United States Department of Labor
Employees' Compensation Appeals Board

E.J., Appellant	)	
	)	
and	)	**Docket No. 12-1948**
	)	**Issued: June 5, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 18, 2012 appellant,through his attorney, filed a timely appeal from the Office of Workers' Compensation Programs' (OWCP) decision dated June 12, 2012. Pursuant to the Federal Employees' Compensation Act[1](FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 14 percent impairment to his right lower extremity and 14 percent impairment to his left lower extremity.

FACTUAL HISTORY

Appellant, a 33-year-old mail handler, injured his lower back on March 4, 1996 while reaching for a container. He filed a claim for benefits on March 4, 1996, which OWCP accepted for lumbar strain and herniated disc at L5-S1.

[1] 5 U.S.C. § 8101 *et seq.*

On August 25, 1999 appellant underwent anterior lumbar discectomy/laminectomy and fusion surgery at L5-S1. The procedure was performed by Dr. John A. Handal, Board-certified in orthopedic surgery.

By decision dated July 17, 2001, OWCP granted appellant a schedule award for a 13 percent permanent impairment of the right leg and a 13 percent permanent impairment of the left leg for the period June 14, 2001 to November 20, 2002, for a total of 74.88 weeks of compensation.

In a January 21, 2010 report, Dr. Nicholas P. Diamond, an osteopath, found that appellant had a 29 percent impairment of each lower extremity pursuant to the American Medical Association,*Guides to the Evaluation of Permanent Impairment*(A.M.A., *Guides*) (sixth edition). On examination he found that manual muscle strength testing of the lower extremities showed the hip flexors, hip adductors and hip abductors graded at 4 out of 5 bilaterally. Dr. Diamond advised that a sensory examination of the lower extremities demonstrated a perceived sensory deficit over the S1 dermatome in both the right and left lower extremities. With regard to the right lower extremity, he applied the net adjustment formula at pages 582 to 584 of the A.M.A., *Guides*.[2]Dr. Diamond found that appellant had a class 1 impairment, the rating utilized at the peripheral nerve impairment grid at Table 16-12, page 534 for sensory deficit, based on a right S1 (sciatic) nerve root impairment; this yielded a four percent impairment for this grid.[3] He calculated the functional history grade by using the Pain Disability Questionnaire (PDQ) test for lower back pain, a questionnaire which calculates functional disability grades by rating the difficulties a patient experiences in performing basic activities of daily living. Dr. Diamond related that appellant had a 119 percent PDQ score, which yielded a grade modifier 3 for functional history, for a severe problem, pursuant to Table 16-6, page 516; and a grade modifier 2 for clinical studies based on electromyogram, nerve conduction studiesand magnetic resonance imaging scan results.[4] Pursuant to the formula set forth at page 584, he then subtracted the grade modifier 1 from functional history and clinical studies, which yielded a net adjusted grade 3 minus 1 and 2 minus 1 -- a total net adjustment of 3, for a nine percent impairment of the right lower extremity.

Dr. Diamond then found that appellant had a class 1 impairment at Table 16-12 for a four out of five motor strength deficit, based on a right (femoral) hip flexor impairment; this yielded a five percent impairment for this grid.[5] He calculated the functional history and clinical studies grade by using the same method, by which he calculated the sensory deficit, which resulted in nine percent impairment of the right lower extremity. Dr. Diamond then found that appellant had a class 1 impairment at Table 16-12 for a four out of five motor strength deficit, based on a right (supragluteal) hip abductors impairment; this yielded an eight percent impairment for this grid.[6] He calculated the functional history and clinical studies grade by using the same method,

[2] A.M.A.,*Guides*582-84.

[3]*Id*. at 534.

[4]*Id.* at 406.

[5]*Id.* at 534.

[6]*Id.*

by which he calculated the sensory and femoral deficits, which resulted in 13 percent impairment of the right lower extremity. Lastly, Dr. Diamond found that appellant had a class 1 impairment at Table 16-12 for a four out of five motor strength deficit, based on a right (obturator) hip adductors impairment; this yielded a one percent impairment for this grid.[7] He calculated the functional history and clinical studies grade by using the same method, by which he calculated the sensory, femoral and supragluteal deficits, which resulted in an additional two percent impairment of the right lower extremity. Dr. Diamond determined that appellant had a combined 29 percent right lower extremity impairment based on the above calculations. He then found that appellant had a combined 29 percent left lower extremity impairment using the identical calculations he relied on for rendering his impairment rating for the right lower extremity.

