United States Department of Labor
Employees' Compensation Appeals Board

W.O, Appellant	)	
and	)	**Docket No. 07-604**
	)	**Issued: April 2, 2008**
U.S. HOUSE OF REPRESENTATIVES, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
No appearance, for the Director

Oral Argument October 16, 2007

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 27, 2006 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated December 28, 2005 and August 11, 2006. The Office granted a schedule award for 35 percent impairment to both lower extremities and denied his request for reconsideration. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.[1]

ISSUES

The issues are: (1) whether appellant has more than 35 percent impairment to his left and right lower extremities, for which he received a schedule award; and (2) whether the Office properly denied his request for further review of the merits pursuant to 5 U.S.C. § 8128(a). On appeal, appellant contends that the Office should accept his bowel, bladder and sexual dysfunction conditions as causally related to his 1996 employment injury and that he has impairment to his upper extremities.

[1] The Board does not have jurisdiction to review the November 17, 2005 decision of the Office Branch of Hearings and Review which denied his request for an oral hearing as untimely. 20 C.F.R. § 501.3.

FACTUAL HISTORY

On March 29, 1996 appellant, then a 48-year-old congressman, sustained injury after he was attacked while on the grounds of the U.S. Capitol. The Office accepted his claim for left-side thoracic disc herniation at T7-8, left-sided T6-7 discectomy and decompression and displaced C6 and C7 intervertebral discs.[2] The Office authorized transpedicular discectomy surgery, which was performed on August 21, 1996 and a left transpedicular T6-7 discectomy decompression surgery performed on May 15, 2002. Appellant subsequently filed claims for a schedule award.[3]

In an October 3, 2002 report, Dr. Joel T. Dall, an attending physician Board-certified in physical medicine and rehabilitation, reviewed the history of injury and medical treatment. He opined that appellant had reached maximum medical improvement and provided an impairment rating. Dr. Dall noted that, although the Department of Labor did not accept impairment ratings to the back, the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) provided impairment ratings for the spine. He advised that if appellant's impairment rating were based solely on his spinal condition, it would represent 20 percent whole person impairment; however, he acknowledged that he was instructed to rate impairment to the lower extremities. Dr. Dall stated that appellant did not have any impairment of the lower extremities and that his "impairment, outside of his spinal injury, has to do with neurologic problems and pain related thereto." He noted that appellant had symptoms of urinary and bowel urgency and sexual dysfunction which could be rated under Table 15-6 of the A.M.A., *Guides*,[4] based on corticospinal tract impairment. Dr. Dall found that appellant had a Class 1 rating and allowed five percent whole person impairment to the bladder and bowel and nine percent impairment for sexual dysfunction.[5] As appellant exhibited a balance problem with his eyes closed, Dr. Dall rated Class 1 impairment for station and gait disorders, allowing five percent whole person impairment.[6] Dr. Dall rated appellant's pain with reference to Tables 18-4 and 18-5, stating that he fell somewhere between Class 2 and 3 (moderate and moderately severe) for which 10 percent impairment was allowed. He stated that he utilized the Combined Values Chart to combine the impairments for pain (10 percent), sexual dysfunction (9 percent), bladder (5 percent), bowel (5 percent) and gait and station (5 percent). Dr. Dall found a total 31 percent whole man impairment. On May 14, 2003 he reiterated appellant's impairment rating.[7]

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[2] Appellant filed for disability retirement under the Federal Employee Retirement System in January 1997, which was accepted by the Office of Personnel Management effective January 3, 1997.

[3] Appellant filed a claim for a recurrence of total disability on August 1, 2002. He noted that he had not returned to his duties since his injury and that he was only able to work part time in a law practice. The Office accepted his recurrence claim.

[4] A.M.A., *Guides* 396-97, Table 15-6.

[5] *Id*. at Table 15-6, subsections d, e and f.

[6] *Id*. at Table 15-6, subsection c.

[7] On September 25, 2003 the Office advised appellant that impairment ratings of the whole person or back could not be the basis of a schedule award. It requested additional medical evidence rating impairment to his lower extremities.

