United States Department of Labor
Employees' Compensation Appeals Board

R.J., Appellant	)	
and	)	**Docket No. 17-0721**
	)	**Issued: August 16, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Grand Rapids, MI, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 13, 2017 appellant, through counsel, filed a timely appeal from a November 28, 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 met his burden of proof to establish greater than one percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

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

On July 12, 2005 appellant, then a 35-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that he sustained a herniated disc at L4-5 with annular tear and narrowing of the left L4 form an due to repetitive pushing, pulling, lifting, bending, and twisting while loading and unloading trucks at work. He noted that he first became aware of his claimed condition and its relation to his federal employment on March 9, 2004. OWCP accepted the claim for lumbar disc displacement.[4]

On April 11, 2006 appellant underwent a three-level lumbar fusion from L4 to S1, with new hardware implanted. On July 25, 2014 OWCP expanded the acceptance of the claim to include nervous system complication from a surgically-implanted device.

Appellant returned to modified work, effective August 9, 2006, for four hours a day with restrictions of only occasionally lifting no more than 20 pounds, frequent lifting of up to five pounds, and a sit/stand option with the ability to operate foot controls. He returned to work a four-hour shift on August 10 and 11, 2006 and afterwards stopped working. Appellant returned to work on November 8, 2006 with restrictions of no lifting over 25 pounds, avoid repetitive bending/ lifting/twisting with a sit/stand option. He was separated from the employing establishment on August 23, 2008. A spinal cord stimulator was implanted on April 18, 2009, with revisions on June 12, 2009, June 8, 2012, and October 10, 2014.

On June 12, 2015 appellant filed a claim for a schedule award (Form CA-7).

By development letter dated June 25, 2015, OWCP advised appellant of the information needed to establish his claim for a schedule award. It noted that appellant's case was accepted for: displacement of lumbar intervertebral disc without myelopathy, nervous system complication from a surgically-implanted central nervous system (CNS) device, thoracic or lumbosacral neuritis or radiculitis not otherwise specified. OWCP explained that appellant should submit a narrative

[3] Docket No. 03-2250 (issued January 22, 2004).

[4] OWCP assigned the present claim File No. xxxxxx254. Appellant has a prior occupational disease claim (Form CA-2) filed on July 29, 1998, alleging that he sustained low back pain and numbness radiating down his right leg. OWCP accepted that claim, assigned File No. xxxxxx036, for disc herniation at L5-S1. Appellant underwent lumbar hemilamenctomy at L5-S1 on May 17, 2001. He underwent a second surgery at the L4-5 level on April 11, 2002, unrelated to his federal employment. On November 15, 2005 OWCP administratively combined File Nos. xxxxxx254 and xxxxxx036, with File No. xxxxxx254 serving as the master file.

report and opinion on impairment from his physician based upon a recent examination. It explained that the physician should provide an opinion with regard to whether appellant's condition was fixed or stable and, if so, the date of maximum medical improvement (MMI). OWCP explained that appellant's physician should utilize the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It also indicated that the rating should be expressed in terms of percentage of loss of use of the affected members or functions of the body and not the body as a whole, except for impairment to the lungs. OWCP also explained that if there was more than one method of evaluation in the A.M.A., *Guides*, (*e.g.*, if range of motion (ROM) was used to determine the rating, where the sixth edition recommended a diagnosis-based impairment (DBI), the physician should provide an explanation for the calculation method chosen. Furthermore, it advised that the *Quic*kDASH (Disabilities of the Arm, Shoulder, and Hand) form should be discussed, if utilized. OWCP further explained that, if the treating physician was unwilling or unable to provide the required report, appellant should inform it in writing and if the case met the essential elements for a schedule award claim (work-related permanent condition and a schedule member) and the medical evidence of record was not sufficient to determine permanent impairment, then he would be scheduled to be seen by a second opinion physician. It afforded appellant 30 days to submit the requested evidence.

In a letter dated November 16, 2014, counsel provided additional medical evidence.

