United States Department of Labor
Employees' Compensation Appeals Board

P.M., Appellant	)	
and	)	**Docket No. 16-0930**
	)	**Issued: August 4, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Monroe, LA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 1, 2016 appellant filed a timely appeal from a January 7, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 33 percent permanent impairment of the left lower extremity and 3 percent permanent impairment of the right lower extremity.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated May 17, 2005, the Board set aside OWCP's April 6 and September 14, 2004 decisions granting appellant a schedule

[1] 5 U.S.C. § 8101 *et seq.*

award for 15 percent permanent impairment of the left lower extremity.[2] It noted that his treating physician diagnosed mild polyneuropathy of the lower extremity by electromyogram (EMG) study, but OWCP's medical adviser had found that appellant was not entitled to an impairment rating for polyneuropathy as it was not an accepted condition. The Board remanded the case for OWCP to determine whether polyneuropathy should be included when calculating the left lower extremity impairment.

On June 22, 2015 an OWCP medical adviser found that appellant had 15 percent permanent impairment due to left ankle arthritis and 12 percent permanent impairment due to polyneuropathy, which he combined to find 25 percent left lower extremity impairment.

In a decision dated July 13, 2005, OWCP granted appellant a schedule award for an additional 10 percent permanent impairment of the left leg, for a total 25 percent impairment.

Appellant, on August 28, 2012, underwent an anterior lumbar fusion at L3-4. He filed a Form CA-7 claim for an increased schedule award on April 25, 2013. Appellant submitted an April 2, 2013 impairment evaluation from Dr. Austin Gleason, III, a Board-certified orthopedic surgeon, finding that he had 12 percent whole person impairment due to his back condition, 20 percent left lower extremity impairment due to patellofemoral arthritis of the knees bilaterally, and 16 percent impairment of the left lower extremity due to problems with his left ankle joint.

On May 13, 2013 an OWCP medical adviser reviewed Dr. Gleason's report and found that appellant was not entitled to a permanent impairment of the spine as it was not a scheduled member. He further determined that Dr. Gleason did not discuss the x-ray findings that he used to evaluate appellant's ankle arthritis and patellofemoral arthritis. The medical adviser recommended that OWCP refer him for a second opinion examination.

On July 29, 2013 OWCP referred appellant to Dr. Jenness D. Courtney, a Board-certified physiatrist, for a second opinion examination. In a report dated August 14, 2013, Dr. Courtney found that appellant had no radiculopathy on examination and thus no impairment of the peripheral nerves of the lower extremity. Citing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he opined that appellant had 20 percent impairment due to ankle arthrodesis and a bilateral 3 percent impairment due to patellofemoral arthritis, which he combined to find 22 percent left lower extremity impairment. Dr. Courtney further found three percent right lower extremity impairment.

Electrodiagnostic studies of the lower extremities performed on November 25, 2013 revealed primarily axonal polyneuropathy.

In an addendum dated December 11, 2013, Dr. Courtney related that nerve conduction studies showed generalized axonal polyneuropathy, but not tarsal tunnel syndrome. He found,

[2] Docket No. 05-473 (issued May 17, 2005). OWCP accepted that on May 22, 2003 appellant, then a 38-year-old automation clerk, sustained an aggravation of lumbar strain, an aggravation of a lumbar herniated disc, an aggravation of bilateral knee osteoarthritis, an aggravation of osteoarthritis of the left ankle, tarsal syndrome of the left ankle, and heterotopic calcification of the left ankle in the performance of duty.

consequently, that appellant did not have additional impairment based on electrodiagnostic studies.

An OWCP medical adviser reviewed Dr. Courtney's report on January 27, 2014 and concurred with his findings.

By decision dated May 15, 2014, OWCP granted appellant a schedule award for 3 percent right lower extremity impairment and an additional 8 percent left lower extremity impairment for a total 33 percent left lower extremity impairment. Appellant appealed to the Board.

By decision dated December 18, 2014, the Board set aside the May 15, 2014 decision.[3] The Board found that the opinion of Dr. Courtney was insufficient to establish the extent of appellant's permanent impairment as he did not identify the x-ray studies used in diagnosing patellofemoral arthritis. The Board further determined that, while Dr. Courtney noted that a nerve conduction study showed sensory and motor axonal polyneuropathy, he did not address whether it caused impairment.[4] The Board remanded the case for OWCP to obtain an opinion regarding the extent of appellant's permanent impairment in accordance with the A.M.A., *Guides*.

OWCP referred appellant on June 2, 2015 to Dr. Douglas C. Brown, a Board-certified orthopedic surgeon, for a second opinion examination.

