United States Department of Labor
Employees' Compensation Appeals Board

E.P., Appellant	)	
and	)	**Docket No. 16-1154**
	)	**Issued: October 26, 2016**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF PRISONS, Anthony, TX, 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 May 11, 2016 appellant filed a timely appeal from a March 23, 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 established more than six percent permanent impairment of the right lower extremity and six percent permanent impairment of the left lower extremity, for which he received schedule awards.

FACTUAL HISTORY

OWCP accepted that on or before September 2, 2014 appellant, a 50-year-old drug abuse treatment specialist, sustained a lumbar sprain, bilateral lumbosacral root lesions, and bilateral lumbosacral neuritis due to factors of his federal employment. Appellant attributed the

[1] 5 U.S.C. § 8101 *et seq.*

conditions to searching and restraining inmates, moving heavy metal furniture during premises searches, and repetitive running.[2]

Dr. Michael Boone, an attending Board-certified physiatrist, provided a December 16, 2014 report relating appellant's complaints of pain, numbness, and weakness in both legs. Electromyogram (EMG) and nerve conduction velocity (NCV) testing in both legs showed acute, severe, right L5-S1 and left S1 radiculopathy. On January 28, 2015 Dr. Boone diagnosed "very severe degenerative and herniated disc disease with spinal stenosis, neural foraminal stenosis," causing "acute unstable nerve injury in both legs."[3] He opined that repetitive running, heavy lifting, and restraining inmates caused or contributed to the diagnosed conditions.

On June 3, 2015 appellant filed a claim for schedule award (Form CA-7). He submitted a June 3, 2015 report from Dr. Boone, which found that appellant had reached maximum medical improvement (MMI). Dr. Boone noted that, as the spine was not a scheduled member of the body under FECA, he used a method described in the July/August 2009 *The Guides Newsletter* of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, A.M.A., *Guides*). Referring to Table 17-4[4] of the A.M.A., *Guides*, he found a class 2 diagnosis-based impairment Class of Diagnosis (CDX) for a lumbar herniated disc with single-level radiculopathy, equaling 12 percent permanent impairment of the whole person. Dr. Boone then interpreted the 12 percent whole person impairment using Table 16-10 "to get more or less a reverse impairment for the lower extremity which yielded 29 percent."[5] He concluded that appellant had "whole body impairment of 29 percent."[6]

An OWCP medical adviser reviewed Dr. Boone's impairment rating on June 18, 2015. He explained that, while Dr. Boone mentioned the appropriate rating method as described in the July/August 2009 *The Guides Newsletter*, he instead utilized Table 17-4, the lumbar spine regional grid in the A.M.A., *Guides*. The medical adviser therefore found that Dr. Boone's impairment rating was of no probative value as he used an improper rating method. He noted that Dr. Boone's clinical findings lacked "sufficient detail to permit a conversion to a Proposed Table Two impairment rating based on a records review." The medical adviser recommended a second opinion referral to obtain an impairment rating in accordance with the appropriate portions of the A.M.A., *Guides*.

[2] A November 4, 2005 position description confirmed that the drug abuse treatment specialist position entailed regular exposure to "physical hazards and dangerous conditions," and was designated as a law enforcement officer position.

[3] A December 9, 2014 magnetic resonance imaging (MRI) scan showed disc herniations at T8-9 and T9-10, a central disc protrusion at T10-11, and broad-based disc herniations with neural foraminal narrowing at each level from T12 to S1.

[4] Table 17-4, page 570 of the sixth edition of the A.M.A., *Guides* is entitled "Lumbar Spine Regional Grid: Spine Impairments."

[5] Table 16-10, page 530 of the sixth edition of the A.M.A., *Guides* is entitled "Impairment Values Calculated From Lower Extremity Impairment."

[6] Dr. Boone submitted progress notes through December 29, 2015 observing continued bilateral pain, paresthesias, and weakness in the L5 and S1 distributions of both lower extremities.

On July 13, 2015 OWCP referred appellant, the medical record, and a statement of accepted facts (SOAF) to Dr. Joshua P. Herzog, a Board-certified orthopedic surgeon, to obtain a second opinion regarding the percentage of permanent impairment to the lower extremities caused by the accepted lumbar conditions. Dr. Herzog provided a January 21, 2016 report, reviewing the medical record and SOAF. On examination, he found bilaterally positive straight leg raising tests, paraspinal tenderness to palpation from L3 to S1 bilaterally, moderately decreased sensation in the L5 distribution bilaterally, and normal strength throughout both legs. Dr. Herzog diagnosed bilateral L5 radiculopathy and a lumbar strain. He opined that appellant had attained MMI.