In a November 3, 2014 report, Dr. Daniel Mankoff, Board-certified in anesthesiology and a pain management physician, explained that, despite long-term treatment, appellant remained symptomatic. He noted that appellant recently underwent placement of a spinal cord stimulator and had some improvement, however, he remained symptomatic. Dr. Mankoff opined that he believed that appellant reached MMI. He advised that appellant had a chronic condition and as such, he would most likely need some continuing care in the future. Regarding his electromyography (EMG) study, Dr. Mankoff explained that it revealed chronic L5 radiculopathy.

In a July 22, 2015 report, Dr. Mankoff saw appellant, and indicated that he had not been examined since last December. He determined that appellant's overall function had improved, with no changes in bowel or bladder functions. Dr. Mankoff noted that appellant reported increased left leg weakness, and his examination found decreased lordosis, with worsening pain on flexion and extension. Facet signs were negative bilaterally and the sacroiliac joints were nonprovocative bilaterally. No trigger points were identified in the bilateral paralumbar musculature. No edema was seen, and muscle tone was normal. Gait was mildly antalgic, deep tendon reflexes were diminished, and sensation was normal in the bilateral lower extremities. Straight leg raising was negative bilaterally. Dr. Mankoff determined that heel and toe standing on the left was weak.

By letter dated September 4, 2015, counsel submitted a September 2, 2015 impairment rating from Dr. Catherine Watkins Campbell, a Board-certified family practitioner.

[5] A.M.A., *Guides* (6th ed. 2009).

In a September 2, 2015 report, Dr. Watkins Campbell noted appellant's history of injury and treatment.[6] She determined that appellant reached MMI on November 3, 2014, the date of Dr. Mankoff's November 3, 2014 report. Dr. Watkins Campbell noted that the short form McGill pain questionnaire which was designed to assess appellant's emotional and psychological response to their pain, revealed moderate tendencies towards symptom magnification. She assigned a functional history grade modifier of 1 based upon appellant's demonstration of a mildly antalgic gait without the use of assistive devices. Dr. Watkins Campbell provided physical examination findings which included normal heel and toe walking and full squat demonstrated. A mildly antalgic gait was noted, with a normal motor examination in both legs and intact reflexes. Dr. Watkins Campbell found a minimal sensory deficit in the lateral right calf and thigh and spasm in the right gluteus. ROM and circumferences were recorded. Straight leg raising was positive on the right leg but negative on the left leg. Dr. Watkins Campbell selected the physical examination grade modifier as grade 3, based upon a severe sensory deficit, and referenced A.M.A., *Guides,* Table 16-11.[7] She found that the physical examination findings with decreased sensation to sharp/dull pain equated to a grade 3 severity deficit in the right L5 nerve root. Dr. Watkins Campbell determined that there was no atrophy or motor deficit found and reflexes were normal. She explained that the primary rating was thoracic or lumbosacral neuritis or radiculitis of the right L5 nerve root, and cited the July/August 2009 *The Guides Newsletter*. Dr. Watkins Campbell determined that the grade modifier for Functional History (GMFH) was equal to 1 (1-1=0). She indicated that the grade modifier for Clinical Studies (GMCS) was not applicable as the EMG and nerve conduction velocity (NCV) studies were over nine months post-injury. Dr. Watkins Campbell determined that the sensory deficit was severe and qualified for a grade C or six percent right lower extremity impairment. She determined that there was no motor impairment rating based upon the examination findings. Dr. Watkins Campbell provided a worksheet documenting her calculations for the sensory loss of the L5 right nerve root, and assigned no changes to her rating after application of the grade modifiers.

Dr. Watkins Campbell's report was forwarded to the district medical adviser (DMA) for review on October 14, 2015.

