

**United States Department of Labor
Employees' Compensation Appeals Board**

S.C., Appellant)	
)	
and)	Docket No. 17-1173
)	Issued: April 4, 2018
DEPARTMENT OF THE TREASURY,)	
INTERNAL REVENUE SERVICE,)	
Richmond, VA, 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
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 8, 2017 appellant filed a timely appeal from a March 17, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.²

ISSUE

The issue is whether appellant has more than 26 percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

¹ 5 U.S.C. § 8101 *et seq.*

² Appellant filed a timely request for oral argument, pursuant to 20 C.F.R. § 501.5(b). After exercising its discretion pursuant to 20 C.F.R. § 501.5(a) the Board, by a September 22, 2017 order, denied appellant's request because it could adequately address appellant's contentions based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 17-1173 (issued September 22, 2017).

FACTUAL HISTORY

This case has previously been before the Board.³ The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On May 31, 1994 appellant, then a 30-year-old tax examiner, filed a traumatic injury claim injured her left knee and lower back when an elevator malfunctioned while she was performing her duties. She underwent a left knee magnetic resonance imaging (MRI) scan on May 11, 1994 due to an April 10, 1994 motor vehicle accident which showed chondromalacia patella of the left knee.⁴ Appellant underwent left knee arthroscopy with chondroplasty patella and lateral tibial plateau on July 12, 1994. On November 29, 1994 she again underwent arthroscopy of the left knee due to internal derangement, with chondromalacia patellae, and maltracking of the patella with chronic lateral subluxation-dislocation.

OWCP accepted the claim for aggravation of preexisting low back and left knee and left ankle sprain. It entered appellant on the periodic rolls on October 3, 1994.

Appellant underwent an April 30, 1995 MRI scan of the left ankle which showed focal soft tissue edema adjacent to the medial malleolus. A December 22, 2005 MRI scan of the lumbar spine revealed facet joint degenerative changes at L3-4, L4-5, and L5-S1.

By decision dated January 13, 1997, OWCP terminated appellant's wage-loss compensation and medical benefits effective that date. By decision dated February 2, 1998, an OWCP hearing representative affirmed the January 13, 1997 decision. Appellant appealed the February 2, 1998 decision to the Board and, by decision dated March 20, 2000, the Board affirmed the termination of her wage-loss compensation and medical benefits effective January 13, 1997.⁵

A lower extremity nerve conduction velocity (NCV) study dated May 4, 2004 demonstrated electrical evidence of right L4, L5, and S1 radiculopathy and denervation of the right side tibialis anterior and gastrocnemius muscles as well as no response in the posterior tibial motor nerve on the right. Dr. Russell I. Abrams, a neurologist, examined appellant on June 1, 2004 for a May 6, 2004 nonemployment injury. He noted that she was at a store when a worker dropped a large wooden rack on her foot. Dr. Abrams noted appellant's history of left foot drop, headaches, cervical radiculopathy, carpal tunnel syndrome, complex regional pain syndrome (CRPS), and lumbosacral radiculopathy. He also diagnosed right peroneal neuropathy.

On July 2, 2008 appellant requested a schedule award (Form CA-7). By decision dated August 11, 2009, OWCP denied her schedule award claim. On August 15, 2009 counsel requested

³ Docket No. 98-1560 (issued March 20, 2000).

⁴ A July 25, 1994 statement of accepted facts (SOAF) noted that appellant had been involved in a motor vehicle accident on April 10, 1994.

⁵ *Supra* note 2.

an oral hearing. By decision dated December 29, 2009, an OWCP hearing representative affirmed the August 11, 2009 decision.

Appellant inquired about a schedule award on October 29, 2010. She provided an August 4, 2004 NCV study showing electrical evidence of right L4, L5, and S1 radiculopathy and denervation of the right side tibialis anterior and gastrocnemius muscles as well as no response in the posterior tibial motor nerve on the right. Appellant submitted a February 23, 2009 operative report for a tibialis posterior tendon transfer through the interosseous membrane to the dorsum of the left foot, and tendo-achilles lengthening left.

