United States Department of Labor
Employees' Compensation Appeals Board

A.R., Appellant	)	
and	)	**Docket No. 19-0250**
	)	**Issued: May 6, 2019**
U.S. POSTAL SERVICE, CUPEY STATION, San Juan, PR, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 1, 2018 appellant filed a timely appeal from a September 25, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[1]

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 16 percent permanent impairment of each lower extremity, for which he previously received schedule award compensation.

[1] Together with his appeal request, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated March 13, 2019, the Board exercised its discretion and denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 19-0250 (issued March 13, 2019).

FACTUAL HISTORY

On October 15, 2013 appellant, then a 44-year-old letter carrier, filed an occupational disease claim (Form CA-2) alleging lower extremity injuries resulting from the performance of his federal duties. He noted that he first became aware of his claimed condition on August 10, 2001 and related it to his federal employment on September 17, 2013. Appellant stopped work on August 10, 2001.

OWCP, by decision dated January 27, 2015, accepted appellant's claim for aggravation displacement of lumbar intervertebral disc without myelopathy, aggravation of bilateral thoracic or lumbosacral neuritis or radiculitis not otherwise specified, aggravation of degeneration of cervical intervertebral disc, other internal derangement of the right knee, and aggravation of osteoarthrosis unspecified of the right lower leg.

On August 31, 2015 appellant filed a claim for a schedule award (Form CA-7) due to his accepted employment injuries. In support of his claim, he submitted an April 10, 2015 report from Dr. Samy F. Bishai, an attending orthopedic surgeon. Dr. Bishai diagnosed herniated lumbar disc at L5-S1, bilateral radiculopathy of the lower extremities, more severe left side, degenerative disc disease of the lumbar and cervical spines, internal derangement of the right knee joint, and degenerative arthritis of the right and left hip joints. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*) and determined that appellant had 16 percent permanent impairment of the left lower extremity due to radiculopathy of the L5 nerve root on the left side. Dr. Bishai found that he had reached maximum medical improvement (MMI) on April 10, 2015, the date of his examination.

On November 2, 2015 OWCP routed Dr. Bishai's report, a statement of accepted facts (SOAF), and the case file to Dr. Henry J. Magliato, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for review and a determination of permanent impairment of the left lower extremity and the date of MMI.

In a November 13, 2015 report, Dr. Magliato noted deficiencies in Dr. Bishai's report including that he had not specifically identified the nerve roots or peripheral nerves and class placement used to calculate his left lower extremity impairment ratings. He also did not rate impairment of appellant's right lower extremity, although he mentioned right-sided radiculopathy, which was not as severe as the left side, in his report. Dr. Magliato recommended that OWCP obtain an addendum report from Dr. Bishai containing a detailed description of the nerve roots or peripheral nerves used to calculate his impairment rating and an evaluation of appellant's right lower extremity permanent impairment.

By letter dated March 18, 2016, OWCP requested that Dr. Bishai review Dr. Magliato's report and provide an addendum report within 30 days.

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

Dr. Bishai, in an addendum report dated April 5, 2016, reiterated the findings set forth in his prior April 10, 2015 report. He advised that appellant's condition had not changed a great deal since his last examination. Dr. Bishai again determined that he had reached MMI as of April 10, 2015. He advised that he would provide a revised impairment rating based on appellant's bilateral lower extremity radiculopathy, the only condition for which he had reached MMI, after reviewing all the medical records related to his condition.

In an additional addendum report dated April 6, 2016, Dr. Bishai again reiterated the findings set forth in his April 10, 2015 report and utilized the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* for calculating permanent impairment of appellant's bilateral lower extremities. He reiterated that appellant had a class 2 impairment for bilateral lower extremity radiculopathy at the L5 nerve root under Table 17-4 on page 570. Dr. Bishai assigned a grade modifier of 2 for functional history (GMFH) because appellant had pain with normal activity. He assigned a grade modifier of 2 for physical examination (GMPE) because appellant had a positive straight leg raising test bilaterally. Dr. Bishai assigned a grade modifier of 2 for clinical studies (GMCS) as electromyogram/nerve conduction velocity (EMG/NCV) studies and a magnetic resonance imaging (MRI) scan of the lumbar spine were positive. He applied the net adjustment formula of (GMFH - CDX) (2-2) + (GMPE - CDX) (2-2) + (GMCS - CDX) (2-2) to find a net adjustment of 0 or grade C. Dr. Bishai determined that appellant had moderate sensory deficit at grade C which yielded a finding of three percent lower extremity impairment. He further determined appellant had a moderate motor power deficit at grade C which yielded 13 percent lower extremity impairment. Dr. Bishai combined these values to conclude that he had a total of 16 percent permanent impairment of each lower extremity due to radiculopathy of the L5 nerve root on the right and left sides.