On September 8, 2003 Dr. Willie E. Thompson, an Office medical adviser Board-certified in orthopedic surgery, reviewed appellant's history of injury and medical treatment. He noted that the most recent surgery was the May 15, 2002 T6-7 discectomy and decompression. Dr. Thompson provided an impairment rating for appellant's left lower extremity, as the disc herniation was to the left side. Under Chapter 15, he rated appellant's thoracic spine impairment as Category III, allowing 15 percent impairment of the whole person.[8] Dr. Thompson then utilized Table 17-3, which converts whole person impairment values to lower extremity impairment, to find 37 percent impairment to the left leg.[9]

On October 24, 2003 the Office advised appellant that he would be referred for a second opinion medical evaluation as Dr. Dall diagnosed conditions which had not been accepted as related to appellant's back injury or surgeries. Appellant was referred for examination to Dr. Alan J. Goldman, a Board-certified neurologist. In a February 16, 2004 report, Dr. Goldman reviewed the history of injury and medical treatment and listed findings on physical examination. He noted appellant's complaints of cervical, thoracic and lumbosacral spine pain, with both bowel and bladder incontinence. Appellant also complained of marked discomfort with sexual activity. Dr. Goldman provided findings on examination of the spine and diagnosed status post discectomies and decompressions at T6-7 and T7-8 with secondary failed back syndrome, thoracic syrinx, T6 through 10, electrophysiologic evidence of bilateral carpal tunnel syndrome, radicular paresthesias of both the upper and lower extremities in association with appellant's thoracic condition; and bowel, sexual and bladder dysfunctions in association with the failed back syndrome and thoracic condition.

Dr. Goldman stated that appellant had sustained a significant injury to his spine in the mid-thoracic region, which necessitated two surgical decompressions. The presence of the thoracic syrinx at T6 through 10 was found to be a post-traumatic phenomena associated with the accepted injury. Dr. Goldman stated that, to a reasonable degree of medical certainty, "[appellant's] bladder, bowel and sexual dysfunctions, along with the radiation of numbness, tingling and a sense of weakness to [both his] upper and lower extremities are associated with the trauma of March 29, 1996." He noted that the origin for all of these complaints resided within the spinal cord. Dr. Goldman rated appellant's total permanent impairment as 40 percent of both lower extremities, stating:

> "I share Drs. Thompson and Dall's confusion and frustration in reference to an impairment rating. In invoking the A.M.A., *Guides* [f]ifth [e]dition, one can look at individual body parts and then apply the principles and values from the [C]ombined [V]alues [C]hart (pages 604 to 606). In going through that [arithmetic] exercise, I would award [appellant] 16 percent impairment for the thoracic spine (section 15.5, [T]able 15-4, [C]ategory 3, page 389); 5 percent to the lumbar spine (section 15.4, [T]able 15-3, [C]ategory 2, page 384); 5 percent for the cervical spine (section 15.6, [T]able 15-5, [C]ategory 3, page 392); 5 percent for urinary sphincter dysfunction ([T]able 15-6, [C]ategory D, [C]lass 1); 5 percent for anal rectal impairment ([T]able 15-6, [C]ategory E, [C]lass 1); and 3

[8] A.M.A., *Guides* 390.

[9] *Id*. at 527, Table 17-3.

> percent for neurologic sexual impairment ([T]able 15-6, [C]category F, [C]lass 1). The impairments in the [C]ombined [V]alues [c]hart produces 34 percent whole person impairment. To that value and in accordance with Chapter 18, [F]igure 18-1, algorithm [B]ox 4, I would add [three] percent for pain. Again, using the combined values system as above. I arrive at a 37 percent whole person impairment. If, however, as requested by the [Office] to simply categorize [appellant's] impairments on the basis of his lower extremities, but recognizing that all such lower extremity phenomena emanate from the thoracic spinal cord injury, I would go to [C]hapter 17, [T]able 17-3, page 527 (whole person impairment values calculated from lower extremity impairment) and take the above 16 percent whole person thoracic spine impairment and convert it for both the lower extremities to arrive at a 40 percent [lower extremity] impairment."[10]

