United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
and	)	**Docket No. 19-1793**
	)	**Issued: August 7, 2020**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Hollywood, FL, 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, Deputy Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On August 27, 2019 appellant, through counsel, filed a timely appeal from a May 22, 2019 merit decision of the Office of Workers' Compensation Programs. 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 cleft lower extremityction 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.*

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish greater than one percent permanent impairment of his left upper extremity, for which he previously received a schedule award; and (2) whether appellant has met his burden of proof to establish any permanent impairment of his right lower extremity or greater than one percent permanent impairment of his left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On December 14, 2015 appellant, then a 44-year-old transportation security officer, filed a traumatic injury claim (Form CA-1) alleging that on December 12, 2015 he sustained injuries to his left side and back when his right foot caught and he fell when dismounting from his stool while in the performance of duty. On February 1, 2016 OWCP accepted the claim for left shoulder joint sprain, lower back and pelvis contusion, and strain of the muscle, fascia, and tendons of the lower back.

In a report dated January 5, 2018, Dr. Stuart B. Krost, Board-certified in physical medicine and rehabilitation, reviewed appellant's history of injury and the medical record, noting that a magnetic resonance imaging (MRI) scan had demonstrated mild narrowing at L2-3, central herniation with mild spondylosis, mild facet arthropathy with mild lateral recess narrowing at L2-3 and L3-4, central herniation with annular fissure at L4-5, and central canal and lateral recess stenosis. On examination of the lower extremities, he noted decreased sensory function at the left lower extremity at the L5 dermatomal distribution. On examination of the upper extremities, Dr. Krost observed mild palpable tenderness at the left shoulder girdle, guarding of the left shoulder on internal and external rotation secondary to pain, and motor control at 4+/5 of the left proximal upper extremity secondary to pain.

Referring to the sixth edition American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] Table 15-5, Dr. Krost determined that the diagnosis of left shoulder sprain, resulted in a default permanent impairment rating of 1 percent. He noted that the class of diagnosis (CDX) of the shoulder diagnosis was 1. Dr. Krost noted a grade modifier for functional history (GMFH) of 1 based on a mild problem of pain with vigorous activity, a grade modifier for physical examination (GMPE) of 1, and a grade modifier for clinical studies (GMCS) of 1. The net adjustment was zero, resulting in the default permanent impairment rating of 1 percent for the left shoulder condition. Referring to Table 17-4 of the A.M.A., *Guides*, Dr. Krost determined that the diagnosis of lumbar disc herniation with chronic left L5 radiculopathy, which resulted in a default permanent impairment of 12 percent. He then noted that the CDX for the lumbar diagnosis was 2, with a GMFH of 2 for a moderate pain with normal activity, a GMPE of 2 for diminished sensory examinations in appropriate distributions interfering with activity, and an inapplicable GMCS. The net adjustment for was zero, resulting in 12 percent permanent impairment of the lumbar spine.

On February 28, 2018 appellant filed a claim for a schedule award (Form CA-7).

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

In a development letter dated March 5, 2018, OWCP informed appellant that the medical evidence of record was insufficient to support his claim because a schedule award could not be paid for permanent impairment of the spine. It explained, however, that such award could be made for permanent impairment of the upper or lower extremities caused by an injury to a spinal nerve. OWCP requested that appellant submit additional medical evidence to support his schedule award claim pursuant to the A.M.A., *Guides*[4] and *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*). It afforded him 30 days to submit this evidence.

On March 30, 2018 OWCP referred the record to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), and requested that he evaluate appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. In a report dated March 29, 2018, Dr. Harris reviewed the medical record, including the report of Dr. Krost. He found that diagnoses of left shoulder contusion and strain, disc herniation at L4-5, and lumbar radiculopathy had been established. Using the diagnosis-based impairment (DBI) method with reference to appellant's left shoulder condition, Dr. Harris found that, under the sixth edition of the A.M.A., *Guides*, Table 15-5, page 401, appellant had one percent upper extremity impairment for residual problems from a shoulder strain injury. He noted that, as there was no documented loss of range of motion (ROM), appellant would have zero percent impairment based on the ROM method, and that as such the DBI method resulted in greater impairment. With reference to appellant's right lower extremity condition, Dr. Harris referred to *The Guides Newsletter*. He noted that, as appellant had no neurologic deficit in the right lower extremity consistent with lumbar radiculopathy, appellant had zero percent permanent impairment of the right lower extremity. With reference to appellant's left lower extremity, Dr. Harris referred again to *The Guides Newsletter*, finding that appellant had one percent impairment of the left lower extremity for residual problems with mild pain/impaired sensation from his left L5 lumbar radiculopathy. He explained that his figures differed from Dr. Krost as Dr. Krost had calculated impairment ratings based on spinal pain, which was not permitted under FECA. Dr. Harris opined that the date of maximum medical improvement was January 5, 2018.

