United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 16-0891**
	)	**Issued: December 19, 2017**
DEPARTMENT OF JUSTICE, U.S. MARSHALS SERVICE, Alexandria, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 29, 2016 appellant, through counsel, filed a timely application for review from a February 26, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has more than four percent permanent impairment of his right lower extremity and three percent permanent impairment of his left lower extremity, for which he has received schedule awards.

FACTUAL HISTORY

This case has previously been before the Board.[3] On December 2, 2013 appellant, then a 41-year-old law enforcement officer, filed an occupational disease claim (Form CA-2) alleging that he sustained spondylolisthesis, spondylosis, severe degenerative disc disease, torn discs, and severe foraminal stenosis as a result of duties of his federal employment, including the wearing of body armor weighing over 50 pounds and extreme physical exertion while pursuing and apprehending fugitives and conducting tactical operations. OWCP accepted his claim for occupational disease on April 28, 2014 for aggravation of cervical spondylosis without myelopathy; aggravation of lumbosacral spondylosis without myelopathy; aggravation of unspecified arthropathy; aggravation of degeneration of the lumbar or lumbosacral intervertebral disc; thoracic or lumbosacral neuritis or radiculitis; aggravated-acquired spondylolisthesis; and displacement of the lumbar intervertebral disc without myelopathy.

On May 9, 2014 appellant filed a claim for wage-loss compensation (Form CA-7) for the period November 7, 2013 to January 3, 2014. By decision dated August 6, 2014, OWCP denied his claim for compensation for the period November 7, 2013 through January 3, 2014. It noted that it had not received a request for authorization for a surgery that resulted in absence from work, and found that the evidence of record failed to support disability during the claimed period. Appellant appealed to the Board, in a decision dated April 20, 2015, the Board affirmed OWCP's August 6, 2014 decision, finding that he had not submitted sufficient medical evidence to establish disability for the relevant time frame.[4] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated by reference.

On August 5, 2014 appellant requested a schedule award. In a report dated October 27, 2014, Dr. Neil Allen, a Board-certified neurologist and internist, examined appellant and rated his permanent impairment of the lower extremities as 7 percent for motor impairment and 6 percent for sensory impairment, for a total 13 percent permanent impairment of each lower extremity. He rendered his rating according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Allen used the spinal nerve impairment method of calculating impairment according to proposed Table 2, p.6 of *The Guides Newsletter,* July/August 2009; and Table 15-14, p.425 of the A.M.A., *Guides*. He noted that appellant had a severe sensory deficit at L5, corresponding to a class 1 impairment for the lower extremities, with a default value of six percent. Dr. Allen applied grade modifiers of 1 for functional history and 2 for clinical studies to both the right L5 lumbar nerve root and the left L5 lumbar nerve root. He noted, with regard to appellant's functional history, that appellant's pain disability questionnaire score was 22 and that he reported pain with

[3] Docket No. 14-1925 (issued April 20, 2015).

[4] *Id.*

strenuous activity. Dr. Allen concluded that appellant, therefore, had a grade modifier of 1 for functional history. He also interpreted a magnetic resonance imaging (MRI) scan of appellant's lumbar spine taken on September 17, 2013. With regard to this clinical study, Dr. Allen noted that appellant had mild disc bulging at L4-5; and diffuse disc bulging with annular tearing and mild facet arthropathy at L5-S1. He further noted that an electromyographic clinical study and a nerve conduction velocity (NCV) study on June 18, 2014 revealed evidence of a right L5 radiculopathy. Dr. Allen, therefore, found that appellant had a grade modifier of 2 for clinical studies. He concluded that the grade modifiers increased the grade to a grade D, six percent permanent impairment due to sensory loss. Regarding appellant's L5 motor deficit, Dr. Allen explained that appellant had a mild motor deficit, with an assigned default value of five percent permanent impairment. He noted that, since appellant reported pain with strenuous activity, he qualified for a grade modifier of 1 for functional history. Dr. Allen again noted that appellant's MRI scan and electromyography (EMG) and NCV studies of the L5 nerve root qualified for a grade modifier of 2 for clinical studies. He concluded that appellant default value of five percent was increased to grade D, which resulted in seven percent permanent impairment for motor deficit.

