Board-certified physiatrist and pain management specialist, diagnosed significant sexual desensitization secondary to prescribed narcotics for lumbar pain caused by the accepted injuries. He prescribed Viagra. OWCP authorized the Viagra prescription. In a January 30, 2003 report, Dr. McQuinn diagnosed urinary retention secondary to prescribed Nortriptyline. On November 2, 2004 he noted continuing sexual dysfunction with loss of sensation. Beginning in 2005, Dr. McQuinn noted appellant's account of episodic urinary incontinence.

On August 25, 2010 Dr. Eubulus Kerr, an attending Board-certified orthopedic surgeon, performed left-sided microscopic decompressions at L4-5 and L5-S1, decompressing the L4-5 nerve root. OWCP authorized the procedure.³

In a June 1, 2011 report, Dr. Kerr noted that appellant reported fecal incontinence. He opined that, based on a June 1, 2011 magnetic resonance imaging (MRI) scan showing spinal stenosis and L4-5 spondylolisthesis, he did "not feel that her fecal incontinence [was] related at all to her lumbar spine pathology."

Appellant consulted several gastroenterologists. In an April 27, 2011 report, Dr. James C. Hogley, an attending Board-certified gastroenterologist, noted that appellant "experienced episodes of fecal incontinence since undergoing lumbar spine surgery and also ha[d] a history of urinary incontinence as well." He recommended anal manometry. Dr. Scott

² On April 10, 2002 OWCP obtained a second opinion from Dr. Daniel K. Lee, a Board-certified neurologist, who found appellant remained totally disabled for work due to the accepted injuries. On April 4, 2003 Dr. Arthur Lyons, a Board-certified neurosurgeon and second opinion physician, found appellant totally disabled for work due to the accepted injuries. OWCP then found a conflict of medical opinion between Dr. Lyons and appellant's attending physicians, and selected Dr. Desmond Erasmus, a Board-certified neurosurgeon, to resolve the conflict. Dr. Erasmus submitted an August 1, 2003 report finding that a lumbar fusion should be considered to address L4-5 disc degeneration caused by the accepted injuries.

³ On December 11, 2010 appellant claimed a schedule award. In support of her claim, she submitted a February 22, 2011 impairment rating from a Dr. Austin Gleason finding a 21 percent whole person impairment according to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). OWCP did not further develop the schedule award claim.

Brill, an attending Board-certified colorectal surgeon, found good rectal sphincter tone on November 22, 2011 examination and recommended deferral of further testing. In a December 22, 2011 report, Dr. Michael Stratton, an attending Board-certified gastroenterologist, diagnosed fecal incontinence and recommended pelvic floor exercises and a high fiber diet.

In an April 6, 2012 report, an OWCP medical adviser opined that appellant's fecal incontinence was related to the accepted lumbar injury and surgeries. On May 15, 2012 OWCP accepted fecal incontinence as work related.

On June 26, 2012 appellant claimed a schedule award for fecal incontinence in conjunction "with loss of use of uterus/cervix and vulva/vagina." In a July 5, 2012 letter, OWCP advised appellant of the type of evidence needed to establish her claim, including a report from her attending physician finding that she attained maximum medical improvement, a description of the claimed impairment and an impairment rating from her attending physician utilizing the sixth edition of the A.M.A., *Guides*. Appellant was afforded 30 days in which to submit such evidence.

In a September 11, 2012 report, Dr. Sanjeevi Tivakaran, an attending physician Board-certified in sleep medicine, diagnosed gastroenteritis superimposed on fecal incontinence.

In a September 25, 2012 report, Dr. Kerr noted appellant's continuing complaints of fecal incontinence of unknown etiology.

By decision dated November 1, 2012, OWCP denied appellant's schedule award claim on the grounds that the medical evidence submitted did not establish that appellant had attained maximum medical improvement, did not fully describe the claimed impairments or provide an impairment rating. It further found that the rectum was not a scheduled member.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ 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.⁶

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability

⁴ 5 U.S.C. § 8107.

⁵ 20 C.F.R. § 10.404.