On May 2, 2016 Dr. Magliato referred to *The Guides Newsletter* and agreed with Dr. Bishai's assessment that appellant had 16 percent permanent impairment of each lower extremity. He also determined that appellant had no permanent impairment of his bilateral upper extremities. Dr. Magliato advised that appellant had reached MMI on April 6, 2016, the date of Dr. Bishai's examination.

OWCP, by decision dated August 25, 2016, granted appellant a schedule award for 16 percent permanent impairment of each lower extremity. The period of the award ran for 92.16 weeks for the period April 6 through January 11, 2016, and was based on the opinions of Dr. Bishai and Dr. Magliato.[3]

On March 23, 2018 appellant filed a claim for an increased schedule award (Form CA-7) due to his accepted employment injuries.

OWCP subsequently received a March 8, 2018 report by Dr. Mark A. Seldes, a Board-certified family practitioner. Dr. Seldes reviewed appellant's medical records, examined him, and provided physical and neurological examination findings. He diagnosed herniated lumbar disc at L5-S1, bilateral radiculopathy of the lower extremities, greater on the left side, degenerative disc

[3] On September 2, 2016 OWCP reissued the August 25, 2016 schedule award decision to reflect that the period of the award ran from April 6, 2016 through January 11, 2018. It paid the schedule award compensation in the amount of $14,598.26.

disease of the lumbar and cervical spines, patellofemoral syndrome of the right knee joint, and degenerative arthritis of the right and left knee joints. Dr. Seldes used the diagnosis-based impairment (DBI) rating method of the sixth edition of the A.M.A., *Guides* to calculate appellant's right lower extremity permanent impairment. He found that, under Table 16-3, page 509, a diagnosis of muscle/tendon strain of tendinitis with moderate motion deficits represented a class 1 impairment. Dr. Seldes assigned a grade modifier of 2 for GMFH under Table 16-7, page 516 due to an antalgic limp with asymmetric shortened stance and appellant's routine use of a cane that he used on the day of his examination. He assigned a grade modifier of 2 for GMPE due to a moderate reduction in appellant's range of motion (ROM). Dr. Seldes did not assign a GMCS. He applied the net adjustment formula of (GMFH - CDX) (2-1) + (GMPE - CDX) (2-1) to find a net adjustment of 3 or grade E. Dr. Seldes again referenced Table 16-3 and found that, under the diagnosis of strain, tendinitis with moderate motion deficits and/or significant weakness represented a grade E or 13 percent permanent impairment of the right lower extremity. He also used the ROM methodology to rate appellant's right lower extremity impairment. Using Table 16-3, page 549, Table 16-25, page 550, and Table 2-1, page 20, Dr. Seldes calculated 30 percent permanent impairment of the right lower extremity. He, therefore, concluded that appellant had 30 percent impairment of the right lower extremity, as the ROM method provided a higher impairment rating than the DBI method. Dr. Seldes determined that appellant had reached MMI on the date of his examination.

In a development letter dated March 29, 2018, OWCP requested that appellant submit a report from his physician regarding his work-related condition in accordance with the sixth edition of the A.M.A., *Guides*. It advised that if appellant's work-related injuries impaired his extremities caused by an injury to the spinal nerve then the physician should render an impairment rating of the affected extremity using *The Guides Newsletter*.

Appellant resubmitted Dr. Seldes' March 8, 2018 report in response to OWCP's development letter.