In a report dated July 7, 2015, Dr. Brown reviewed appellant's history of injury and the medical reports of record. He noted that a nerve conduction showed mild or tarsal tunnel syndrome and polyneuropathy. On examination Dr. Brown found no ankle reflexes and a positive Tinel's sign at the left ankle tarsal tunnel. He further found patellofemoral crepitus of both knees with range of motion of 0 to 135 degrees. Dr. Brown advised that x-rays of the left ankle showed osteoarthritis with joint space narrowing. He diagnosed spondylolisthesis and a surgically repaired herniated disc at L3-4, mild bilateral patellofemoral chondromalacia, a ganglion cyst of the right knee, moderate left ankle arthritis with reduced motion, and left tarsal tunnel syndrome. Citing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), Dr. Brown found 3 percent impairment of each knee, 20 percent impairment of the left ankle due to arthritis, 1 percent impairment due to tarsal tunnel syndrome, and 12 percent whole person impairment arising from a spinal condition.

Dr. Brown provided an addendum report dated August 3, 2015. For the left ankle, he identified the diagnosis as class 2 osteoarthritis using Table 16-2 on page 506, which yielded a default value of 20 percent. Dr. Brown found that appellant had a grade modifier of two for functional history, clinical studies, and physical examination, and thus no adjustment from the default value. For the bilateral knees, he identified the diagnosis as class 1 patellofemoral

[3] Docket No. 14-1437 (issued December 18, 2014).

[4] The Board additionally noted that OWCP medical adviser should have subtracted the total prior left lower extremity impairment in determining the extent of impairment.

chondromalacia using Table 16-3 on page 511, with a default value of three percent. Dr. Brown applied grade modifiers of one for functional history, physical examination, and clinical studies, which yielded no adjustment. He additionally used Table 16-12 on page 536 to find three percent left lower extremity impairment due to peripheral nerve impairment from tarsal tunnel syndrome of the medial plantar nerve. Dr. Brown further determined that appellant had 12 percent whole person impairment using Table 17-4 on page 571, relevant to determining impairments of the spine. He concluded that he had 25 percent lower extremity impairment or 10 percent whole person impairment.

In a supplemental report dated November 18, 2015, Dr. Brown advised that appellant's "ankle had no modifier, the spine had no modifier, [and] the knees also had no modifier." He confirmed the findings from his prior report.

On December 15, 2015 an OWCP medical adviser applied the tables and provisions of the A.M.A., *Guides* to Dr. Brown's clinical findings.[5] He diagnosed status postlumbar fusion at L3-4, bilateral patellofemoral chondromalacia, and left ankle degenerative joint disease. Using Table 16-3 on page 511 of the A.M.A., *Guides*, the medical adviser found that appellant had three percent impairment of each lower extremity due to the identified diagnosis of class 1 patellofemoral chondromalacia. For the left lower extremity, he found an additional impairment of 20 percent due to class 2 degenerative joint disease of the ankle with joint space narrowing, for a combined 22 percent left lower extremity impairment according to the Combined Values Chart. The medical adviser opined that appellant had no neurological deficits bilaterally due to radiculopathy. He noted that FECA did not provide an award for the back or spine. The medical adviser disagreed with Dr. Brown's finding that appellant had one percent impairment due to tarsal tunnel syndrome as he did not "demonstrate any neurologic deficit consistent with tarsal tunnel syndrome…." He concluded that appellant had no more than the previously awarded 33 percent permanent impairment of the left lower extremity and 3 percent permanent impairment of the right lower extremity.

By decision dated January 7, 2016, OWCP denied appellant's claim for an increased schedule award.

On appeal appellant contends that OWCP did not consider whether he had impairment due to polyneuropathy as previously instructed by the Board.

LEGAL PRECEDENT

The schedule award provision of FECA,[6] and its implementing federal regulations,[7] 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,

[5] An OWCP medical adviser reviewed Dr. Brown's opinion on September 25, 2015 and found that it was insufficient to support an impairment rating as he did not provide grade modifiers or explain his conclusions. It appears that the medical adviser did not review Dr. Brown's August 3, 2015 addendum report.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

The sixth edition requires identifying the impairment Class of Diagnosis condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

ANALYSIS

OWCP accepted appellant's claim for an aggravation of lumbar strain, an aggravation of a herniated lumbar disc, an aggravation of bilateral knee osteoarthritis, an aggravation of osteoarthritis of the left ankle, tarsal tunnel syndrome of the left ankle, and a heterotopic calcification of the left ankle as the result of a May 22, 2003 employment injury.