Regarding the left leg, Dr. Herzog referred to Proposed Table 2 of the July/August 2009 *The Guides Newsletter*, finding a class 1 CDX for a moderate sensory deficit in the L5 dermatome. He found a grade modifier for functional history (GMFH) of 1, a grade modifier for clinical studies (GMCS) of zero, and no applicable grade modifier for findings on physical examination (GMPE). Applying the net adjustment formula of (GMFH-CDX) + (GMCS-CDX), or (1-1) + (0-1), he found a net adjustment of -1, moving the default grade of C to B, equaling three percent impairment of the left lower extremity. Dr. Herzog found an additional three percent permanent impairment of the left lower extremity due to mild motor deficits in the L5 distribution, using the same tables and equations as he relied on in assessing sensory impairment. Using the Combined Values Chart, Dr. Herzog found six percent permanent impairment of the left lower extremity. He explained that appellant had equivalent findings and test results in the right leg as for the left. Dr. Herzog therefore assessed six percent permanent impairment of the right lower extremity for mild sensory and motor deficits in the L5 dermatome, utilizing the same methods of calculation as for the left leg.

An OWCP medical adviser reviewed Dr. Herzog's impairment rating on March 3, 2016 and concurred with his findings and calculations.

By decision dated March 23, 2016, OWCP issued appellant schedule awards for six percent permanent impairment of each lower extremity, based on Dr. Herzog's opinion. The period of the award ran from January 21 to September 18, 2016.

LEGAL PRECEDENT

The schedule award provision of FECA[7] and its implementing regulations[8] 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

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

appropriate standard for evaluating schedule losses.[9] The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.[10]

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.[11] A schedule award is not payable for the loss, or loss of use, of a part of the body that is not specifically enumerated under FECA.[12] Moreover, neither FECA nor its implementing regulations provides for a schedule award for impairment to the back or to the body as a whole. Furthermore, the back is specifically excluded from the definition of organ under FECA.[13]

Amendments to FECA, passed in 1960, 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.[14] 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 Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009) is to be applied.[15]

ANALYSIS

OWCP accepted that appellant sustained a lumbar sprain, bilateral lumbosacral root lesions, and bilateral lumbosacral neuritis.

Appellant filed a claim for a schedule award on June 3, 2015. In support of his claim, he provided a June 3, 2015 impairment rating from Dr. Boone, a Board-certified physiatrist. Dr. Boone utilized Table 17-4 and 16-10 to calculate a "more or less reverse impairment" of the lower extremities of 29 percent. He also referred to 29 percent whole person permanent impairment. The Board notes, however, that FECA does not authorize schedule awards for

[9] *Id*. *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (January 2010); and Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (January 2010).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

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

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

[13] *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

[14] *Supra* note 12.

[15] *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.

permanent impairment of the whole person.[16] As an OWCP medical adviser explained, Dr. Boone used an improper rating methodology, as he should have relied on Proposed Table 2 of the July/August 2009 *The Guides Newsletter*.

OWCP obtained a second opinion on July 13, 2015 from Dr. Herzog, a Board-certified orthopedic surgeon. Dr. Herzog reviewed the medical record and a SOAF, and provided detailed findings on clinical examination. He observed sensory and motor deficits in the L5 dermatomes bilaterally. Referring to Proposed Table 2 of the July/August 2009 *The Guides Newsletter*, Dr. Herzog found six percent impairment of the left and right lower extremities due to sensory and motor impairment in the L5 dermatome caused by the accepted bilateral lumbosacral nerve conditions. An OWCP medical adviser concurred with Dr. Herzog's impairment rating and his method of calculation.

On March 23, 2016 OWCP issued schedule awards for six percent permanent impairment of each lower extremity, based on Dr. Herzog's impairment rating as the weight of the medical evidence. The Board finds that OWCP properly relied on Dr. Herzog's clinical findings and impairment rating regarding the lower extremities, as reviewed by the medical adviser. His opinion was based on a review of the record and SOAF, as well as a detailed examination. Dr. Herzog applied the appropriate portions of the A.M.A., *Guides* and *The Guides Newsletter* to his clinical findings regarding the lower extremities. OWCP's medical adviser concurred with his assessment. Therefore, OWCP's March 23, 2016 schedule award is proper under the law and facts of this case.

On appeal, appellant contends that OWCP should have relied on Dr. Boone's impairment rating as he was familiar with appellant's condition, and based his opinion on a thorough clinical examination and electrodiagnostic testing results. Appellant alleges that Dr. Herzog did not perform a complete physical examination, and spent only one to three minutes with him. As set forth above, Dr. Boone misapplied the A.M.A., *Guides*, and did not provide sufficiently detailed clinical findings to allow another practitioner to calculate a schedule award. Dr. Herzog provided detailed clinical findings, and applied the appropriate portions of the A.M.A., *Guides* to them.

Appellant may request, at any time, a schedule award or increased schedule, 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 had no more than six percent permanent impairment of the right lower extremity and six percent permanent impairment of the left lower extremity, for which he received schedule awards**.**

[16] *N.D.*, 59 ECAB 344 (2008).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 23, 2016 is affirmed**.**

Issued: October 26, 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