In an October 19, 2015 report, the DMA, Dr. Morley Slutsky, Board-certified in occupational medicine, indicated that he had reviewed Dr. Watkins Campbell's report. He explained that the date of MMI was established as the date of her examination. Dr. Slutsky noted that the claim was accepted for a disc displacement at L4-5, and that numerous surgeries at that level and L3-4 and L5-S1 followed. Regarding the right L5 lumbar nerve root, he referred to A.M.A., *Guides* Section 16-4a clinical assessment and grading deficits and Table 16-11.[8] Dr. Slutsky noted the criteria and explained that, if nerve conduction testing was done, there should be at least major sensory nerve conduction block if physical examination was consistent with sensory severity grade 2 and there should be axon loss or no recordable sensory nerve action potential (snap) if physical examination was consistent with sensory grade severity. He explained that clinically, appellant demonstrated normal to decreased sensation in the right L5 distribution.

[6] Dr. Watkins Campbell's history of injury also included that appellant was loading a truck when he slipped on a piece of paper that was on the floor of the truck resulting in a fall. However, she did not indicate the date of the fall.

[7] A.M.A., *Guides* 533.

[8] *Id*. at 532-533.

Dr. Slutsky assigned a value of grade 1 for sensory severity and explained that his assignment was due to significant variance in the findings. He also noted that Dr. Watkins Campbell assigned grade 3. Dr. Slutsky concurred with the net adjustment as indicated by Dr. Watkins Campbell. However, he explained that he arrived at one percent impairment as opposed to the six percent of Dr. Watkins Campbell. Dr. Slutsky noted that no right or left motor or sensory deficits were identified relative to the allowed condition.

Furthermore, Dr. Slutsky noted that appellant's EMG scan and NCV testing from September 16, 2014 demonstrated electrodiagnostic evidence of an old L5 radiculopathy on the right, with evidence of old, minimal axonal loss and no electrodiagnostic evidence of a left lumbosacral plexopathy or mononeuropathy. He explained that on December 2, 2014 a nonantalgic gait was noted, however, appellant's June 24, 2015 sensory examination was normal in both legs. Dr. Slutsky referred to Table 16-11[9] of the A.M.A., *Guides,* for sensory and motor severity and related the criteria for assigning a grade to sensory losses. He explained that NCV testing should have identified a total conduction block if the physical examination was consistent with sensory severity, grade 2 severity. Dr. Slutsky explained that appellant had normal to decreased sensation, and therefore the appropriate value for sensory severity would be grade 1, due to the significant variance. He also considered any potential motor loss in the affected nerve branch, arriving at the same rating as Dr. Watkins Campbell, zero impairment. Regarding a sensory class, Dr. Slutsky referred to the July/August 2009 *The Guides Newsletter,* Table 2, pages 5 to 6 and explained a motor severity placed appellant into class 1 with default grade C equal to 1 percent left extremity impairment. Regarding motor deficit grade, he explained that manual muscle testing involved groups of muscles and depended upon the patient's cooperation and was subject to his or her unconscious control. Dr. Slutsky explained that to be valid, the results should be concordant with other observable pathologic signs and medical evidence, with specifications for measurements and consistency. He concluded that appellant had no significant lower extremity motor loss and found that normal motor testing placed him into class 1, with the final lower extremity equal to zero percent. Regarding a functional history grade modifier, Dr. Slutsky concurred with the rating physician and confirmed that appellant continued with symptoms of a mild antalgic gait not requiring the use of a single gait or external orthotic device for stabilization. He also noted that there was no documentation of a positive Trendelenburg and appellant was not eligible for a grade modifier greater than 1. Dr. Slutsky referred to Table 16-7[10] for physical examination adjustment and explained that that the physical examination modifier was not relevant as the neurologic findings were used to establish the impairment range. He referred to Table 16-8[11] for clinical studies and concurred with the rating physician. Dr. Slutsky explained that the EMG/NCV testing should not be used as it was more than nine months old. He explained that the grade modifier would be 1 and would not affect the final net adjustment. Dr. Slutsky determined that the rating for sensory impairment was equal to 1 and motor impairment was equal to 0. He

[9] *Id.*

[10] *Id*. at 517.

[11] *Id*. at 519.

referred to the Combined Values Chart[12] and determined that appellant was entitled to one percent impairment of the right lower extremity.

