

FACTUAL HISTORY

This case was previously before the Board.² Appellant, a 59-year-old carpenter, injured his low back and tailbone when he slipped and fell at work on September 13, 1999. OWCP accepted his claim for lumbar sprain and coccyx disorder. On October 3, 2002 appellant filed a claim (Form CA-7) for a schedule award. The last time the case was before the Board, OWCP had denied his claim for a schedule award based on the September 23, 2010 findings of Dr. Ian Blair Fries, a Board-certified orthopedic surgeon and impartial medical examiner (IME).³ Dr. Fries determined that appellant did not have any permanent lower extremity impairment due to his accepted conditions.⁴ He explained that there were no physical, imaging, or electrodiagnostic findings to support lower extremity impairment. On November 8, 2010 OWCP issued a decision denying appellant's claim for a schedule award, which the Branch of Hearings and Review affirmed on June 28, 2011. On appeal, the Board set aside the hearing representative's June 28, 2011 decision.

In its December 11, 2012 decision, the Board found that Dr. Fries' September 23, 2010 report was not well rationalized. Dr. Fries had based his opinion, in part, on ostensibly outdated clinical studies.⁵ Additionally, he did not adequately address appellant's June 24, 2008 lumbar magnetic resonance imaging (MRI) scan.⁶ Dr. Fries specifically commented on two earlier lumbar MRI scans from October 1999 and February 2001, as well as an August 2001 lumbar computerized tomography (CT) scan, but neglected to address the more recent June 2008 lumbar

² Docket No. 12-58 (issued December 11, 2012).

³ OWCP declared a conflict in medical opinion between appellant's physician, Dr. David Weiss, a Board-certified orthopedic surgeon, and Dr. Andrew A. Merola, OWCP's district medical adviser (DMA). In an April 22, 2010 report, Dr. Weiss found 39 percent left lower extremity under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2008). He rated appellant for peripheral nerve impairment under Table 16-12, A.M.A., *Guides* 535 (6th ed. 2008). Dr. Weiss relied on prior examination findings from April 15, 2002. Dr. Merola reviewed the record on May 24, 2010, and found 28 percent left lower extremity impairment under Table 16-12, A.M.A., *Guides* 534-36 (6th ed. 2008).

⁴ Dr. Fries provided the following diagnoses: (1) chronic low back pain -- minor L4-5 and L5-S1 disc degeneration; (2) bilateral lower extremity peripheral neuropathies, left greater than right; (3) depression and anxiety; and (4) diabetes mellitus. Although he found no lower extremity impairment, he found one percent whole person impairment under Table 17-4, Lumbar Spine Regional Grid, A.M.A., *Guides* 570 (6th ed. 2008). On October 12, 2010 Dr. Henry J. Magliato, a Board-certified orthopedic surgeon and DMA, noted, *inter alia*, that whole person awards were not acceptable under FECA.

⁵ Dr. Fries referenced electromyography and nerve conduction velocity (EMG/NCV) studies dated May 10, 2000 and August 27, 2001. Neither study revealed evidence of lumbosacral radiculopathy. However, the August 27, 2001 study revealed lower extremity mild peripheral neuropathy. Dr. Fries did not obtain any additional studies when he examined appellant in September 2010.

⁶ In his September 23, 2010 report, Dr. Fries noted that appellant provided additional medical records, which included a report of a June 24, 2008 lumbar MRI scan. His description of the reported findings included mention of disc desiccations from L1 through S1, and disc bulging from L1 through L5. Dr. Fries also noted that the report indicated evidence of bilateral foraminal encroachment at the L4-5 level, left greater than right. At that same level, there was also evidence of narrowing and indentation of the thecal sac, mild central stenosis, and facet hypertrophy.

MRI scan results.⁷ Consequently, the Board instructed OWCP to refer the case back to Dr. Fries so that he could provide additional explanation regarding the diagnostic tests of record. Also, Dr. Fries was afforded the option of obtaining additional testing if necessary.⁸

On remand, OWCP referred the case back to Dr. Fries for further review. The claims examiner advised Dr. Fries to review the electrodiagnostic studies and MRI scan results, including the June 24, 2008 lumbar MRI scan findings. OWCP asked Dr. Fries to explain why he believed the existing reports were sufficient to support his prior opinion and why new diagnostic testing should not be obtained. It also asked that he explain why the testing presented, including the 2008 MRI scan, did not support the existence of a radicular syndrome and/or lower extremity peripheral nerve impairment. OWCP further advised Dr. Fries that he could obtain updated diagnostic testing and/or undertake further clinical examination if necessary to render a new opinion regarding impairment.

