

He was struck from behind and thrown from his postal vehicle. Appellant's accepted conditions include aggravation of lumbar degenerative disc disease and aggravation of lumbar spinal stenosis.³ OWCP also authorized a January 10, 2001 laminectomy at L4-5. When the case was previously on appeal, appellant had filed a claim for lower extremity permanent impairment which OWCP denied. The April 12, 2010 schedule award decision was based on the March 25, 2010 opinion to Dr. Edward R. Mulcahy, a Board-certified orthopedic surgeon and OWCP referral physician.

In setting aside OWCP's April 12, 2010 decision, the Board identified various deficiencies in Dr. Mulcahy's report. The Board explained that, once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case. Because of deficiencies in Dr. Mulcahy's second opinion evaluation, the Board remanded the case for further development. Additionally, the Board identified the appropriate methodology for rating spinal nerve extremity impairment. The September 21, 2011 decision is incorporated herein by reference.

At OWCP's request, Dr. Mulcahy reexamined appellant on January 12, 2012. He diagnosed preexisting lumbar degenerative disc disease (DDD) and spinal stenosis, which were permanently aggravated by the September 13, 1999 work-related MVA.⁴ Dr. Mulcahy explained that appellant continued to suffer low back pain and right leg radiculopathy secondary to lumbar spinal stenosis, DDD and surgery with postoperative scarring. On physical examination, appellant exhibited significant limitation in lumbar range of motion and positive straight leg raising test on the right side. Dr. Mulcahy also noted that appellant ambulated with an antalgic gait favoring the right leg. Appellant used a cane in his left hand. Dr. Mulcahy stated that appellant's symptoms had been present for many years and were not expected to resolve. Based on his examination and review of the record, he found 20 percent impairment of the right lower extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (2008).⁵

In reports dated February 15 and April 9, 2012, the district medical adviser (DMA) found three percent bilateral lower extremity spinal nerve impairment based on a moderate sensory deficit at L5.⁶ It explained that Dr. Mulcahy applied an incorrect methodology for rating appellant's lumbar-related lower extremity impairment.

³ Appellant has additional accepted conditions involving both the upper and lower extremities. He also received a schedule award for impairment of the left upper extremity. While this information is not germane to the current issue on appeal, a more detailed account of all of appellant's accepted conditions and OWCP-approved surgery is set forth in the Board's previous decision dated September 21, 2011.

⁴ All of appellant's other employment-related conditions had reportedly resolved.

⁵ Dr. Mulcahy referenced Chapter 15, The Lower Extremities, A.M.A., *Guides* 493 (6th ed. 2008). However, he did not identify which Figure(s) and/or Table(s) he relied on in finding 20 percent right lower extremity impairment.

⁶ Appellant reached maximum medical improvement on March 27, 2007.

By decision dated December 14, 2012, OWCP granted a schedule award for three percent impairment of both the left and right lower extremity. The award covered a period of 17.28 weeks from March 27 to July 25, 2007.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.⁷ FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁸ Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).⁹

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.¹⁰ The list of scheduled members includes the eye, arm, hand, fingers, leg, foot and toes.¹¹ Additionally, FECA specifically provides for compensation for loss of hearing and loss of vision.¹² 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.¹³

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.¹⁴ However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.¹⁵ The sixth edition of the A.M.A., *Guides* (2008) provides a specific methodology for rating spinal nerve extremity impairment.¹⁶ It was designed for situations where a particular

⁷ For a total or 100 percent loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

⁸ 20 C.F.R. § 10.404 (2012).

⁹ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

¹⁰ *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

¹¹ 5 U.S.C. § 8107(c).

¹² *Id.*

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

¹⁴ 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a); see *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

¹⁵ Federal (FECA) Procedure Manual, Part 2 -- *supra* note 9 at Chapter 2.808.6a(3).

¹⁶ 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."

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 FECA procedure manual.¹⁷

ANALYSIS

Pursuant to the Board's September 21, 2011 instructions, OWCP obtained additional medical evidence regarding the cause and extent of any lower extremity impairment. Dr. Mulcahy reexamined appellant on January 12, 2012 and diagnosed lumbar DDD and spinal stenosis. Both conditions preexisted appellant's accepted employment injury, but according to Dr. Mulcahy the September 13, 1999 work-related MVA permanently aggravated appellant's lumbar DDD and spinal stenosis. As a result, appellant continued to suffer low back pain and right leg radiculopathy.¹⁸ The noted radiculopathy stemmed from the L5 nerve root. Dr. Mulcahy further found that appellant had 20 percent impairment of the right lower extremity (RLE) pursuant to the A.M.A., *Guides* (6th ed. 2008).

Dr. Mulcahy's January 12, 2012 report established that appellant's current lumbar and lower extremity complaints are causally related to his September 13, 1999 employment injury. However, Dr. Mulcahy's 20 percent RLE impairment rating is inconsistent with FECA-approved methodology for rating spinal nerve extremity impairment.¹⁹ The DMA instead found three percent bilateral lower extremity spinal nerve impairment based on a moderate sensory deficit at L5. Unlike Dr. Mulcahy, the DMA referenced the appropriate tables for rating spinal nerve extremity impairment which have been incorporated in FECA procedure manual.²⁰

The Board finds that the DMA's impairment rating is consistent with FECA and the A.M.A., *Guides* (6th ed. 2008) and thus, represents the weight of the medical evidence regarding the extent of appellant's bilateral lower extremity impairment. The record does not include any credible evidence demonstrating that appellant has greater than three percent bilateral lower extremity impairment.

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

Appellant has not established that he has greater than three percent bilateral lower extremity impairment.

¹⁷ See Federal (FECA) Procedure Manual, Part 3 -- *supra* note 9 at Chapter 3.700, Exhibit 4.

¹⁸ All other injury-related conditions had reportedly resolved.

¹⁹ See *supra* note 17.

²⁰ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 6, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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