



## ISSUE

The issue is whether appellant met his burden of proof to establish more than 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity, for which he previously received schedule awards.

## FACTUAL HISTORY

On January 13, 1999 appellant, then a 47-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on January 12, 1999 he sustained a low back injury due to lifting at work. He stopped work on January 13, 1999.<sup>3</sup>

OWCP initially accepted appellant's claim for a lumbar strain and later expanded the accepted conditions to include a herniated disc at L4-5.

On January 20, 2000 appellant underwent OWCP-authorized lumbar microlaminotomy and discectomy at L3-4. Additional OWCP-authorized spinal surgery was performed at L4-5 in January 2001.<sup>4</sup>

After development of the medical evidence, OWCP issued an October 13, 2006 decision granting appellant a schedule award for six percent permanent impairment of his right lower extremity. The award ran for 17.28 weeks and was based on an impairment rating derived under the standards of the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5<sup>th</sup> ed. 2001) (A.M.A., *Guides*).

In a report dated May 26, 2015, Dr. Samy F. Bishai, an attending Board-certified orthopedic surgeon, determined that appellant had 24 percent permanent impairment of his left lower extremity and 31 percent permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides* (6<sup>th</sup> ed. 2009). In making his impairment rating, Dr. Bishai used Table 17-4 (Lumbar Spine Regional Grid) beginning on page 570 of the sixth edition.

On July 8, 2015 appellant filed a claim for compensation (Form CA-7) claiming an increased schedule award due to his accepted January 13, 1999 work injury.

OWCP indicated that Dr. Bishai improperly used the Lumbar Spine Regional Grid, rather than *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009) (*The Guides Newsletter*),<sup>5</sup> to evaluate appellant's permanent impairment. In September 2015 OWCP referred appellant to Dr. William Dinenberg, a Board-

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<sup>3</sup> Appellant received continuation of pay and then returned to light-duty work without pay loss. He later returned to regular work.

<sup>4</sup> Appellant previously underwent microlaminectomy and discectomy of L5-S1 on January 4, 1991 due to a nonwork-related condition.

<sup>5</sup> See *infra* notes 15 through 17.

certified orthopedic surgeon, for a second opinion medical examination and impairment rating under the standards of the A.M.A., *Guides*.

In an October 20, 2015 report, Dr. Dinenberg discussed appellant's factual and medical history, including the results of diagnostic testing, and reported the findings of his physical examination of appellant on October 9, 2015. He diagnosed lumbar herniated nucleus pulposus at L4-5, now status post laminectomy and discectomy times two, at L4-5 and L5-S1, and administratively accepted lumbar sprain. Dr. Dinenberg noted that appellant had a positive straight leg raise bilaterally and absent S1 reflex on the right, diminished sensation in the lateral aspect of the right foot and plantar surface of the right foot, and slight weakness on planter flexion on the right. Appellant also had some subjective decreased sensation on the plantar surface medially on the left foot. Dr. Dinenberg found that appellant reached maximum medical improvement on May 26, 2015. He indicated that he needed to obtain electromyogram (EMG) and nerve conduction velocity (NCV) test results before providing an impairment rating.

Dr. Dinenberg arranged for EMG/NCV diagnostic testing to be conducted on November 2, 2015 and the findings of the testing contained an impression of "chronic bilateral L5 and S1 radiculopathies still with evidence of denervation" and "reinnervation patterns and no conclusive electrical evidence of any coexisting peripheral neuropathy in both lower extremities at this time."

In a January 27, 2016 supplemental report, Dr. Dinenberg discussed the November 2, 2015 EMG/NCV findings and determined that appellant had 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity. With respect to the right lower extremity, he noted that, using *The Guides Newsletter*, a moderate sensory deficit in the L5 distribution gave three percent permanent impairment, a mild motor deficit distribution related to the L5 nerve root gave five percent permanent impairment, a moderate S1 sensory deficit gave two percent permanent impairment, and a mild motor deficit associated with the S1 nerve root gave three percent permanent impairment. Dr. Dinenberg noted that totaling these figures gave eight percent permanent impairment for the right L5 motor and sensory deficits and five percent permanent impairment for the right S1 motor and sensory deficits. He combined these values, using the Combined Values Chart of the sixth edition of the A.M.A., *Guides*, to find 13 percent permanent impairment of the right lower extremity. Dr. Dinenberg indicated that, with respect to the left lower extremity, appellant had a mild S1 sensory deficit only seen on examination which gave him one percent permanent impairment of this extremity.

