United States Department of Labor
Employees' Compensation Appeals Board

A.G., Appellant	)	
	)	
and	)	**Docket No. 18-0815**
	)	**Issued: January 24, 2019**
DEPARTMENT OF VETERANS AFFAIRS, JESSE BROWN MEDICAL CENTER, Chicago, IL, 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 7, 2018 appellant, through counsel, filed a timely appeal from a September 26, 2017 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 to consider 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 met his burden of proof to establish more than 14 percent permanent impairment of the left lower extremity and 14 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

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

On January 25, 2011 appellant, then a 58-year-old air conditioning equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging that on December 27, 2010 he sustained contusion, groin pull, bruises, and sprain when he slipped on ice and fell. OWCP accepted the claim for a back contusion.[4]

On June 15, 2011 appellant filed a Form CA-1 alleging that on June 8, 2011 he sustained bilateral lumbar and cervical muscle spasms due to moving heavy equipment and materials. OWCP accepted the claim for intervertebral lumbosacral degenerative disc disease and thoracic or lumbosacral radiculitis or neuritis.[5] By letter dated March 9, 2012, it placed appellant on the periodic rolls for temporary total disability.[6]

On March 14, 2016 OWCP received a November 28, 2015 impairment rating from Dr. Anatoly M. Rozman, a Board-certified physiatrist. Dr. Rozman determined that appellant had permanent impairment of his lower extremities using the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[7] He indicated that he used *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment (July/August 2009) (*The Guides Newsletter*) to calculate appellant's bilateral lower extremity impairment based on a diagnosis of bilateral lumbar radiculopathy.

Dr. Rozman found 25 percent permanent impairment of appellant's left lower extremity due to sensory and motor deficits associated with the L4-5 lumbar radiculopathy. He also found 24 percent permanent impairment of appellant's right lower extremity due to sensory and motor deficits associated with the L5-S1 nerve distribution. In reaching this determination for the left

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[3] Docket No. 14-0799 (issued February 3, 2015).

[4] OWCP assigned File No. xxxxxx804.

[5] OWCP assigned File No. xxxxxx094. On September 21, 2011 OWCP File Nos. xxxxxx804 and xxxxxx094 were combined, with the latter as the master file number.

[6] In letters dated March 7 and April 11, 2012, the employing establishment informed OWCP that it had terminated appellant's employment effective November 4, 2011 for cause during the probationary period. By decision dated May 14, 2014, an OWCP hearing representative terminated appellant's wage-loss compensation and medical benefits. By decision dated February 3, 2015, the Board affirmed the termination. *See supra* note 3.

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

lower extremity, Dr. Rozman assigned a grade C for moderate L4 sensory deficit resulting in three percent permanent impairment. Using grade modifiers for a moderate impairment resulted in an adjustment of plus two or five percent left lower extremity permanent impairment for sensory impairment. Dr. Rozman then found an impairment rating of 13 percent based on moderate-to-severe motor deficits and adjusted grade modifier of +2. He found the same impairment rating and adjusted grade modifier for L5 resulting in 18 percent left lower impairment rating. Dr. Rozman noted that the A.M.A., *Guides* "recommends to use just 50 [percent] of the second nerve impairment at the same limb" totaling 25 percent combined left lower extremity permanent impairment for left L4-5 radiculopathy. For the right L5 severe lumbar radiculopathy he found three percent permanent impairment for moderate sensory loss. Applying grade modifiers resulted in an adjustment of plus two or five percent right lower extremity permanent impairment. For moderate S1 sensory loss Dr. Rozman assigned two percent permanent impairment. Applying grade modifiers resulted in an adjustment of plus two or five percent permanent impairment rating. Next Dr. Rozman calculated appellant's motor impairment at L5, which he classed as moderate resulting in 13 percent based on moderate-to-severe motor deficits. He found eight percent permanent impairment for S1 moderate deficits. Applying grade modifiers resulted in an adjustment of +2 or 10 percent permanent impairment. Dr. Rozman found 18 percent permanent impairment for the L5 nerve root based on 5 percent impairment for sensory loss and 13 percent impairment for motor loss. He determined that appellant had 13 percent permanent impairment for the S1 nerve root based on 3 percent sensory loss and 10 percent motor impairment. However, using 50 percent for second nerve damage of the same limb at L5 resulted in a final 24 percent impairment rating for the right lower extremity. Using the Combined Values Chart at page 604 he determined that appellant had a total 46 percent permanent impairment of his lower extremities.