⁶ *Id.*; *Jacqueline S. Harris*, 54 ECAB 139 (2002).

and Health (ICF).⁷ Under the sixth edition, the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).⁸ The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

It is the claimant's burden to establish that he or she has sustained a permanent impairment of the scheduled member or function as a result of any employment injury.⁹ OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of maximum medical improvement), describes the impairment in sufficient detail so that it can be visualized on review and computes the percentage of impairment in accordance with the A.M.A., *Guides*.¹⁰

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.¹¹ Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,¹² no claimant is entitled to such an award.¹³ However, in 1966, amendments to FECA modified the schedule award provision 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. As the schedule award provision of FECA includes the uterus/cervix and vulva/vagina,¹⁴ a claimant may be entitled to a schedule award for permanent impairment for originating in those organs or if the cause of the impairment originated in the spine.¹⁵ However, there is no provision under FECA or its implementing regulations for the colon or rectum.¹⁶

ANALYSIS

OWCP accepted that appellant sustained a lumbosacral sprain, herniated L5-S1 disc, lumbosacral neuritis, lumbar radiculopathy, lumbago, adhesive arachnoiditis, fecal incontinence, major depressive disorder and an adjustment reaction with anxiety and depression.

⁷ A.M.A., *Guides* 3 (6th ed., 2008) Section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

⁸ A.M.A., *Guides* 494-531 (6th ed., 2008).

⁹ *Tammy L. Meehan*, 53 ECAB 229 (2001).

¹⁰ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(b) (August 2002).

¹¹ *Henry B. Floyd, III*, 52 ECAB 220 (2001).

¹² FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

¹³ *Thomas Martinez*, 54 ECAB 623 (2003).

¹⁴ 5 U.S.C. § 8107(c)(22); 20 C.F.R. § 10.404.

¹⁵ *C.R.*, Docket No. 09-2301 (issued August 13, 2010).

¹⁶ *D.J.*, Docket No. 11-1359 (issued February 24, 2012).

On June 26, 2012 appellant claimed a schedule award for fecal incontinence in conjunction with loss of use of the uterus/cervix and vulva/vagina. Attending Board-certified gastroenterologists, Dr. Hobley and Dr. Stratton, and Dr. Brill, an attending Board-certified colorectal surgeon, diagnosed fecal incontinence in 2011. OWCP accepted fecal incontinence as work related. However, there is no provision under FECA or its implementing regulations for impairment to the colon or rectum.¹⁷ The Secretary did not determine, pursuant to the discretionary authority granted in section 8107(c)(22) of FECA, that a gastrointestinal impairment constitutes an important external or internal organ or function of the body.¹⁸ FECA does not provide for OWCP to add organs or functions to the compensation schedule on a case-by-case basis and the Board does not have the power to enlarge the provisions of either statute or regulations.¹⁹ Therefore, appellant is not entitled to a schedule award for fecal incontinence.

Appellant also submitted reports regarding sexual dysfunction. On October 1, 2002 Dr. Stephenson, an attending Board-certified psychiatrist, noted sexual desensitization due to prescribed narcotics. OWCP authorized Viagra but did not accept sexual desensitization as work related. Dr. McQuinn, an attending Board-certified neurologist, prescribed Viagra on November 2, 2004 for sexual desensitization. However, neither physician opined that appellant had sustained a permanent impairment of the cervix, uterus, vulva or vagina due to the accepted lumbar injuries or treatment for those injuries. Their opinions are therefore insufficient to establish appellant's entitlement to a schedule award.²⁰

OWCP advised appellant by July 5, 2012 letter to submit a report from her attending physician establishing that she had attained maximum medical improvement, describing any permanent impairment, and rating such impairment according to the sixth edition of the A.M.A., *Guides*. However, appellant did not submit such evidence. Therefore, OWCP properly denied her schedule award claim.

Appellant may request a 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 not established that she sustained a ratable impairment of the uterus, cervix, vulva, vagina and rectum due to an accepted lumbar injury and surgeries.

¹⁷ *D.J.*, *supra* note 16.

¹⁸ *K.F.*, Docket No. 10-2160 (issued May 11, 2011).

¹⁹ *Janet C. Anderson*, 54 ECAB 394 (2003).

²⁰ *Tammy L. Meehan*, *supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 1, 2012 is affirmed.

Issued: April 22, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board