On September 20, 2011 appellant filed a Form CA-7 claim for a schedule award, seeking an additional schedule award for partial loss of use of his right and left lower extremities.[8]

In a November 7, 2011 report, Dr. Christopher R. Brigham, a specialist in internal medicine and an OWCP medical adviser, found that appellant had a 14 percent impairment of the left and right lower extremities under the sixth edition of the A.M.A., *Guides* stemming from his accepted lower back conditions. He advised that spinal nerve impairment evaluations which affected the extremities had been clarified in the July/August 2009 issue of *The Guides Newsletter* because the sixth edition of the A.M.A., *Guides* had not provided a separate approach to rating spinal nerve impairments, like those which had appeared in prior editions of the A.M.A., *Guides*. Dr. Brigham stated that *The Guides Newsletter* issued proposed new tables to rate spinal nerve impairments for upper and lower extremity impairments, which provided values for rating spinal nerve impairment by means of the process defined for the sixth edition in rating peripheral nerve injuries. He advised that, due to the need for consistency with the sixth edition's Chapter 17, *The Spine and Pelvis*, all impairment values are class 1. Dr. Bingham stated:

> "The sixth edition, page 430, explains the process for the upper extremity (the lower extremity process is similar)
>
> > (a) In the left column identify the nerve involved and then identify the severity of the sensory and/or motor deficit.
> >
> > (b) Adjust the impairment as described in Section 15.3, Adjustment Grid and Grade Modifiers: Non-Key Factors, excluding Table 15 8, Physical Examination Adjustment, since these neurologic examination findings define the impairment values in Table 15-20 Adjustments are made only for functional history (Table 15-7) and clinical studies (Table 15-9) (i.e., electrodiagnostic studies).

[7] *Id.*

[8] The Board notes that, although OWCP granted appellant a schedule award for a 26 percent bilateral leg impairment in its July 17, 2001 decision, the October 21, 2011 statement of accepted facts indicated that the award was for a 26 percent bilateral lower extremity impairment.

(c) Combine motor and sensory impairments at the UEI value

> "This same process can be used with the new proposed tables. The correct column and row are identified. The ratings for the sensory component and the motor component are adjusted for functional history and for clinical studies (if electromyography was performed when the patient was near maximum medical improvement). The sensory and the motor ratings are combined."

Dr. Brigham stated that the method by which Dr. Diamond rated impairment for the peripheral nerves, using Chapter 16, was not the appropriate method for rating such impairments. He found, based on Dr. Diamond's examination findings, that there was mild sensory deficit over the S1 nerve root distribution bilaterally. Dr. Brigham advised that, with regard to the motor deficits, hip abduction corresponded with the L5 nerve root and hip flexion and adduction was innervated by the L3 nerve root. He therefore found that the rating for appellant's bilateral lower extremity impairment should be based on "mild" deficits of the S1 nerve root for sensory deficits and L3 and L5 nerve roots for motor deficits. With regard to appellant's motor deficits, Dr. Brigham calculated his impairment for the L5 nerve root by relying on Proposed Table 2 of *The Guides Newsletter*, *Spinal Nerve Impairment*. He stated that there was a class 1 rating for mild motor deficit related to the grade 4 + out of 5 hip abduction weakness, which fell in the L5 distribution category and produced a default impairment of five percent for the lower extremity. Dr. Brigham then found that, pursuant to section 16.3a, page 516, *Adjustment Grid -- Functional History* and Table 16-6, *Functional History Adjustment -- Lower Extremities* at page 516, appellant's impairment rated a grade modifier 3 based on the PDQ score of 119.[9]

Dr. Brigham found that under Section 17.3c, page 518, *Adjustment Grid -- Clinical Studies*, at page 577 and Table 16-8, *Clinical Studies Adjustment -- Lower Extremities* at page 519, appellant's impairment rated a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and L5 nerve root pathology. Based on the above calculations, Dr. Brigham found that the net adjustment compared to diagnosis class 1 was a plus 3, which was a grade E impairment and produced nine percent lower extremity impairment.