In a letter dated April 10, 2018, OWCP forwarded the DMA's March 29, 2018 report to appellant and requested that Dr. Krost review the report and respond whether he agreed with the DMA's calculations, or that he provide an opinion citing to the A.M.A., *Guides* tables to determine a calculation in disagreement. Appellant was afforded 30 days for submission of additional evidence.

By decision dated September 25, 2018, OWCP granted appellant a schedule award for one percent permanent impairment of the left upper extremity and one percent permanent impairment of the left lower extremity. The award ran for six weeks from January 5 through February 15, 2018.

On October 25, 2018 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on March 12, 2019.

On April 15, 2019 OWCP received an electromyogram and nerve conduction velocity study dated October 31, 2017 which was an essentially normal study, with chronic neuropathic changes in the musculature commonly innervated by L5 on the left with no ongoing denervation.

By decision dated May 22, 2019, a hearing representative affirmed the September 25, 2018 decision.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[4] and its implementing 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 of a member 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 through its implementing regulations, OWCP has adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[7] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[8]

In addressing impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[9] After a CDX is determined (including identification of a default grade), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[8] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[9] *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

[10] A.M.A., *Guides* 383-492; *see M.P.*, Docket No. 13-2087 (issued April 8, 2014).

[11] *Id.* at 411.

determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s)."[12]

The FECA Bulletin advises:

"Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM); and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[13]

The Bulletin further advises:

"If the medical evidence of record is [in]sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence.[14]

"Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the CE should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the CE's letter, the CE should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physicians evaluation, the CE should route that report to the DMA for a final determination."[15]

ANALYSIS -- ISSUE 1

The Board finds that the case is not in posture for decision regarding permanent impairment of appellant's left upper extremity.

In a report dated January 5, 2018, Dr. Krost indicated that he had utilized the sixth edition A.M.A., *Guides* to determine that appellant's left shoulder sprain resulted in one percent permanent impairment based upon the DBI rating method. He noted that, regarding ROM of the left shoulder, appellant had guarding of the left shoulder on internal and external rotation

[12] FECA Bulletin No. 17-06 (May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

[13] *Id.*

[14] *E.P.*, Docket No. 19-1708 (issued April 15, 2020); *id.*

[15] *Id.*

secondary to pain, however, he did not provide ROM measurements. OWCP properly referred Dr. Krost's report to its DMA, Dr. Harris. Using the DBI method with reference to appellant's left shoulder condition, Dr. Harris found that, under the sixth edition of the A.M.A., *Guides*, Table 15-5, page 401, appellant had one percent permanent impairment of the left upper extremity for residual problems from his left shoulder strain, concurring with Dr. Krost's findings. He noted that, as there was no documented loss of motion, appellant would have zero percent impairment based on the ROM method, and that, as such, the DBI method resulted in greater impairment.

Pursuant to FECA Bulletin No. 17-06, if the ROM method of rating permanent impairment is allowed, after review of the DBI rating, and the ROM findings are incomplete, the DMA should advise as to the medical evidence necessary to complete the ROM method of rating if the medical evidence of record is insufficient to rate appellant's impairment using ROM.

Herein, OWCP did not follow the procedures outlined in FECA Bulletin No. 17-06 after the DMA advised that there were no documented ROM findings of record to rate appellant's permanent impairment utilizing the ROM methodology.[16] While OWCP did forward the DMA's report to appellant, it did not ask that Dr. Krost clarify whether appellant had a loss of ROM on an organic basis and if so to provide three measurements of appellant's left shoulder ROM.