In reports dated February 9 and 25, 2015, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP medical adviser, determined that appellant had 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. He indicated that he had not seen the January 27, 2016 report of Dr. Dinenberg. Dr. Harris advised that he applied the standards of *The Guides Newsletter* and noted that appellant had three percent permanent impairment of his right lower extremity for residual problems with moderate pain/impaired sensation from his right L5 lumbar radiculopathy. He had five percent permanent impairment of his right lower extremity for residual problems with mild motor weakness from his right L5 lumbar radiculopathy. Dr. Harris noted that appellant had two percent permanent

impairment of his right lower extremity for residual problems with moderate pain/impaired sensation from his right S1 lumbar radiculopathy. Appellant had three percent permanent impairment of his right lower extremity for residual problems with mild motor weakness from his right S1 lumbar radiculopathy. Dr. Harris noted that, utilizing the Combined Values Chart of the sixth edition of the A.M.A., *Guides*, appellant had a total permanent impairment of his right lower extremity of 13 percent. Appellant had one percent permanent impairment of his left lower extremity due to mild pain/impaired sensation from his left S1 lumbar radiculopathy.

In a March 17, 2016 decision, OWCP granted appellant a schedule award for one percent permanent impairment of his left lower extremity and an additional seven percent permanent impairment of his right lower extremity. The award was based on the impairment ratings of Dr. Dinenberg and Dr. Harris. Appellant now had been compensated for a total right extremity impairment of 13 percent.

In a May 3, 2016 letter, appellant, through counsel, requested reconsideration of OWCP's March 17, 2016 decision. Counsel argued that there was a conflict in the medical opinion evidence between the February 2016 impairment ratings of Dr. Dinenberg and Dr. Harris, on the one hand, and the impairment rating contained in an April 12, 2016 report of Dr. Bishai.

In an April 12, 2016 report, Dr. Bishai detailed appellant's prior findings on physical examination and diagnostic testing and reported the findings of his physical examination of appellant on that date. He indicated that he felt that appellant had a greater degree of peripheral sensory and motor deficit than found by Dr. Dinenberg. Dr. Bishai determined that the findings on physical examination, combined with the diagnostic testing results, showed a number of motor and sensory deficits associated with the L5 and S1 nerve distributions that were moderate to severe in nature. He noted that he applied the standards of Table 2 of *The Guides Newsletter* to determine that appellant had 24 percent permanent impairment of his left lower extremity and 31 percent permanent impairment of his right lower extremity. Dr. Bishai indicated that, when he calculated the impairment rating for appellant's L5 nerve root radiculopathy on the right side, he found that appellant had a severe sensory deficit giving him 6 percent lower extremity impairment and that he had a severe motor deficit giving him 13 percent lower extremity impairment. He noted that, by combining the two values, he gave appellant 18 percent lower extremity impairment for the right side related to L5 nerve root radiculopathy. As for the radiculopathy of the S1 nerve root on the right side, appellant had severe sensory deficit which gave him 4 percent lower extremity impairment and a severe motor deficit which gave him 13 percent lower extremity impairment. These values were combined using the Combined Values Chart to find a total permanent impairment of the right lower extremity of 31 percent.

With regard to the left side, Dr. Bishai determined that, as for the S1 nerve root radiculopathy on the left side, appellant had moderate sensory deficit which gave him two percent lower extremity impairment. Appellant had moderate motor deficit which gave him eight percent lower extremity impairment. The total impairment rating was obtained by combining the sensory impairment with the motor impairment to give a combined value of 10 percent lower extremity impairment. With regard to the L5 nerve root radiculopathy on the left side, appellant had moderate sensory deficit which gave him 3 percent left lower extremity impairment and he had moderate motor deficit which gave him 13 percent left lower extremity

impairment. These values were combined using the Combined Values Chart to find a total permanent impairment of the left lower extremity of 24 percent.