In a letter dated February 18, 2011, OWCP requested additional medical evidence supporting appellant's claim for permanent impairment. In a report dated February 24, 2012, Dr. Gerald E. Dworkin, an osteopath, examined her for schedule award purposes. He noted that appellant's May 31, 1994 injury at work resulted in trauma to her legs and back. Dr. Dworkin reviewed her operative reports dated July 12 and November 29, 1994, and February 23, 2009. He also described an April 16, 2011 contracted left toe extensor tendon surgical release. Dr. Dworkin diagnosed traumatic low back pain consistent with multi-level radiculopathy and left-sided sciatica, chronic chondromalacia of the left knee, left foot drop, and CRPS of the left leg. He determined that appellant had reached maximum medical improvement and applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*),⁶ finding 18 percent permanent impairment for her low back pain, 8 percent permanent impairment for her left knee chondromalacia, 16 percent permanent impairment for her left foot drop was, and 28 percent permanent impairment for CRPS. Dr. Dworkin determined that she had 32 percent permanent impairment of the left leg and 20 percent permanent impairment of the whole person.

Appellant filed a schedule award claim (Form CA-7) on June 21, 2012. On August 13, 2015 OWCP prepared a new SOAF noting her May 31, 1994 employment injury and listing as the only accepted condition aggravation of preexisting lumbar sprain. On September 1, 2015 OWCP's medical adviser reviewed appellant's claim and found that Dr. Dworkin's report was not sufficiently detailed to establish her permanent impairment for schedule award purposes as he failed to provide reference to specific tables of the A.M.A., *Guides*, failed to provide the grade modifiers he relied on in reaching the impairment ratings, failed to utilize the appropriate tables for peripheral nerve injuries, and failed to appropriately apply the reflex sympathetic dystrophy (RSD) provisions. He recommended a second opinion evaluation.

On November 10, 2015 OWCP referred appellant, a SOAF, and a list of specific questions for a second opinion examination with Dr. Lawrence Barr, an osteopath, to assess her permanent impairment for schedule award purposes. In a December 8, 2015 report, Dr. Barr reported her history of dropping 30-feet in an elevator resulting in left knee, ankle, and low back pain. He also noted that appellant had motor vehicle accidents in 1994 and 2011. Dr. Barr reviewed her medical history, including surgeries and diagnostic studies. On physical examination he found shortness of her left foot as well as lack of Achilles or knee jerk reflexes in the left lower extremity. Appellant's right calf measured 46 centimeters, while her left calf was 44 centimeters. Her right

⁶ A.M.A., *Guides* (6th ed. 2009).

ankle was 27 centimeters, while her left ankle was 29.5 centimeters. Appellant had no motion of the left ankle and could not move her toes. She also exhibited decreased sensation on the dorsum of the foot. Appellant's left knee demonstrated parapatellar tenderness with crepitus. Dr. Barr diagnosed lumbar sprain, sprain and contusion of the left knee, and left foot drop. He opined that these conditions were related to appellant's accepted employment injury of May 31, 1994. Dr. Barr found that she had 7 percent permanent impairment of the whole person based on her spine injury, 10 percent permanent impairment of the whole person due to her left knee conditions, and 5 percent permanent impairment of the lower extremity due to her left ankle and foot conditions.

On December 23, 2015 Dr. Barr provided a supplemental report with citations to the A.M.A., *Guides*. He continued to address appellant's spinal impairment through the whole person and referenced page 570 of the A.M.A., *Guides*, Lumbar Spine Regional Grid. Dr. Barr noted that he used pages 510 and 511 of the A.M.A., *Guides*, and that her left knee was a class 1, grade C impairment. He also found that appellant's left ankle and foot drop should be evaluated through Table 16-12, peripheral nerve impairments, page 535 of the A.M.A., *Guides* and result in 30 percent impairment of the whole person.