In a supplemental report dated January 21, 2013, Dr. Fries reviewed appellant's electrodiagnostic studies and lumbar MRI/CT scans. He chose not to obtain additional diagnostic studies or examine appellant further. Dr. Fries indicated that the October 20, 1999 MRI scan, which was contemporaneous with appellant's work-related fall, did not document evidence of trauma. He further commented that bulging annuli were commonly seen with degenerative findings which were not proof of trauma. Dr. Fries also stated that the repeat lumbar MRI scan on February 14, 2001 demonstrated degenerative findings consistent with age, and not evidence of trauma. Appellant's August 20, 2001 postmyelogram lumbar CT scan similarly failed to show evidence of trauma. Dr. Fries then reviewed Dr. Gajarawala's interpretation of appellant's June 24, 2008 lumbar MRI scan. He commented that the reported findings of 1999 and 2008 were compatible with slowly advancing age-related multilevel spinal degeneration, and there was no specific evidence of trauma.

Dr. Fries next commented on the May 10, 2000 and August 27, 2001 EMG/NCV results. He noted that the initial study showed no evidence of acute lumbosacral radiculopathy, and did not identify any other pathology. With respect to the August 27, 2001 study, Dr. Fries noted there was no evidence of lumbosacral radiculopathy or myelopathy. However, there were findings consistent with mild lower extremity peripheral neuropathies, left greater than right. Dr. Fries explained that the August 27, 2001 study confirmed the absence of a lower extremity condition due to trauma or from other nontraumatic spinal pathology. According to him, the late finding of mild bilateral peripheral neuropathy was not traumatic, noting that it occurred well after appellant's accident. However, Dr. Fries was unable to determine the etiology of the noted peripheral neuropathy. He explained that addressing the etiology would require further evaluation outside the realm of appellant's workers' compensation case.

In response to OWCP's request for an explanation of why the current record should suffice without further testing, Dr. Fries indicated that multiple imaging and electrodiagnostic studies had not confirmed trauma. He further explained that because there were no traumatic

⁷ The October 20, 1999 and June 24, 2008 lumbar MRI scans were both interpreted by Dr. Jatin M. Gajarawala, a Board-certified radiologist, who is also Board-certified in nuclear medicine.

⁸ The Board's December 11, 2012 decision is incorporated herein by reference.

findings on studies since appellant's accident, any new study could not now identify 1999 trauma. Dr. Fries indicated that he could not say whether new imaging would demonstrate current pathology unrelated to trauma.

As to OWCP's inquiry regarding why the testing presented, including the 2008 MRI scan, did not support the existence of a radicular syndrome and/or lower extremity peripheral nerve impairment, Dr. Fries noted that an MRI scan cannot diagnose the presence or absence of radiculopathy or lower extremity peripheral nerve impairment. He further explained that an MRI scan demonstrates anatomy, and any findings on MRI scan were entirely incidental to any claim that appellant had spinal pathology reflected in his lower extremities. With respect to the electrodiagnostic studies, Dr. Fries explained that there was no evidence of a neurologic condition in appellant's lower extremities related to his spine. Only the most recent August 27, 2001 study showed a peripheral neuropathy, which he indicated could be due to a metabolic disorder or other intrinsic nerve pathology, but not trauma. Dr. Fries further explained that, when he examined appellant on September 8, 2010, there were no neurologic findings in his lower extremities. In particular, there were no motor, sensory, or reflex changes, and bilateral straight leg raising test failed to provoke radicular symptoms.

In conclusion, Dr. Fries noted that further review of the imaging and electrodiagnostic reports had not changed his prior opinion. He reiterated that the various MRI/CT scans and electrodiagnostic studies did not evidence trauma. Dr. Fries also stated that new diagnostic studies and/or imaging would not change his opinion concerning the residuals from the accident appellant sustained more than 13 years ago.

In an April 17, 2013 decision, OWCP denied appellant's claim for a schedule award based on Dr. Fries' opinion.

By decision dated August 2, 2013, the Branch of Hearings and Review, however, set aside OWCP's April 17, 2013 decision and remanded the case to OWCP so that the DMA could review Dr. Fries' January 21, 2013 supplemental report.

In a report dated September 24, 2013, Dr. Magliato, the DMA, expressed his view that Dr. Fries' results should be accepted. He noted that Dr. Fries clearly explained his reasoning as to why he found no objective evidence of any radiculopathy related to the original job injury.

By decision dated December 3, 2013, OWCP again denied a schedule award based on Dr. Fries' opinion.