By letter dated October 22, 2015, OWCP requested that Dr. Watkins Campbell provide an addendum to address Dr. Slutsky's differing rating, but no response was received.

By decision dated January 20, 2016, OWCP granted appellant a schedule award for one percent permanent impairment of his right upper extremity. The award ran for the period July 14 to August 4, 2015, for a total of 3.12 weeks of compensation.

By letter dated January 28, 2016, appellant requested a telephonic hearing, which was held before an OWCP hearing representative on September 13, 2016.

During the hearing, counsel noted that OWCP's decision indicated that the award was paid to the right upper extremity as opposed to the right lower extremity. He argued that the rating was based on sensory loss, with grading ranging between one and three resulting in the difference in final ratings. Counsel noted that this can be determined by the pinprick test. He argued that the DMA's opinion was diminished because he questioned the consistency of the examination. Counsel argued that her client had several procedures inserting hardware and revising it, and she did not feel he would exaggerate his complaints. He asked that OWCP consider whether Dr. Watkins Campbell's rating of grade 3 was appropriate.

The record remained open for 30 days. However, no comments were received from appellant or the employing establishment.

By decision dated November 28, 2016, OWCP's hearing representative affirmed the January 20, 2016 schedule award decision, as modified. He found that, while OWCP correctly identified the percentage of impairment and the rate of pay, it incorrectly identified the rated member as the right upper extremity, when it was in fact the right lower extremity, as documented both in the award letter and the payment worksheet. The hearing representative explained that this error created a small overpayment of compensation as the award for 1 percent permanent impairment of an arm was 3.12 weeks, whereas the award for 1 percent of a leg was only 2.88 weeks. He noted that counsel argued that there was a change in grade value of the loss rather than the incorrectly identified limb the hearing representative affirmed by January 20, 2016 decision, with respect to the percentage of impairment, but modified the decision to correctly identify the rated member as the right lower extremity, with entitlement to 2.88 weeks of compensation.

LEGAL PRECEDENT

The schedule award provisions of FECA[13] and its implementing regulations[14] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

[12] *Id*. at 604.

[13] *See* 5 U.S.C. § 8101 *et seq*.

[14] 20 C.F.R. § 10.404.

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.[15] The claimant has the burden of proving that the condition for which a schedule award is sought is causally related to his or her employment.[16]

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole.[17] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[18] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.[19] It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. The FECA-approved methodology is premised on evidence of radiculopathy affecting the upper and/or lower extremities. The appropriate tables for rating spinal nerve extremity impairment are incorporated in the Federal (FECA) Procedure Manual.[20]

In addressing lower extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH and if electrodiagnostic testing were done, GMCS.[21] The net adjustment formula is (GMFH-CDX) + (GMCS-CDX).[22]

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[15] Effective May 1, 2009, OWCP began using the A.M.A., *Guides* (6th ed. 2009). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[16] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[17] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[18] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (February 2013).

[19] The methodology and applicable tables were initially published in *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment," Using the Sixth Edition (July/August 2009).

[20] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4. (January 2010).

[21] A.M.A., *Guides* 533.

[22] *Id.* at 521.

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.[23]

ANALYSIS

OWCP accepted that appellant sustained displacement of lumbar intervertebral disc without myelopathy, nervous system complication from a surgically-implanted CNS device, thoracic or lumbosacral neuritis or radiculitis not otherwise specified.

On November 3, 2014 Dr. Mankoff opined that appellant had obtained MMI. On June 12, 2015 appellant filed a claim for a schedule award (Form CA-7).

In a September 2, 2015 report, Dr. Watkins Campbell noted appellant's history of injury and treatment. She also advised that the short form McGill pain questionnaire revealed moderate tendencies towards symptom magnification. Dr. Watkins Campbell determined that appellant reached MMI on November 3, 2014, the date of Dr. Mankoff's report. She also determined that appellant had a six percent permanent impairment to the right lower extremity.