With regard to the L3 nerve root impairment, Dr. Brigham again relied on Proposed Table 2 of *The Guides Newsletter*, *Spinal Nerve Impairment*. He stated that there was a class 1 rating for mild motor deficit related to the grade 4 out of 5 hip abduction flexion and adduction, which fell into the L3 distribution and produced a left lower extremity default impairment of three percent. Dr. Bingham found that, under section 17.3a, *Adjustment Grid -- Functional History*, at page 516 and Table 16-6, *Functional History Adjustment -- Lower Extremities*, at page 516, appellant was not assigned a grade modifier for the L3 nerve root because the A.M.A., *Guides* state at page 516 that a functional history grade modifier should be applied only to the single, highest diagnosis-based impairment. In accordance with this principle, he found that the motor loss of the L5 nerve root produced the higher rating.

Dr. Bingham further found that, under section 17.3c, page 518, *Adjustment Grid -- Clinical Studies*, at page 577 and Table 16-8, page 519, *Clinical Studies Adjustment -- Lower*

[9] Dr. Brigham noted that the grade modifier for physical examination was excluded in all of Dr. Diamond's calculations because this factor was used to place appellant in the correct diagnosis class.

Extremities at page 519, appellant should be assigned a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and L3 nerve root pathology. Based on this calculation he determined that the net adjustment compared to diagnosis class 1 was a +1, which was a grade D and yielded four percent lower extremity impairment.

With regard to appellant's sensory deficit at the S1 nerve root, Dr. Brigham found a class 1 rating for mild sensory deficit related to the S1 distribution, which produced a one percent lower extremity default impairment under Proposed Table 2 of *The Guides Newsletter*, *Spinal Nerve Impairment*. He stated that under section 16.3a and Table 16-6 appellant was not assigned a functional history grade modifier because the A.M.A.,*Guides*, as noted above, because this was already applied to the motor rating for the L5 nerve root. Dr. Bingham then found that, under section 17.3c, page 577, *Adjustment Grid -- Clinical Studies* and Table 16-8, page 519, *Clinical Studies Adjustment -- Lower Extremities* at page 519, appellant should be assigned a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and S1 nerve root pathology. Pursuant to this calculation he found that the net adjustment compared to diagnosis class 1 was a +1, which was a grade D and produced one percent lower extremity impairment.

Dr. Bingham concluded that the three ratings above, combined using the Combined Values Chart at page 604, totaled a 14 percent lower extremity impairment for both lower extremities. As appellant had already received an award of 26 percent bilateral impairment for the right and left lower extremities, Dr. Bingham found that appellant had sustained no additional impairment entitling him to a greater schedule award.

By decision dated November 14, 2011, OWCP determined that appellant had a total 28 percent bilateral, permanent impairment of the lower extremities. As he had already received a schedule award for a 26 percent bilateral, permanent impairment of the lower extremities, it found that he had an additional two percent bilateral impairment of the lower extremities or an additional one percent impairment for each extremity, for the period January 21 to March 2, 2010, for a total of 5.75 weeks of compensation.

By letter dated November 18, 2011, appellant, through his attorney, requested an oral hearing, which was held on March 28, 2012. At the hearing appellant stated that he had severe lower back pain, which radiated down his legs to his feet; this resulted in his laminectomy for L5-S1 fusion surgery in August 1999. He also related that he experienced pain, burning, tingling and numbness in his hips and knees due to nerve damage, a disc pressing on his nerve, in his lower back. Appellant's attorney contended at the hearing that a conflict of medical opinion existed between Dr. Brigham and Dr. Diamond regarding the degree of lower extremity impairment stemming from his accepted lower back condition which required referral to an impartial medical examiner.

In an April 10, 2012 report, Dr. Michael M. Cohen, Board-certified in pain medicine, stated that appellant continued to report pain and weakness over the lower extremities, with occasional buckling of either leg and experienced difficulty lifting his left leg while walking. He advised that appellant still had radicular pain down both legs with significant bilateral knee pain.

By decision dated June 12, 2012, an OWCP hearing representative affirmed the November 14, 2011 decision.

LEGAL PRECEDENT

The schedule award provision of FECA[10] and its implementing regulations[11] 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.[12] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[13]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, a schedule award is not payable under FECA for injury to the spine.[14] In 1960, amendments to FECA modified the schedule award provisions 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. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[15]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The GuidesNewsletter*"Rating Spinal Nerve Extremity Impairment using the sixth edition" (July/August 2009) is to be applied.[16]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404. Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009).

[12] *Id.*

[13] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[14] *Pamela J. Darling*, 49 ECAB 286 (1998).