OWCP amended the SOAF on February 2, 2016 to reflect appellant's accepted conditions of aggravation of preexisting left knee strain, left ankle sprain, and lumbar sprain. OWCP's medical adviser reviewed the record on March 2, 2016 and applied the A.M.A., *Guides*. He found that appellant had 10 percent impairment of the left leg as a result of post-traumatic patella chondromalacia with documented osteochondral fracture.⁷ The medical adviser noted that, to rate her spinal impairment under FECA, it must impact her lower extremity, and must be evaluated under *The Guides Newsletter*, July/August 2009.⁸ He found that appellant had one percent impairment of the left leg due to mild pain and impaired sensation from left L5 lumbar radiculopathy. The medical adviser noted that Dr. Barr's rating of 10 percent whole person impairment for residual problems with the left knee was, in all likelihood, a typographical error as the medical adviser believed he meant 10 percent of the lower extremity due to problems with the left knee. He further found five percent leg impairment for residual left ankle problems following her tendon transfer.⁹ The medical adviser utilized the Combined Values Chart and found that appellant had 26 percent permanent impairment of her left leg.¹⁰

By decision dated May 26, 2016, OWCP granted appellant a schedule award for 26 percent permanent impairment of the left lower extremity. The period of the award was for 74.88 weeks from May 1, 2016 through May 15, 2017. OWCP granted appellant a payment of \$10,241.61 for

⁷ *Id.* at 511, Table 16-3.

⁸ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700 (January 2010) (Exhibits 1, 4).

⁹ A.M.A., *Guides* 501, Table 16-2.

¹⁰ *Id.* at 604.

the period December 8, 2015 through May 15, 2017.¹¹ It informed her that her continuing schedule award payments would be \$1,661.00 every four weeks throughout the remainder of the award period.

On October 2, 2016 OWCP requested that appellant complete a Form CA-1032 for the previous 16 months. It informed her that her checks were generated on a 28-day cycle. OWCP provided the dates of cycle checks for the years 2013 through 2016. The first check cycle listed was for 2013 and covered the period January 13 through February 9, 2013. This information was to inform appellant of the dates that her checks would be issued during the period covered by her schedule award. She completed the CA-1032 form on November 3, 2016.

By decision dated March 17, 2017, OWCP reissued appellant's schedule award decision granting her a schedule award for 26 percent permanent impairment of her left lower extremity. It clarified that the period of the award was from December 8, 2015 through May 15, 2017 and payment from December 8, 2015 through May 28, 2016 was \$10,241.61. Appellant's continuing payment for her schedule award was \$1,661.00 every four weeks through from May 29, 2016 through May 15, 2017.

On appeal appellant contends that the October 2, 2016 Form CA-1032 from OWCP indicated that her schedule award benefits would begin on January 2013.

LEGAL PRECEDENT

The schedule award provision of FECA¹² and its implementing regulations¹³ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.¹⁴

No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.¹⁵ Because neither FECA nor the regulations provide for the payment

¹¹ The record includes a payment in the amount of \$10,241.61 for the period December 8, 2015 through May 28, 2016. OWCP also provided a payment in the amount of \$1,661.00 for the period May 29 through June 25, 2016.

¹² 5 U.S.C. § 8107.

¹³ 20 C.F.R. § 10.404.

¹⁴ For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *supra* note 8 at Chapter 3.700, (January 2010) exhibit 1.

¹⁵ *W.D.*, Docket No. 10-0274 (issued September 3, 2010); *William Edwin Muir*, 27 ECAB 579 (1976).

of a schedule award for the permanent loss of use of whole person or the back or spine,¹⁶ no claimant is entitled to such an award.¹⁷

Amendments to FECA, however, 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. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.¹⁸

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.¹⁹ OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures which memorializes proposed tables outlined in a July/August 2009, *The Guides Newsletter*.²⁰

In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).²¹

ANALYSIS

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

OWCP accepted appellant's May 31, 1994 claim for aggravation of preexisting low back and left knee strains as well as left ankle sprain. Appellant underwent left knee arthroscopy with chondroplasty patella and lateral tibial plateau on July 12, 1994 and on November 29, 1994 she underwent arthroscopy of the left knee due to internal derangement, with chondromalacia patellae, and maltracking of the patella with chronic lateral subluxation-dislocation. She also underwent tibialis posterior tendon transfer through the interosseous membrane to the dorsum of the left foot, and tendo-Achilles lengthening left on February 23, 2009.

Appellant requested a schedule award and submitted medical evidence from Dr. Dworkin diagnosing traumatic low back pain consistent with multi-level radiculopathy and left-sided

¹⁶ FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

¹⁷ *W.D.*, *supra* note 15. *Timothy J. McGuire*, 34 ECAB 189 (1982).

¹⁸ *W.D.*, *supra* note 15. *Rozella L. Skinner*, 37 ECAB 398 (1986).