By decision dated July 21, 2016, OWCP found that appellant did not meet his burden of proof to establish more than 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity. It found that the weight of the medical evidence regarding appellant's permanent impairment rested with the opinion of Dr. Harris and that the April 12, 2016 report of Dr. Bishai was of limited probative value with respect to appellant's permanent impairment.<sup>6</sup>

### **LEGAL PRECEDENT**

The schedule award provision of FECA<sup>7</sup> and its implementing regulations<sup>8</sup> 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.<sup>9</sup> The effective date of the sixth edition of the A.M.A., *Guides* is May 1, 2009.<sup>10</sup>

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.<sup>11</sup> 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.<sup>12</sup> 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.<sup>13</sup>

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

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<sup>6</sup> OWCP noted, "In reviewing Dr. Bishai's follow-up report dated April 12, 2016, essentially the same examination information was presented as in his previous report dated May 26, 2015. The findings were nearly identical with a change in straight leg raising to positive at 30 degrees and sciatic nerve stretching test positive at 30 degrees -- when both of these findings were previously reported at 60 degrees."

<sup>7</sup> 5 U.S.C. § 8107.

<sup>8</sup> 20 C.F.R. § 10.404 (1999).

<sup>9</sup> *Id.*

<sup>10</sup> FECA Bulletin No. 09-03 (issued March 15, 2009).

<sup>11</sup> *Pamela J. Darling*, 49 ECAB 286 (1998).

<sup>12</sup> *Thomas J. Engelhart*, 50 ECAB 319 (1999).

<sup>13</sup> *James E. Mills*, 43 ECAB 215, 219 (1991); *James E. Jenkins*, 39 ECAB 860, 866 (1990).

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.<sup>14</sup>

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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup>

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 grade modifier for Functional History (GMFH) and, if electrodiagnostic testing was done, grade modifier for Clinical Studies (GMCS).<sup>18</sup> The net adjustment formula is (GMFH-CDX) + (GMCS-CDX).<sup>19</sup>

### ANALYSIS

OWCP accepted that on January 13, 1999 appellant sustained a lumbar strain and a herniated disc at L4-5.<sup>20</sup> On October 13, 2006 it granted a schedule award for six percent permanent impairment of his right lower extremity. Appellant later claimed entitlement to additional schedule award compensation due to his January 13, 1999 work injury. On March 17, 2016 OWCP granted him a schedule award for one percent permanent impairment of his left lower extremity and an additional seven percent permanent impairment of his right lower extremity. By decision dated July 21, 2016, OWCP found that appellant did not meet his burden

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<sup>14</sup> *Supra* note 12.

<sup>15</sup> 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.

<sup>16</sup> *D.S.*, Docket No. 14-12 (issued March 18, 2014).

<sup>17</sup> See *E.D.*, Docket No. 13-2024 (issued April 24, 2014); *D.S.*, Docket No. 13-2011 (issued February 18, 2014).

<sup>18</sup> A.M.A., *Guides* 515-21, 533.

<sup>19</sup> *Id.* at 521.

<sup>20</sup> On January 20, 2000 appellant underwent OWCP-authorized lumbar microlaminotomy and discectomy at L3-4. Additional OWCP-authorized spinal surgery was performed at L4-5 in January 2001.

of proof to establish more than 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity.

The Board finds that there is a conflict between the opinions of OWCP's physicians, Dr. Dinenberg and Dr. Harris, and an attending physician, Dr. Bishai, regarding the extent of the permanent impairment of appellant's lower extremities.