[15] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[16] *See G.N.*, Docket No. 10-850 (issued November 12, 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

(GMFH) and if electrodiagnostic testing were done, Clinical Studies (GMCS).[17] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[18]

ANALYSIS

The Board notes that a schedule award is not payable under FECA for injury to the spine[19] or based on whole person impairment.[20] However, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[21] OWCP accepted conditions of lumbar strain and herniated disc at L5-S1 and authorized a laminectomy/disc fusion surgery on August 25, 1999. It granted appellant a schedule award for a 13 percent impairment to his right leg and a 13 percent impairment to his left leg in its July 17, 2001 decision, an October 21, 2011 statement of accepted facts indicated that he had been granted a schedule award in July 2001 for a 26 percent bilateral lower extremity impairment. Appellant subsequently stated at the March 28, 2012 hearing that the symptoms of pain, numbness and tingling in his legs, which eventually required surgery in August 1999, were actually caused by nerve damage in the L5-S1 region, which radiated down his legs into his feet.

Appellant sought an additional schedule award in September 2011. Dr. Diamond's January 21, 2010 report rated a 29 percent impairment of each lower extremity based on motor and sensory deficits, stemming from his accepted L5 herniated disc condition. Dr. Brigham reviewed Dr. Diamond's report on November 7, 2011 and found that appellant had no additional, ratable impairment for motor and sensory deficits under the sixth edition of the A.M.A., *Guides*. He determined that Dr. Diamond failed to utilize the proposed new tables in *The Guides Newsletter*, July/August 2009 and page 430 of the A.M.A., *Guides*. Dr. Brigham explained that the examiner is required to use neurologic examination findings, apply them to the net adjustment at Table 15-7, Table 15-8 and Table 15-9 and then combine the motor and sensory impairments. He stated that this same process can be used with the new proposed tables in *The Guides Newsletter*, July/August 2009, in which the ratings for the sensory and motor components are calculated through this process, adjusted for functional history and clinical studies, then combined. Dr. Brigham properly determined that Dr. Diamond's report was not rendered in conformance with the applicable protocols of the sixth edition because he did not rely on the July/August 2009 issue of *The Guides Newsletter*.

Relying on Dr. Diamond's examination findings, Dr. Brigham stated that appellant's hip abduction corresponded with the L5 nerve root and that hip flexion and adduction were innervated by the L3 nerve root. He determined that the rating for appellant's bilateral lower extremity impairment should be based on "mild" deficits of the S1 nerve root for sensory deficits

[17] A.M.A., *Guides* 533

[18] *Id.* at 521.

[19] *Supra* note 14.

[20] *N.M.*, 58 ECAB 273, n.9 (2007).

[21] *Supra* note 15.

and L3 and L5 nerve roots for motor deficits. Dr. Brigham calculated his impairment for the L5 nerve root by relying on Proposed Table 2 of *The Guides Newsletter, Spinal Nerve Impairment*. He rated a class 1 impairment for mild motor deficit related to the grade 4 + out of 5 hip abduction weakness, which placed the impairment within the L5 distribution category and produced a default impairment of five percent for the lower extremity. Dr. Brigham then found that, pursuant to Section 16.3a, page 516, *Adjustment Grid -- Functional History* and Table 16-6, *Functional History Adjustment -- Lower Extremities* at page 516, appellant's impairment rated a grade modifier 3 based on the PDQ score of 119. He further determined that pursuant to section 17.3c, page 518, *Adjustment Grid -- Clinical Studies*, at page 577 and Table 16-8, *Clinical Studies Adjustment -- Lower Extremities* at page 519, appellant's impairment rated a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and L5 nerve root pathology. In accordance with these calculations, Dr. Brigham found that the net adjustment compared to diagnosis class 1 was a plus 3, a grade E impairment, which yielded a nine percent lower extremity impairment.