OWCP, on June 22, 2018, routed Dr. Seldes' report, a SOAF, the case file, and a set of questions, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP DMA, for review and a determination of permanent impairment of the bilateral lower extremities.

In a June 29, 2018 report, the DMA reviewed the medical record and Dr. Seldes' March 8, 2018 report. He noted that the medical record established a diagnosis of right knee strain. The DMA disagreed with Dr. Seldes' 30 percent bilateral lower extremity impairment rating as it was based on the ROM method. He explained that the sixth edition of the A.M.A., *Guides* did not allow for an impairment rating based on the ROM method for appellant's diagnosed condition. The DMA noted that diagnoses in the particular regional grids that may alternatively be rated using the ROM methodology were followed by an asterisk. He advised that the diagnosis of right knee strain was not followed by an asterisk. The DMA referenced appellant's previous schedule awards for 16 percent permanent impairment of each lower extremity and concluded that, based on the above, he had no increased bilateral lower extremity permanent impairment.

By decision dated September 25, 2018, OWCP denied appellant's claim for an additional schedule award based on the opinion of the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA,[4] and its implementing federal regulations,[5] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[8] In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[9] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the grade modifier for functional history (GMFH), grade modifier for physical examination (GMPE), and grade modifier for clinical studies (GMCS). The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[10] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[11]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and extent of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[12]

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id*. at § 10.404(a).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[8] A.M.A., *Guides* (6th ed. 2009), page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[9] *Id.* at 509, Table 16-3.

[10] *Id.* at 515-22.

[11] *Id.* at 23-28.

[12] *See supra* note 7 at Chapter 2.808.6(f) (March 2017).

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 16 percent permanent impairment of each lower extremity, for which he previously received schedule award compensation.

OWCP accepted appellant's claim for aggravation displacement of lumbar intervertebral disc without myelopathy, aggravation of bilateral thoracic or lumbosacral neuritis or radiculitis not otherwise specified, aggravation of degeneration of cervical intervertebral disc, other internal derangement of the right knee, and aggravation of osteoarthrosis unspecified of the right lower leg. By decision dated August 25, 2016, it granted him schedule award compensation for 16 percent permanent impairment of each lower extremity. On March 23, 2018 appellant filed a claim for an increased schedule award due to his accepted employment injuries.

Appellant's physician, Dr. Seldes, utilized the DBI method to rate appellant's right lower extremity impairment. Utilizing Table 16-3, page 509, Table 16-7, page 516 of the sixth edition of the A.M.A., *Guides*, he determined that appellant had 13 percent permanent impairment of the right lower extremity due to muscle/tendon strain of tendinitis with moderate motion deficits. Dr. Seldes also used the ROM method to rate appellant's right lower extremity impairment. Using Table 16-3, page 549, Table 16-25, page 550, and Table 2-1, page 20, he determined that appellant had 30 percent impairment of the right lower extremity. Dr. Seldes concluded that appellant had 30 percent impairment of the right lower extremity, as the ROM method provided a higher impairment rating than the DBI method.

Dr. Harris, a DMA, disagreed with Dr. Seldes' impairment rating because it was based on the ROM method. He correctly opined that the ROM rating method was not available as an alternative to the DBI rating method because appellant's diagnosis of right knee strain was not eligible for ROM rating method under the A.M.A., *Guides*.[13] The DMA referenced appellant's previous schedule award compensation for 16 percent permanent impairment of each lower extremity, which is higher than Dr. Seldes' 13 percent right lower extremity permanent impairment rating based on the DBI methodology. He maintained that, based on the above, appellant had no increased bilateral lower extremity permanent impairment.

The Board finds that the DMA properly applied the A.M.A., *Guides* to find that appellant had no more than 16 percent permanent impairment of each lower extremity, for which he previously received schedule award compensation. As such, appellant has not met his burden of proof to establish increased permanent impairment greater than what was previously awarded.

On appeal appellant contends that he is entitled to an increased schedule award for his right knee. For the reasons discussed above, he has not established entitlement to a greater schedule award.

[13] *See* A.M.A., *Guides* 543.

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 more than 16 percent permanent impairment of each lower extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the September 25, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 6, 2019
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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