Appellant requested a hearing, which was held on May 21, 2014. OWCP also received a May 19, 2014 updated impairment rating from his physician, Dr. Weiss. In this report, Dr. Weiss found without additional examination 30 percent left lower extremity impairment due to spinal nerve impairment involving the L4, L5, and S1 nerve roots. He identified sensory deficits at L5 and S1, as well as motor deficits involving L4, L5, and S1.⁹

⁹ Although Dr. Weiss applied a different methodology than his April 22, 2010 impairment rating, he continued to rely on the same April 15, 2002 examination findings. *See supra* note 3.

In an August 5, 2014 decision, OWCP's hearing representative affirmed OWCP's December 3, 2013 decision.

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.¹⁰ 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.¹¹ Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).¹²

No schedule award is payable for a member, function, or organ of the body that is not specified in FECA or the implementing regulations.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 back condition affects the upper and/or lower extremities.¹⁵ The A.M.A., *Guides* (6th ed. 2008) provides a specific methodology for rating spinal nerve extremity impairment.¹⁶ It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine.¹⁷ The rating methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities.¹⁸

FECA provides that, if there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician

¹⁰ For a complete loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

¹¹ 20 C.F.R. § 10.404.

¹² 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 and Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

¹³ *W.C.*, 59 ECAB 372, 374-75 (2008); *Anna V. Burke*, 57 ECAB 521, 523-24 (2006).

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 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a(3).

¹⁶ *Id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

¹⁷ *Id.*

¹⁸ *Id.*

who shall make an examination.¹⁹ For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."²⁰ Where OWCP has referred the employee to an IME to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-rationalized and based upon a proper factual background, must be given special weight.²¹

ANALYSIS

The Board finds that OWCP properly deferred to Dr. Fries' opinion as the IME. Dr. Fries provided a well-rationalized report based on a proper factual and medical history. He also accurately summarized the relevant medical evidence.²² Additionally, Dr. Fries provided a thorough physical examination. He also provided detailed findings and medical rationale supporting his opinion. In his January 21, 2013 report, Dr. Fries explained that, when he examined appellant on September 8, 2010, there were no neurologic findings in his lower extremities. He specifically noted there were no motor, sensory, or reflex changes, and straight leg raising test failed to provoke radicular symptoms. Dr. Fries further explained that the electrodiagnostic studies did not reveal evidence of lumbosacral radiculopathy.²³ He also explained that appellant's imaging studies did not reveal evidence of trauma, and the latest MRI scan from June 2008 was consistent with slowly advancing age-related multilevel spinal degeneration. As the IME, Dr. Fries' opinion is entitled to determinative weight.²⁴

Absent evidence of radiculopathy, there is no basis for rating spinal nerve extremity impairment under FECA.²⁵ Accordingly, the Board finds that OWCP properly relied on Dr. Fries' findings in determining that appellant had no left lower extremity impairment.

In a May 19, 2014 updated report, Dr. Weiss found a combined 30 percent left lower extremity impairment due to spinal nerve impairment involving the L4, L5, and S1 nerve roots. He essentially applied a different rating methodology to his April 15, 2002 examination findings. This is the same underlying data that Dr. Weiss used to prepare his April 22, 2010 impairment

¹⁹ 5 U.S.C. § 8123(a); see 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The DMA, acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

²⁰ *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

²¹ *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

²² Counsel noted that Dr. Fries referenced an "August 27, 2010" EMG/NCV. The actual study was from 2001. A part from this typographical error, Dr. Fries accurately summarized the results of the August 27, 2001 electrodiagnostic study.

²³ Although the August 27, 2001 EMG/NCV revealed evidence of mild bilateral peripheral neuropathy, Dr. Fries indicated that this was not the result of trauma. He diagnosed diabetes mellitus, but did not specifically comment on whether appellant's lower extremity peripheral neuropathy was related to his diabetes. Dr. Fries explained that the neuropathy could be due to a metabolic disorder or other intrinsic nerve pathology, but it was not trauma related.

²⁴ *Supra* note 21.

²⁵ *Supra* note 16.

rating, which formed the basis of the medical conflict that Dr. Fries was selected to resolve.²⁶ Subsequent reports from a physician who was on one side of a medical conflict that has since been resolved would generally be insufficient to overcome the weight accorded the IME's report and/or insufficient to create a new medical conflict.²⁷

Under the circumstances, Dr. Weiss' continued reliance on 12-year-old data is also insufficient to overcome the weight properly accorded Dr. Fries' opinion. His May 19, 2014 report is also clearly insufficient to create a new conflict in medical opinion. The Board finds that OWCP properly denied appellant's claim for a schedule award.

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 weight of the medical evidence does not demonstrate a ratable impairment of appellant's leg.

²⁶ See *supra* note 3.

²⁷ *I.J.*, 59 ECAB 408, 414 (2008).

ORDER

IT IS HEREBY ORDERED THAT the August 5, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 2, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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