OWCP forwarded Dr. Allen's report along with a statement of accepted facts to a district medical adviser (DMA) for review. In a December 1, 2014 report, the DMA, referring to the A.M.A., *Guides* Newsletter, July/August 2009, agreed with Dr. Allen's grade modifiers and net adjustment for the functional history and clinical studies assigned to the sensory component of the right L5 nerve root. He however related that appellant only had a mild, not moderate L5 sensory loss. The DMA disagreed with Dr. Allen's assignment of a class 1 for the left L5 nerve root, he agreed with Dr. Allen's grade modifier for functional history, but disagreed with the grade modifier for clinical studies, finding a clinical history adjustment of zero was preferable to Dr. Allen's adjustment of 2. He explained that his grade modifier for clinical studies differed from Dr. Allen's because diagnostic studies had revealed no evidence of left-sided L5 nerve root compression. As such, the final net adjustment was -1, with the final grade B and impairment of the left lower extremity of three percent. For the right lower extremity the clinical history adjustment resulted in four percent permanent impairment for mild sensory loss. The final percentage of permanent impairment according to the DMA was four percent for the right lower extremity and three percent for the left lower extremity. Regarding appellant's motor deficit, the DMA concluded however that appellant had zero percent impairment for L5 motor deficit, as he had no significant motor loss. The date of maximum medical improvement was October 2, 2014.

By decision dated May 11, 2015, OWCP granted appellant a schedule award for four percent permanent impairment of the right lower extremity and three percent permanent impairment for the left lower extremity. It noted that the weight of medical evidence rested with its DMA.

On May 18, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. With his request, appellant attached a November 7, 2013 operative report, which had been previously reviewed by OWCP and included in the medical record forwarded to the DMA. In this report, Dr. Edward J. Goldberg, a Board-certified orthopedic surgeon, reviewed the procedures performed on that date of a Gill laminectomy at L3; a left L1-2 hemilaminectomy and discectomy; a posterolateral spinal fusion at L3-4; and a cancellous allograft. He noted that appellant's pre- and postoperative diagnoses were isthmic

spondylolisthesis at L3-4 and a left L1-2 herniated nucleus pulposis. There were no complications.

The hearing was held on January 11, 2016. At the hearing, counsel argued that the DMA in this case has a history of reducing the percentages of impairment based on disagreement with treating physicians' grade modifiers. He alleged that the DMA fabricated the evidence he cited in disagreement with Dr. Allen's grade modifier for clinical studies of the left L5 nerve root. Counsel suggested that the DMA used stale medical evidence in calculating appellant's percentage of impairment.

By decision dated February 26, 2016, the hearing representative affirmed OWCP's May 11, 2015 decision. She found that appellant had not met his burden of proof to establish an additional schedule award. The hearing representative noted that no medical evidence had been received indicating that his impairment had been calculated incorrectly, and that the DMA's report was well reasoned and did not rely on stale medical evidence, but merely reviewed historical documentation to evaluate Dr. Allen's medical findings.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members, functions, and organs of the body. 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 for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[7] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[8] For decisions issued after May 1, 2009, the sixth edition is used to calculate schedule awards.[9] It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included.[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

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[8] *Id.*

[9] FECA Bulletin No. 09-0003 (issued March 15, 2009).

[10] *See Dale B. Larson*, 41 ECAB 481, 490 (1990); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3.a.3 (January 2010). This portion of OWCP's procedure provides that the impairment rating of a given scheduled member should include any preexisting permanent impairment of the same member or function.

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

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 provide 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]

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.[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] The Board has long recognized the discretion of OWCP to adopt and utilize various editions of the A.M.A., *Guides* for assessing permanent impairment.[16] In particular, the Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter,* as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[17]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[18]

ANALYSIS

The Board finds that this case is not in posture for decision.