Dr. Brigham also relied on Proposed Table 2 of *The Guides Newsletter, Spinal Nerve Impairment* to calculate the L3 nerve root impairment. He derived a class 1 rating for mild motor deficit related to the grade 4 out of 5 hip abduction flexion and adduction, which was within the category of L3 distribution at that table and yielded a left lower extremity default impairment of three percent. Dr. Bingham did not assign appellant a grade modifier for the L3 nerve root under section 17.3a, *Adjustment Grid -- Functional History*, at page 516 and Table 16-6, *Functional History Adjustment -- Lower Extremities*, at page 516, because the A.M.A., *Guides* state at page 516 that a functional history grade modifier should be applied only to the single, highest diagnosis-based impairment. In accordance with this principle, Dr. Bingham found that the motor loss of the L5 nerve root produced the higher rating. He further found that, under section 17.3c, page 518, *Adjustment Grid -- Clinical Studies*, at page 577 and Table 16-8, *Clinical Studies Adjustment -- Lower Extremities* at page 519, appellant should be assigned a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and L3 nerve root pathology. Dr. Brigham found based on this calculation that the net adjustment compared to diagnosis class 1 was a +1, which was a grade D impairment and yielded four percent lower extremity impairment.

Regarding appellant's sensory deficit at the S1 nerve root, Dr. Brigham found a class 1 rating for mild sensory deficit related to the S1 distribution, yielding a one percent lower extremity default impairment under Proposed Table 2 of *The Guides Newsletter, Spinal Nerve Impairment*. He stated that under section 16.3a and Table 16-6 appellant was not assigned a functional history grade modifier because, as noted above, this was already applied to the motor rating for the L5 nerve root. Dr. Bingham then found that, under section 17.3c, page 577, *Adjustment Grid -- Clinical Studies* and Table 16-8, page 519, *Clinical Studies Adjustment -- Lower Extremities* at page 519, appellant should be assigned a grade modifier 2 based on imaging studies confirming the pathology of a disc injury and S1 nerve root pathology. Pursuant to this calculation he found that the net adjustment compared to diagnosis class 1 was a +1, which was a grade D and produced one percent lower extremity impairment. Dr. Bingham determined that these three ratings totaled a 14 percent lower extremity impairment for both lower extremities. Based on this report, OWCP awarded appellant an additional one percent impairment for each lower extremity in its November 14, 2011 decision.

The Board finds that Dr. Brigham, OWCP's medical adviser, properly applied the A.M.A., *Guides* to rate appellant's bilateral lower extremity impairment and that his report constitutes the weight of medical opinion. As noted above, for peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter*"Rating Spinal Nerve Extremity Impairment using the sixth edition"(July/August 2009) is to be applied.[22] Dr. Brigham relied on the July/August 2009 edition of *The Guides Newsletter* and provided a thorough, well-rationalized report in conformance with the applicable tables and protocols of the A.M.A., *Guides* in rendering his impairment rating. The report from Dr. Diamond, in contrast, did not meet the standards for rating lower extremity impairment for appellant's condition set forth in the sixth edition of the A.M.A., *Guides* and the July/August 2009 edition of *The Guides Newsletter*. His report does not provide adequate medical rationale in support of his opinion that appellant is entitled to a 29 percent schedule award for the right and left lower extremity.[23] OWCP properly determined that Dr. Diamond's report did not provide a basis for a schedule award under FECA[24] and that appellant was not entitled to greater than a 14 percent schedule award for the bilateral lower extremities in its November 14, 2011 decision.

Appellant subsequently requested an oral hearing and submitted the April 10, 2012 report from Dr. Cohen. As his report did not include an impairment rating, it does not provide a basis for an additional schedule award. In his appeal to the Board, appellant's attorney reiterates his argument that there is a conflict in the medical evidence between Dr. Diamond and Dr. Brigham regarding the proper degree of impairment to the lower extremities stemming from appellant's accepted lower back conditions. The Board is not persuaded by this argument. The question of whether a claimant is entitled to a schedule award is a medical one. As discussed above Dr. Brigham's November 7, 2011 report, the only impairment rating rendered in conformance with the applicable protocols of the A.M.A., *Guides* represented the weight of the medical evidence in this case. OWCP's hearing representative thoroughly reviewed the medical evidence of record and properly determined that it was not sufficient to establish that appellant had greater permanent impairment of the lower extremities than the 14 percent already awarded. The June 12, 2012 decision of OWCP is affirmed.

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.

[22] *Seesupra note* 16.

[23] *William C. Thomas*, 45 ECAB 591 (1994).

[24] The Board notes that a description of appellant's impairment must be obtained from appellant's physician, which must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations. *See Peter C. Belkind*, 56 ECAB 580, 585 (2005).

CONCLUSION

The Board finds that appellant has no more than a 14 percent permanent impairment of the right lower extremity and a 14 percent permanent impairment of the left lower extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the June 12, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 5, 2013
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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