Dr. Slutsky, the DMA, advised that he was in agreement with Dr. Watkins Campbell with regard to her findings. He noted that he had an exception with regard to her findings with regard to the right L5 lumbar nerve root. Dr. Slutsky's conclusion resulted in one percent impairment rating, taking into consideration the discrepancy for the L5 lumbar nerve root. As both the rating physician and the DMA were in agreement with regard to the other findings, the Board will address the discrepancies regarding the right L5 lumbar nerve root.

The Board notes that Dr. Watkins Campbell provided appellant with an impairment rating of six percent based upon the L5 nerve root. Dr. Watkins Campbell found that appellant had decreased sensation to sharp and dull and provided appellant a physical examination grade 3 of severity deficit. She explained that the primary rating was thoracic or lumbosacral neuritis or radiculitis of the right L5 nerve root, and cited the July/August 2009 *The Guides Newsletter*. Dr. Watkins Campbell also referenced Table 16-6[24] for functional history adjustment and Table 16-11.[25] She selected the physical examination grade modifier as grade 3, and explained that her selection was based upon a severe sensory deficit. Dr. Watkins Campbell found that the physical examination findings with decreased sensation to sharp/dull pain equated to a grade 3 severity deficit in the right L5 nerve root. However, the DMA, reviewed Dr. Watkins Campbell's report and explained that he was in agreement with the rating physician with the exception of the rating of a grade 3 severity deficit. Dr. Slutsky explained that nerve conduction testing should have identified a total conduction block if the physical examination was consistent with sensory severity, grade 2 severity. He explained that appellant had normal to decreased sensation, and therefore the appropriate value for sensory severity would be grade 1, due to the significant

[23] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013); *see also L.R.*, Docket No. 14-0674 (issued August 13, 2014).

[24] A.M.A., *Guides* 516.

[25] *Id*. at 533.

variance. The Board also notes that Dr. Watkins Campbell noted that the McGill pain questionnaire revealed moderate tendencies towards symptom magnification. Dr. Slutsky also considered any potential motor loss in the affected nerve branch, arriving at the same rating as Dr. Watkins Campbell, zero impairment. He proceeded to rate appellant and concluded that appellant had no significant lower extremity motor loss and had normal motor testing, which placed him into class 1. Dr. Slutsky utilized the net adjustment formula, and found that a final lower extremity equal to 0 percent.[26] Regarding a functional history grade modifier, he concurred with the rating physician and confirmed that appellant continued with symptoms of a mild antalgic gait not requiring the use of a single gait or external orthotic device for stabilization. Dr. Slutsky also noted that there was no documentation of a positive Trendelenburg and appellant was not eligible for a grade modifier greater than 1. He referred to Table 16-7[27] for physical examination adjustment and explained that that the physical examination modifier was not relevant as the neurologic findings were used to establish the impairment range. Dr. Slutsky referred to Table 16-8[28] for clinical studies and concurred with the rating physician. He explained that the EMG/NCV testing should not be used as it was more than nine months old. Dr. Slutsky explained that the grade modifier would be 1 and would not affect the final net adjustment. He determined that the rating for sensory impairment was equal to 1 and motor impairment was equal to 0, utilizing the net adjustment formula. Dr. Slutsky referred to the Combined Values Chart[29] and determined that appellant was entitled to one percent impairment of the right lower extremity.

By letter dated October 22, 2015, OWCP provided Dr. Watkins Campbell with a copy of Dr. Slutsky's report and requested her comment. However, Dr. Watkins Campbell did not provide a response. As she did not explain how she selected the higher grade, her grade selection was insufficient to be utilized. The Board finds that Dr. Slutsky provided a valid rating in conformance with the A.M.A., *Guides.* The Board finds no evidence demonstrating a greater percentage of impairment using the A.M.A., *Guides*.

Appellant may request a schedule award or increased schedule award at any time 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 not met his burden of proof to establish greater than one percent permanent impairment of the right lower extremity, for which he previously received a schedule award.

[26] *See supra* note 21.

[27] A.M.A., *Guides* 517.

[28] *Id*. at 519.

[29] *Id*. at 604.

ORDER

IT IS HEREBY ORDERED THAT the November 28, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 16, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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