The Office requested clarification of Dr. Goldman's impairment rating. In an August 27, 2004 report, Dr. Goldman repeated the diagnoses, noting that an impairment rating of the lower extremities did not encompass the whole of appellant's complaints. He addressed the symptoms arising from appellant's cervical, thoracic and lumbosacral spine, noting that the injury resulted in bowel and bladder incontinence with sexual dysfunction. Dr. Goldman noted that recently obtained magnetic resonance imaging scans of the spinal cord showed disc protrusions with effacement of the spinal cord in the T3, T4, T5, T6, T7, T8, T9 and T10 nerve distribution, injury to the corticospinal tracks of the lumbar spine at L4, L5 and S1 and an osteophytic disc complex supplying the C4, C5, C6 and C7 nerve roots. He again provided whole person impairment ratings under Chapter 15 for appellant's spine and reiterated the five percent whole person impairment ratings for urinary sphincter and bladder dysfunction and for sexual dysfunction. Allowing for pain under Chapter 18 and allowing an eight percent whole person impairment under Table 15-5 for the lower cervical neuronal pathways, Dr. Goldman concluded that appellant had 53 percent whole person impairment. He doubted that appellant had reached maximum medical improvement as to his spine, as it was conceivable further intervention might be necessary. In an October 6, 2004 letter, Dr. Goldman opined that for rating purposes, the date of maximum medical improvement was August 27, 2005.[11]

On October 19 and November 23, 2004, Dr. Thompson reviewed the medical evidence. He utilized Table 15-4, to rate appellant's thoracic spine impairment as Category V which provides for a 28 percent whole person impairment.[12] Dr. Thompson then applied Table 17-3, to convert the whole person impairment value to impairment of the lower extremities, which he noted as 70 percent to the lower extremities, assigning 35 percent impairment to both the left and right legs. The Office medical adviser stated that the diagnosis-related estimates allowed evaluation of the thoracic spine, assessing impairment of the whole person which could then be

[10] Dr. Goldman stated that, under Table 17-3, he converted 16 percent "whole person" impairment to 40 percent "whole person" impairment. This appears to be a typographical error, as the conversion at Table 17-3 is whole person to lower extremity impairment. He also indicated that appellant's cervical dysfunction caused radicular symptoms to both upper extremities, aside from the diagnosed carpal tunnel condition.

[11] On November 23, 2004 Dr. Goldman rated 53 percent impairment to the arms and legs with 53 percent impairment for the bladder, blower and sexual dysfunction.

[12] A.M.A., *Guides* 389, Table 15-4.

converted to a rating of the lower extremities. He stated that thoracic syrinx was an accumulation of fluid due to postoperative changes which did not represent a pathologic state meriting an impairment rating. Dr. Thompson noted that appellant's more recent surgery was in 2002 and that subsequent medical reports noted good control of the bowel and bladder functions. He recommended urological examination of appellant as there were numerous causes for bladder and erectile dysfunction. Thereafter, the case could be revisited for an impairment rating, if warranted. Dr. Thompson opined that appellant's carpal tunnel syndrome was not casually related to his thoracic spine injury. He stated that appellant had reached maximum medical improvement on May 15, 2003, one year following the most recent surgery.

On February 18, 2005 the Office granted schedule awards for 35 percent impairment to both lower extremities. The period of the award ran from May 13, 2003, the date of maximum medical improvement, to February 19, 2005.

On October 12, 2005 appellant requested a hearing before an Office hearing representative. He advised that he had not received the February 18, 2005 schedule award until September 28, 2005. Appellant submitted additional medical evidence in support of his claim.

In a November 17, 2005 decision, the Office Branch of Hearings and Review denied appellant's hearing request as untimely.

By letters dated November 28 and December 8, 2005, appellant requested reconsideration of his claim. He noted that the Office had not considered impairment to his upper extremities, bladder, bowel or sexual dysfunction.

In a December 28, 2005 decision, the Office denied modification of the February 18, 2005 schedule award. The Office found that the schedule award covered his lower extremities, as it was the only impairment accepted as related to the back injury he sustained. It noted that the issue of schedule awards for any additional impairment was under development.[13] The weight of medical evidence did not establish greater than 35 percent impairment to the right or left legs.

By letter dated March 1, 2006, appellant requested reconsideration of the December 28, 2005 decision.

In an August 11, 2006 decision, the Office denied appellant's request for further merit review.