In a report dated October 27, 2014, Dr. Allen, a Board-certified neurologist and internist, examined appellant and rated his permanent impairment of the lower extremities as 7 percent for

[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 10.

[15] *See G.N.*, Docket No. 10-0850 (issued November 12, 2010); *see also supra* note 10 at Chapter 3.700, Exhibit 1, note 5 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[16] *D.S.*, Docket No. 14-0012 (issued March 18, 2014).

[17] *See E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

[18] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

motor impairment and 6 percent for sensory impairment, for a total of 13 percent lower extremity impairment of each lower extremity. He rendered his rating according to the sixth edition of the A.M.A., *Guides*. Dr. Allen used the spinal nerve impairment method of calculating impairment according to proposed Table 2, p.6 of *The Guides Newsletter*, July/August 2009; and Table 15-14, p.425 of the A.M.A., *Guides*. Significantly, appellant's treating physician determined that appellant had a severe sensory loss at L5, and a mild motor deficit at L5. Dr. Allen applied grade modifiers of 1 for functional history and 2 for clinical studies to both the right L5 lumbar nerve root and the left L5 lumbar nerve root. He noted, with regard to appellant's functional history, that his pain disability questionnaire score was 22 and that he reported pain with strenuous activity. Dr. Allen also interpreted an MRI scan of appellant's lumbar spine taken on September 17, 2013. With regard to this clinical study, he found diffuse disc bulging with annular tearing and mild facet arthropathy at L5-S1. Dr. Allen further noted that an electromyographic clinical study and an NCV on June 18, 2014 revealed evidence of a right L5 radiculopathy.

In a December 1, 2014 report, the DMA stated that appellant only had a mild L5 sensory loss and no L5 motor deficit. He however agreed with Dr. Allen's grade modifiers and net adjustment for functional history of 1 and clinical studies of 2 of the right L5 nerve root. For the left L5 nerve root, the DMA agreed with Dr. Allen's grade modifier for functional history, but disagreed with the grade modifier for clinical studies, finding a clinical history adjustment of zero was preferable to Dr. Allen's adjustment of 2. He explained that his grade modifier for clinical studies differed from Dr. Allen's because diagnostic studies had revealed no evidence of left-sided L5 nerve root compression. As such, the final net adjustment was -1, with the final grade B and impairment of the left lower extremity of three percent. The final percentage of permanent impairment according to the DMA was four percent for the right lower extremity and three percent for the left lower extremity.

The DMA's report, was not based on an examination of appellant, and did not sufficiently explain his conclusion that appellant had only a mild sensory loss and that there was absence of left-sided L5 nerve root compression necessitating a clinical studies grade modifier of zero even in the presence of findings from appellant's MRI scan, EMG and NCV studies of the lumbar spine. The DMA also did not fully explain his conclusion that appellant had no motor deficit, given Dr. Allen's findings that appellant did have pain with strenuous activity. In previous schedule award decisions, the Board has found that a reasoned opinion by an OWCP medical adviser will not usually constitute the weight of the medical evidence in an accepted disability case, even if the medical adviser is a Board-certified specialist in the appropriate field of medicine and the attending physician is not a specialist and offers no rationale. This is because the medical adviser has not examined the claimant while the attending physician has.[19]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[20] As the DMA's report was not well rationalized regarding the degree of appellant's sensory loss and

[19] *M.D.*, Docket No. 16-0207 (issued June 3, 2016).

[20] *See L.T.*, Docket No. 13-1290 (issued December 18, 2013).

motor deficit due to his L5 nerve root compromise, OWCP should prepare a statement of accepted facts and refer him to a second opinion physician for examination and evaluation.

Accordingly, the case is remanded to OWCP for referral to a second opinion physician for consideration as to whether appellant has more than four percent permanent impairment of his right lower extremity and three percent permanent impairment of his left lower extremity. After OWCP has developed the case record consistent with the Board's directive, a *de novo* decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the February 26, 2016 decision of the Office of Workers' Compensation Programs is set aside, and the case remanded for further development consistent with this decision.

Issued: December 19, 2017
Washington, DC

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

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

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