On prior appeal the Board set aside an OWCP schedule award decision granting appellant 15 percent permanent impairment of the left lower extremity. It remanded the case for OWCP to consider whether polyneuropathy of the lower extremity should be included in the impairment rating as either employment related or a preexisting condition.[11]

OWCP, on remand, determined that the medical evidence established that appellant had 15 percent lower extremity impairment due to left ankle arthritis and 12 percent impairment due to polyneuropathy. It granted him a schedule award for an additional 10 percent left lower extremity impairment.

On August 14, 2013 Dr. Courtney, an OWCP referral physician, found that appellant had no peripheral nerve impairment due to his back condition, but had an impairment due to left ankle arthrodesis and bilateral patellofemoral arthritis. An OWCP medical adviser concurred with his findings. Based on Dr. Courtney's opinion, by decision dated May 15, 2014, OWCP granted appellant a schedule award for an additional eight percent left lower extremity impairment and three percent right lower extremity impairment.

On appeal for the second time, the Board found that the opinion of Dr. Courtney was insufficient to support an impairment rating as the physician did not identify the x-rays relied upon or address whether he had an impairment due to polyneuropathy.

---

[8] *Id.* at § 10.404(a).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] A.M.A., *Guides* 494-531.

[11] Preexisting impairments are included in determining the amount of a schedule award for a member of the body that sustained an employment-related impairment. *See Mike E. Reid*, 51 ECAB 543 (2000).

On remand OWCP referred appellant to Dr. Brown for a second opinion examination. Dr. Brown provided a report dated July 7, 2015 and addendum dated August 3, 2015. He reviewed appellant's history of schedule awards for a left ankle and right knee condition as well as polyneuropathy. Dr. Brown noted that a nerve conduction study showed tarsal tunnel syndrome and polyneuropathy and that x-rays revealed osteoarthritis of the left ankle with narrowing of the joint spacing. He diagnosed spondylolisthesis and a repaired herniated disc at L3-4, mild bilateral patellofemoral chondromalacia, a right knee ganglion cyst, moderate left ankle arthritis with loss of motion, and left ankle tarsal tunnel syndrome. Citing the A.M.A., *Guides*, Dr. Brown identified the diagnosis as class 2 osteoarthritis of the ankle using Table 16-2, which yielded a default impairment of 20 percent. He applied grade modifiers of two for functional history, clinical studies, and physical examination, which after using the net adjustment formula yielded no change from the default value.[12] Dr. Brown further identified the diagnosis of bilateral patellofemoral chondromalacia, class 1, which yielded a default value of three percent under Table 16-3. He applied a grade modifier of one for all categories which yielded no adjustment.[13] Dr. Brown found that appellant had three percent impairment left tarsal tunnel syndrome under Table 16-12. He combined the percentages to find 25 percent left lower extremity impairment.

Dr. Brown additionally determined that appellant had 12 percent whole person impairment due to an impairment of the spine under Table 17-4. FECA, however, specifically excludes the back as an organ and, therefore, the back does not come under the provisions for payment of a schedule award.[14] Additionally, FECA does not provide for impairment of the whole person.[15]

An OWCP medical adviser reviewed Dr. Brown's opinion on December 15, 2015 and concurred with his finding of 3 percent bilateral impairment due to chondromalacia of the knees and 20 percent impairment due to degenerative joint disease of the left ankle, for a total of 3 percent permanent impairment of the right lower extremity and 22 percent permanent impairment of the left lower extremity. He noted that there was no evidence of a neurological deficit of the lower extremity due to radiculopathy. The medical adviser further found that there was no objective evidence to support tarsal tunnel syndrome. The Board notes, however, that Dr. Brown found a positive Tinel's sign of the left ankle at the tarsal tunnel. Even with the additional three percent impairment found by Dr. Brown for tarsal tunnel syndrome, however, appellant would not be entitled to an additional schedule award beyond the 33 percent previously awarded for the left lower extremity.

Appellant has not submitted any evidence in accordance with the A.M.A., *Guides* showing more than 33 percent permanent impairment of the left lower extremity and 3 percent

[12] Utilizing the net adjustment formula discussed above, (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (2-2) + (2-2) + (2-2) = 0, yielded a zero adjustment.

[13] (1-1) + (1-1) + (1-1) = 0.

[14] 5 U.S.C. § 8101(19); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[15] *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

impairment of the right lower extremity. Consequently, he has not met his burden to establish an increased schedule award.

On appeal appellant contends that OWCP failed to consider whether he had impairment due to polyneuropathy. OWCP, however, previously awarded him 12 percent lower extremity impairment due to polyneuropathy. Appellant has the burden to establish an increased impairment.[16]

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 Board finds that appellant has no more than 33 percent permanent impairment of the left lower extremity and 3 percent permanent impairment of the right lower extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 7, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 4, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[16] *See D.H.*, 58 ECAB 358 (2007); *Annette M. Dent*, 44 ECAB 403 (1993).