On March 21, 2016 appellant filed a claim for a schedule award (Form CA 7).

In a September 8, 2016 report, Dr. Todd Fellars, an orthopedic surgeon, acting as OWCP's district medical adviser reviewed a statement of accepted facts (SOAF) and medical records, and thereafter determined that appellant had 15 percent total lower extremity permanent impairment using Table 2 as set forth in the July/August 2009 *The Guides Newsletter*. He found appellant had a baseline three percent impairment for both L4-5 and L5-S1 moderate sensory impairment. Dr. Fellars then adjusted based on grade modifiers, which resulted in four percent permanent impairment for L4-5 and two percent impairment for L5-S1. Using Table 16-11, page 533, he found five percent impairment for L4-5 and L5-S1 motor weakness. Applying the grade modifiers resulted in seven percent permanent impairment for L5 and two percent permanent impairment for S1. Using Appendix A, page 603 resulted in 15 percent total lower extremity permanent impairment. Dr. Fellars disagreed with Dr. Rozman regarding weakness as he concluded that appellant had a mild weakness and not moderate. He also found the date of maximum medical improvement to be November 28, 2015, the date of Dr. Rozman's impairment rating.

On September 23, 2016 OWCP received a March 8, 2016 magnetic resonance imaging (MRI) scan reporting mild L2-3 and L3-4 bilateral foraminal stenosis, moderate L4-5 bilateral foraminal stenosis, mild-to-moderate L5-S1 bilateral foraminal stenosis, and possible acute arachnoiditis.

On October 31, 2016 OWCP received a September 19, 2016 supplemental report from Dr. Fellars dated September 19, 2016 in which he concluded that appellant had a total of 14 percent

right lower extremity permanent impairment and 14 percent left lower extremity permanent impairment. Applying Table 2 as set forth in the July/August 2009 *The Guides Newsletter*, Dr. Fellars determined that appellant had a class 1 impairment for moderate sensory loss for left L4-5 and right L5-S1 and bilateral plantar flexion and dorsiflexion weakness, which would equal three percent permanent impairment of the left lower extremity and three percent permanent impairment of the right lower extremity. He calculated grade modifiers resulting in an adjustment of plus one, resulting in four percent permanent impairment for sensory loss for L4-5 and four percent permanent impairment for sensory loss for L5-S1. Next, Dr. Fellars calculated motor weakness using Table 16-11, p. 533 to find 5 percent impairment for bilateral L4-5 (equaling 10 percent), and 5 percent for bilateral L5-S1. He explained that combining these two values yielded a total permanent impairment of the left lower extremity of 14 percent and 14 percent permanent impairment of the right lower extremity or total 26 percent lower extremity permanent impairment.

By decision dated January 19, 2017, OWCP granted appellant a schedule award for 14 percent permanent impairment of his right lower extremity and 14 percent permanent impairment of his left lower extremity. The award covered a period of 80.64 weeks and ran from November 28, 2015 to June 14, 2017.

On January 25, 2017 counsel requested a telephonic hearing before a hearing representative, which was held on July 13, 2017.

In a July 14, 2017 report, Dr. Rozman indicated that his impairment rating had not changed based on accepted conditions of lumbosacral intervertebral disc and thoracic or lumbosacral radiculitis or neuritis. He reviewed a March 8, 2016 MRI scan which showed moderate bilateral L4-5 foraminal stenosis, moderate L5-S1 foraminal stenosis, and L5-S1 descending nerve root position peripheral to the thecal sac as the result of arachnoiditis/inflammatory changes. Dr. Rozman found no change in his permanent impairment rating.