[13] The record reflects that appellant was referred to Dr. George W. Middleton, a urologist, for examination. On February 9, 2006 the Office advised appellant that his report would be reviewed to determine his eligibility for a schedule award.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of the Federal Employees' Compensation Act[14] and the implementing regulations[15] 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, the Act 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.[16]

Schedule awards under the Act are limited to specific members or functions of the body as enumerated under section 8107 and the federal regulations.[17] Although the A.M.A., *Guides* present a rating system for impairment of the spine, it is well-established that the back is not a member, function or organ of the body as defined in the schedule or by regulation.[18] Congress specifically excluded the back as an organ under the Act.[19] Since the back or spine is not a body part which is provided for under the Act, there is no schedule award available for any impairment of the spine. However, consideration may be given to impairment originating in the spine which affects a member or bodily function listed under the schedule, such as the legs or arms.[20] Similarly, it is well established that schedule awards are not payable for whole person impairment.[21] While the A.M.A., *Guides* provide rating systems for both individual body parts and whole person impairment, the Act defines impairment to specific members and functions of the body. Therefore, any whole person impairment rating must be properly converted to a rating of a member, function or organ of the body as listed under the schedule.

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[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

[16] *Id.*; *see Billy B. Scoles*, 57 ECAB ___ (Docket No. 05-1696, issued December 7, 2005).

[17] *See Jacqueline S. Harris*, 54 ECAB 139 (2002) (denial of schedule award for an emotional condition); *Leroy M. Terska*, 53 ECAB 247 (2001) (denial of schedule award for loss of taste and smell); *Kenneth O. Pratt*, 49 ECAB 687 (1998) (denial of schedule award for loss of a tooth); *Edgar L. Pake*, 35 ECAB 1011 (1984) (denial of schedule award for the heart).

[18] *See Vanessa Young*, 55 ECAB 575 (2004); *Terry E. Mills*, 47 ECAB 309 (1996); *Robert E. Wingate*, 38 ECAB 361 (1987).

[19] 5 U.S.C. § 8101(20). *See Francesco C. Veneziani*, 48 ECAB 572, 578 (1997); *Edna M. Johnson*, 33 ECAB 593 (1982).

[20] *See* 20 C.F.R. § 10.404(a); *Tomas Martinez*, 54 ECAB 623 (2003).

[21] *See Robert Romano*, 53 ECAB 649 (2002); *John Yera*, 48 ECAB 243 (1996).

ANALYSIS -- ISSUE 1

Appellant sustained injury to his back on March 29, 1996, accepted for a left-sided thoracic disc herniation at T7-8, left-sided T6-7 discectomy and decompression and displaced C6 and C7 intervertebral discs. He received a schedule award for 35 percent impairment to both his left and right lower extremities. The Board finds that the case is not in posture for decision due to deficiencies in the medical evidence of record.

Dr. Dall opined that appellant had a total 31 percent whole person impairment due to injury to the thoracic spine. He stated that, if rating appellant's spinal impairment alone, this would represent 20 percent whole person impairment. Dr. Dall noted that he had been requested to rate impairment to appellant's lower extremities due to the accepted injury. However, he found 31 percent whole man impairment, after combining impairment for urinary (5 percent) and bowel (5 percent) urgency, sexual dysfunction (9 percent) and station and gait disorder (5 percent) under Table 15-6 with 10 percent impairment for pain under Chapter 18.[22] The Board notes that the whole person impairment rating provided by Dr. Dall does not conform to the request by the Office that he rate impairment to appellant's lower extremities. As noted, there is no provision under the Act allowing compensation under a schedule award for impairment to the spine or whole person. Moreover, Dr. Dall took into consideration several medical conditions that were not accepted by the Office as arising out of the 1996 injury. He did not address appellant's impairment with reference to Chapter 17 of the A.M.A., *Guides* that provide the assessment principles for rating lower extremity impairment, including impairment due to peripheral nerve injuries.[23] The rating provided by Dr. Dall is of diminished probative value.

On February 16, 2004 Dr. Goldman indicated that appellant had 40 percent impairment to his lower extremities arising from the thoracic spine injury. In reaching this impairment rating, Dr. Goldman followed the example of Dr. Dall and included impairment ratings under Table 15 6 for urinary sphincter dysfunction, anal rectal impairment and sexual impairment, combined with a rating for pain under Chapter 18. In addition, he provided ratings for the cervical, thoracic and lumbosacral spine under Tables 15-3, 15-4 and 15-5 in finding a combined whole person impairment rating of 16 percent. Dr. Goldman also noted that he had been requested to rate impairment to the lower extremities based on the accepted injury, but stated that he was giving recognition to the fact that "all such lower extremity phenomena emanate from the thoracic spinal cord injury." He advised that under Table 17-3, the 16 percent whole person impairment could be converted to lower extremity impairment, which he described as 40 percent "whole person."[24] In a November 22, 2004 report, Dr. Goldman opined that appellant had a 53 percent permanent impairment of his arms and legs and a 53 percent permanent impairment due based on bladder, bowel and sexual dysfunction.