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."<sup>21</sup> When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of FECA, to resolve the conflict in the medical evidence.<sup>22</sup>

In a January 27, 2016 report, Dr. Dinenberg determined that appellant had 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity. With respect to the right lower extremity, he noted that, using *The Guides Newsletter*, a moderate sensory deficit in the L5 distribution gave 3 percent permanent impairment, a mild motor deficit distribution related to the L5 nerve root gave 5 percent permanent impairment, a moderate S1 sensory deficit gave 2 percent permanent impairment, and a mild motor deficit associated with the S1 nerve root gave 3 percent permanent impairment. Dr. Dinenberg noted that totaling these figures gave eight percent permanent impairment for the right L5 motor and sensory deficits and five percent permanent impairment for the right S1 motor and sensory deficits. He combined these values, using the Combined Values Chart of the sixth edition of the A.M.A., *Guides*, to find 13 percent permanent impairment of the right lower extremity. Dr. Dinenberg indicated that, with respect to the left lower extremity, appellant had a mild S1 sensory deficit only seen on examination which gave him one percent permanent impairment of this extremity.

In reports dated February 9 and 25, 2015, Dr. Harris, an OWCP medical adviser, determined that appellant had 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity. He advised that he applied the standards of *The Guides Newsletter* and noted that appellant had three percent permanent impairment of his right lower extremity for residual problems with moderate pain/impaired sensation from his right L5 lumbar radiculopathy. Dr. Harris had five percent permanent impairment of his right lower extremity for residual problems with mild motor weakness from his right L5 lumbar radiculopathy. He indicated that appellant had two percent permanent impairment of his right lower extremity for residual problems with moderate pain/impaired sensation from his right S1 lumbar radiculopathy. Appellant had three percent permanent impairment of his right lower extremity for residual problems with mild motor weakness from his right S1 lumbar radiculopathy. Dr. Harris noted that, using the Combined Values Chart, appellant had a total permanent impairment of his right lower extremity of 13 percent. Appellant

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<sup>21</sup> 5 U.S.C. § 8123(a).

<sup>22</sup> *William C. Bush*, 40 ECAB 1064, 1075 (1989).

had one percent permanent impairment of his left lower extremity due to mild pain/impaired sensation from his left S1 lumbar radiculopathy.

In contrast to the opinions of Dr. Dinenberg and Dr. Harris, Dr. Bishai indicated in his April 12, 2016 report that he applied the standards of Table 2 of *The Guides Newsletter* to determine that appellant had 24 percent permanent impairment of his left lower extremity and 31 percent permanent impairment of his right lower extremity. He indicated that he felt that appellant had a greater degree of peripheral sensory and motor deficit than found by Dr. Dinenberg. Dr. Bishai determined that the findings on physical examination, combined with the diagnostic testing results, showed a number of motor and sensory deficits associated with the L5 and S1 nerve distributions that were moderate to severe in nature. He provided various impairment ratings for the right lower extremity due to motor and sensory loss associated with the L5 and S1 nerves. These values were combined, using the Combined Values Chart, to find a total permanent impairment of the right lower extremity of 31 percent. Dr. Bishai also provided various impairment ratings for the left lower extremity due to motor and sensory loss associated with the L5 and S1 nerves. These values were combined, using the Combined Values Chart, to find a total permanent impairment of the left lower extremity of 24 percent.

In its July 21, 2016 decision, OWCP found that Dr. Bishai's April 12, 2016 report was substantially similar to his previously considered May 26, 2015 report. However, Dr. Bishai's April 12, 2016 report documents a technical difference, despite the same clinical results because he provided new examination findings and calculated his impairment rating based on *The Guides Newsletter*, i.e., the appropriate standards for evaluating lower extremity impairment,<sup>23</sup> rather than Table 17-4 (Lumbar Spine Regional Grid) beginning on page 570 of the sixth edition of the A.M.A., *Guides*.

Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence regarding the extent of the permanent impairment of appellant's lower extremities. On remand OWCP should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After carrying out this development, OWCP should issue a *de novo* decision regarding appellant's claim.

### **CONCLUSION**

Due to a conflict in the medical opinion evidence, the case is not in posture for decision regarding whether appellant has more than 1 percent permanent impairment of his left lower extremity and 13 percent permanent impairment of his right lower extremity, for which he previously received schedule awards.

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<sup>23</sup> See *supra* notes 15 through 17.



**ORDER**

**IT IS HEREBY ORDERED THAT** the July 21, 2016 decision of the Office of Workers' Compensation Programs is set aside and remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: May 16, 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