¹⁹ *Supra* note 14 at Chapter 2.808.5c(3) (February 2013); *supra* note 8 at Chapter 3.700 (January 2010) Exhibit 4.

²⁰ *Supra* note 8.

²¹ A.M.A., *Guides* 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

sciatica, chronic chondromalacia of the left knee, left foot drop, and complex regional pain disorder, RSD of the left lower extremity. Dr. Dworkin indicated that he had applied the A.M.A., *Guides* and found that her low back pain was 18 percent permanent impairment, her left knee chondromalacia was 8 percent permanent impairment, her left foot drop was 16 percent permanent impairment, and her CRPS was 28 percent permanent impairment. He determined that appellant had 32 percent permanent impairment of the left lower extremity and 20 percent permanent impairment of the whole person. FECA, however, does not provide for impairment of the whole person.²² Further, it specifically excludes the back as an organ and, therefore, the back does not come under the provisions for payment of a schedule award.²³ As Dr. Dworkin's did not comport with FECA and did not include correlation with the A.M.A., *Guides*, his report is of little probative value to establish appellant's permanent impairment for schedule award purposes.²⁴

OWCP referred appellant for a second opinion evaluation with Dr. Barr. In his December 8, 2015 report, Dr. Barr diagnosed lumbar sprain, sprain and contusion of the left knee, and left foot drop. He found that appellant had 7 percent permanent impairment of the whole person based on her spine injury, 10 percent permanent impairment of the whole person due to her left knee conditions, and 5 percent permanent impairment of the lower extremity due to her left ankle and foot conditions. Dr. Barr submitted a supplemental report dated December 23, 2015, noting that he used pages 510 and 511 of the A.M.A., *Guides* and that her left knee was a class 1, grade C impairment. He also found that appellant's foot drop should be evaluated through Table 16-12, page 535 of the A.M.A., *Guides* and result in 30 percent impairment of the whole person. Dr. Barr also improperly addressed her permanent impairment in terms of the whole person and failed to provide any explanation of his calculation of appellant's under the A.M.A., *Guides*. This report also lacks the probative value necessary to establish appellant's permanent impairment for schedule award purposes.²⁵

OWCP's medical adviser reviewed the medical evidence of record on March 2, 2016 and found that appellant had one percent permanent impairment of the left lower extremity due to impaired sensation from left L5 lumbar radiculopathy. While the medical adviser properly referenced *The Guides Newsletter*, July/August 2009 for the accepted back strain condition, he summarily concluded that she had one percent permanent impairment of her left leg as it related to the back strain. The medical adviser did not provide any explanation as to how he arrived at his conclusion.²⁶ The same defect is present in the medical adviser's evaluation of appellant's 10 percent permanent impairment of the left leg as a result of post-traumatic patella chondromalacia with documented osteochondral fracture and 5 percent leg impairment for residual problems with her left ankle after her tendon transfer. He did not provide an explanation as to how he arrived at his conclusions, did not provide evaluation of the appropriate grade modifiers, and did not provide

²² V.B., Docket No. 17-1326 (issued October 19, 2017).

²³ *Id.*

²⁴ F.S., Docket No. 16-0783 (issued September 26, 2017).

²⁵ *Id.*

²⁶ T.W., Docket No. 16-0176 (issued January 10, 2018).

application of the lower extremity formula. Thus, the medical adviser's impairment rating on its face is insufficient to establish the degree of appellant's permanent impairment.²⁷

It is well established that proceedings under FECA are not adversarial in nature and that while the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.²⁸ Once OWCP undertook development of the evidence by referring appellant to a second opinion physician and an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.²⁹ The Board will, therefore, set aside OWCP's March 17, 2017 decision and remand the case for clarification of the second opinion report by Dr. Barr. After this and such other development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

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

²⁷ See *Carl J. Cleary*, 57 ECAB 563 (2006) (an opinion which is not based upon the standards adopted by the Board as appropriate for evaluating scheduled losses is of little probative value in determining the extent of permanent impairment).

²⁸ *John J. Carlone*, 41 ECAB 354, 358-60 (1989).

²⁹ *Supra* note 26.

ORDER

IT IS HEREBY ORDERED THAT the March 17, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: April 4, 2018
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