[22] In FECA Bulletin No. 01-05, issued January 29, 2001, the Office noted that medical examiners should not use Chapter 18 to rate impairment due to pain for any condition that can be adequately rated on the basis of the body and organ impairment systems provided in the other chapters of the A.M.A., *Guides*. Dr. Dall did not explain why Chapter 18 was an appropriate method for rating pain in this case.

[23] *See* A.M.A., *Guides* 550-53, Chapter 17.2l.

[24] The Board notes the conversion should be from "whole person" to "lower extremity."

As noted, a schedule award is not payable for an impairment of the whole person.[25] Moreover, the record reflects that the Office is in the process of developing the medical evidence to determine whether appellant has any bowel, bladder or sexual dysfunction causally related to his accepted injury and whether he has any upper extremity impairment. As these were not accepted conditions as of the date of the present schedule award determination, they were properly excluded from consideration. There is also some question as to whether appellant has reached maximum medical improvement, as Dr. Goldman provided conflicting statements in his August 27 and October 6, 2004 reports. For these reasons, Dr. Goldman's impairment rating is of reduced probative value.

Dr. Thompson, an Office medical adviser, reviewed the medical evidence and correlated the findings on physical examination to the A.M.A., *Guides*.[26] He advised that he utilized the diagnosis-related estimates of Chapter 15 to rate impairment of the thoracic region. Based on the clinical findings, Dr. Thompson placed appellant's impairment in Category V, for which a range of 25 to 28 percent whole person impairment is allowed. This Category notes impairment of the lower extremity as defined in Category III (ongoing neurologic impairment of the lower extremity related to a thoracolumbar injury, documented by examination of motor and sensory functions, reflexes or findings of unilateral atrophy above or below the knee related to no other condition) with loss of structural integrity as defined in Category IV (alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as translation of one vertebra on another of more than 2.5 millimeter). He allowed the maximum 28 percent whole person rating for the affected lower extremities and utilized Table 17-3 of the A.M.A., *Guides* to convert the impairment rating from whole person to impairment of the lower extremities. Dr. Thompson noted that 28 percent whole person impairment converts to 70 percent impairment of the lower extremities. However, he went on to state that the 70 percent impairment provided under Table 17-3 would be assigned as 35 percent impairment to each lower extremity. It is not readily apparent to the Board, however, that this is a proper application of Table 17-3.[27] In Dr. Thompson's September 8, 2003 report, the medical adviser utilized Chapter 15 and Table 17-3 to rate impairment to appellant's left lower extremity. His application of Table 17-3 is not consistent in this case. For this reason, the impairment rating by Dr. Thompson is also of reduced probative value.

The Board finds that the medical evidence of record does not provide a clear picture of the extent of disability to appellant's lower extremities. The case will be returned to the Office for further development of the medical evidence. On appeal, appellant contends that the Office erred in not considering impairment to his upper extremities, bowel, bladder and sexual dysfunction. As noted, the Office advised appellant that it was developing his claim with respect to whether these conditions are causally related to his 1996 injury. Therefore, these aspects of

[25] *D.H.*, 58 ECAB ___ (Docket No.06-2160, issued February 12, 2007); *Marilyn S. Freeland*, 57 ECAB ___ (Docket No.06-563, issued June 7, 2006); *T.M.*, 56 ECAB 273 (2005).

[26] Where an examining physician provides an impairment rating which does not conform to the Office's standards, an Office medical adviser may review the evidence and provide an impairment rating. *See*

[27] *See C.I.*, Docket No. 07-804 (issued July 23, 2007); *Scott D. Hoskins*, Docket No. 04-200 (issued May 4, 2004).

appellant's claim are in an interlocutory posture. There are no final Office decisions addressing these conditions over which the Board may take jurisdiction.[28] Given the Board's disposition of the first issue, the second issue is rendered moot.

CONCLUSION

The Board finds that the case is not in posture for decision. The case is remanded to the Office for further development as to whether appellant has more than 35 percent impairment to both lower extremities.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 11, 2006 and December 28, 2005 are set aside. The case is remanded for further action in conformance with this decision.

Issued: April 2, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[28] 20 C.F.R. § 501.2(c).