By decision dated September 26, 2017, OWCP's hearing representative affirmed the January 19, 2017 schedule award determination.

LEGAL PRECEDENT

Under section 8107 of FECA[8] and section 10.404 of the implementing federal regulations,[9] schedule awards are payable for permanent impairment of specified body members, functions, or organs. FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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.[10]

[8] 5 U.S.C. § 8107.

[9] 20 C.F.R. § 10.404.

[10] *D.J.*, 59 ECAB 620 (2008); *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

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.[11] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[12] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment.[13] 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.[14]

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 functional history (GMFH) and if electrodiagnostic testing were done, grade modifier based on clinical studies (GMCS).[15] The net adjustment formula is (GMFH-CDX) + (GMCS-CDX).[16]

FECA provides that if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[17] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[18] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[19]

ANALYSIS

The Board finds that this case is not in posture for decision as an unresolved conflict remains in the medical opinion evidence between the opinions of OWCP's DMA, Dr. Fellars, and

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[11] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo,* 51 ECAB 361, 367 (2000).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(c)(3) (March 2017).

[13] The methodology and applicable tables were initially published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment, using the sixth edition (July/August 2009).

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

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

[16] *Id.* at 521.

[17] 5 U.S.C. § 8123(a); *see also A.R.,* Docket No. 18-0632 (issued October 19, 2018).

[18] *See C.H.,* Docket No. 18-1065 (issued November 29, 2018).

[19] *Id.*

Dr. Rozman, appellant's treating physician, regarding the percentage of permanent impairment of appellant's lower extremities. This conflict requires referral to an impartial medical examiner.

In his November 28, 2015 report, Dr. Rozman opined that based on *The Guides Newsletter*, Table 2, for spinal nerve impairment of the lower extremity, appellant's base grade for L4-5 radiculopathy was increased by applying grade modifiers. He thereafter determined that appellant had 25 percent permanent impairment of the left lower extremity for left L4-5 radiculopathy. For the right L5-S1 severe lumbar radiculopathy, Dr. Rozman determined that appellant had 24 percent permanent impairment for sensory and motor loss. He found a total 46 percent lower extremity permanent impairment using the Combined Values Chart on page 604. In a July 14, 2017 report, Dr. Rozman reviewed a March 8, 2016 MRI scan and reiterated his impairment rating of 46 percent for both lower extremities.

OWCP referred Dr. Rozman's November 28, 2015 report to Dr. Fellars, the DMA for OWCP, who disagreed with Dr. Rozman's impairment rating. Dr. Fellars concluded that appellant had 14 percent left lower extremity permanent impairment and 14 percent right lower extremity permanent impairment. Using the Combined Values Chart he arrived at a total of 26 percent permanent impairment of the lower extremities. Dr. Fellars disagreed with Dr. Rozman's application of grade modifiers and impairment rating, for example he explained that the grade modifiers Dr. Rozman applied should be modified for lower functional history and clinical studies adjustments. He also opined that appellant had mild motor weakness, not moderate/severe, and therefore appellant's baseline impairment for motor weakness was 5 percent, not 13 percent.

As noted above, if there is disagreement between an employee's physician and an OWCP referral physician, OWCP will appoint a referee physician or impartial medical specialist who shall make an examination.[20] As there is an unresolved conflict in the medical evidence regarding the extent of the permanent impairment of his bilateral lower extremities due to his accepted conditions, the case must be remanded to OWCP for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence in accordance with 5 U.S.C. § 8123(a). After such further 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.

[20] 5 U.S.C. § 8123(a); *see G.W.*, Docket No. 17-0957 (issued June 19, 2017); *R.S.,* Docket No. 10-1704 (issued May 13, 2011); *S.T.,* Docket No. 08-1675 (issued May 4, 2009).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 26, 2017 is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: January 24, 2019
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