On remand OWCP should obtain the necessary evidence as required under FECA Bulletin No. 17-06.[17] After it obtains the evidence necessary to complete the rating as described above, the case should be referred to a DMA to independently calculate impairment to the right upper extremity using both ROM and DBI methods and identify the higher rating.[18] If Dr. Krost does not provide the necessary evidence, OWCP should refer appellant for a second opinion evaluation. Following this and such further development as deemed necessary, OWCP shall issue a *de novo* decision.[19]

LEGAL PRECEDENT -- ISSUE 2

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.[20] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[21] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was

[16] *See C.T.*, Docket No. 18-1716 (issued May 16, 2019).

[17] *J.S.*, Docket No. 19-0483 (issued October 10, 2019).

[18] *See J.V.*, Docket No. 18-1052 (issued November 8, 2018); *M.C.*, Docket No. 18-0526 (issued September 11, 2018).

[19] *J.F.*, Docket No. 17-1726 (issued March 12, 2018).

[20] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see B.W.*, Docket No. 18-1415 (issued March 8, 2019); *J.M.*, Docket No. 18-0856 (issued November 27, 2018); *N.D.*, 59 ECAB 344 (2008); *Tania R. Keka*, 55 ECAB 354 (2004).

[21] *Id.* at § 8107(c); *id*. at § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. 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.[22]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met his burden of proof to establish any permanent impairment of his right lower extremity or more than one percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

Referring to Table 17-4 of the A.M.A., *Guides*, Dr. Krost determined that the diagnosis was lumbar disc herniation with chronic left L5 radiculopathy, which resulted in a default impairment of 12 percent. He did not provide a specific permanent impairment rating of appellant's left lower extremity.

In accordance with its procedures, OWCP properly routed the case record to its DMA, Dr. Harris, who indicated that he had reviewed Dr. Krost's January 5, 2018 report. With reference to appellant's lumbar spine condition, in his March 29, 2018 report, Dr. Harris correctly noted that FECA does not allow a schedule award for the spine, though it does allow for schedule awards for spinal nerve injuries resulting in impairment of the extremities.[23] With reference to appellant's left lower extremity condition, he referred to *The Guides Newsletter*, finding that he had one percent impairment of the left lower extremity for residual problems with mild pain/impaired sensation from his left L5 lumbar radiculopathy. Dr. Harris found that, with regard to appellant's right lower extremity, as appellant had no neurologic deficit in the lower extremity consistent with lumbar radiculopathy, he would have a zero percent impairment of the right lower extremity.

The Board finds that the DMA properly applied the standards of the A.M.A., *Guides* and *The Guides Newsletter* to the physical examination findings of Dr. Krost. The DMA accurately summarized the relevant medical evidence including findings on examination, and reached conclusions about appellant's conditions which comported with these findings.[24] He noted that the A.M.A., *Guides* did not allow for an impairment rating based on ROM for this diagnosis. The DMA properly referred to *The Guides Newsletter* in calculating appellant's percentage of permanent impairment of the lower extremities based on a spinal condition. As his report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[25] There is no medical evidence of record utilizing the appropriate tables of the sixth edition of the A.M.A., *Guides* or *The Guides Newsletter* demonstrating a greater percentage of permanent impairment of the left lower extremity or a ratable permanent impairment

[22] *Supra* note 7 at Chapter 3.700, Exhibit 4 (January 2010).

[23] *Supra* note 21.

[24] *M.S.*, Docket No. 19-1011 (issued October 29, 2019); *W.H.*, Docket No. 19-0102 (issued June 21, 2019); *J.M.*, Docket No. 18-1387 (issued February 1, 2019).

[25] *See M.S.*, *id.*; *D.S.*, Docket No. 18-1816 (issued June 20, 2019).

of the right lower extremity. Accordingly, the Board finds that, as appellant has not submitted medical evidence establishing greater than one percent impairment of the left lower extremity, or establishing ratable permanent impairment of the right lower extremity, he has not met his burden of proof to establishment entitlement to additional schedule award compensation for the lower extremities.

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 the case is not in posture for decision regarding appellant's left upper extremity schedule award. The Board further finds, however, that he has not met his burden of proof to establish any permanent impairment of his right lower extremity or greater than one percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the May 22, 2019 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: August 7, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board