United States Department of Labor
Employees' Compensation Appeals Board

B.B., Appellant	)	
and	)	**Docket No. 20-1187**
	)	**Issued: November 18, 2021**
U.S. POSTAL SERVICE, POST OFFICE, Hinsdale, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 12, 2020 appellant filed a timely appeal from a February 20, 2020 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.[2]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than 13 percent permanent impairment of her left upper extremity and 10 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation; and

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the February 20, 2020 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

(2) whether appellant has met her burden of proof to establish permanent impairment of her lower extremities due to her accepted lumbar conditions.

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 December 1, 2009 appellant, then a 53-year-old sales and service distribution associate, filed a traumatic injury claim (Form CA-1) alleging that on November 30, 2009 she sustained a lower back and left shoulder injury while in the performance of duty. OWCP accepted the claim, assigned OWCP File No. xxxxxx704, for lumbar sprain and left shoulder and rotator cuff sprain. Appellant underwent OWCP-authorized left shoulder rotator cuff repair, acromioplasty, and distal clavicle resection on April 14, 2010.[4] She retired effective April 21, 2011.

On June 26, 2012 under the current claim, appellant filed a claim for compensation (Form CA-7) for a schedule award due to her accepted left shoulder and lumbar conditions.

By decision dated January 2, 2014, OWCP granted appellant a schedule award for 10 percent permanent impairment of her left upper extremity. The award ran 31.2 weeks for the period July 28, 2013 to March 3, 2014 and was based on the impairment rating of Dr. David H. Garelick, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA) who had reviewed the second opinion reports of Dr. Allan Brecher, a Board-certified orthopedic surgeon, for permanent impairment based upon appellant's distal clavicle resection.

Following further development, the DMA, Dr. Garelick, concluded that appellant had 13 percent permanent impairment of the left upper extremity, which consisted of 7 percent permanent impairment due to her left shoulder rotator cuff condition, and 6 percent permanent impairment of her left carpal tunnel.

By decision dated June 19, 2015, OWCP granted her a schedule award for an additional 3 percent permanent impairment of the left upper extremity, for 13 percent total impairment, but denied entitlement to an additional schedule award for the right upper extremity greater than the 10 percent right upper extremity permanent impairment previously awarded under OWCP File No. xxxxxx845. The period of the additional award ran for 9.36 weeks from March 24 to

[3] Docket No. 17-1949 (issued October 16, 2018).

[4] OWCP previously accepted that appellant sustained a sprain of lumbosacral (joint) (ligament), displacement of lumbar intervertebral disc at L4-5 without myelopathy; and thoracic or lumbosacral left-sided neuritis or radiculitis due to a September 3, 1991 employment injury, under OWCP File No. xxxxxx544. It also previously accepted that she sustained bilateral carpal tunnel syndrome (CTS) due to a September 2, 1991 employment injury, under OWCP File No. xxxxxx845. In October 1995, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right upper extremity, under OWCP File No. xxxxxx845. On May 26, 2012 appellant filed a claim for compensation (Form CA-7) for a schedule award due to her accepted bilateral CTS under OWCP File No. xxxxxx845. OWCP File Nos. xxxxxx704, xxxxxx544, and xxxxxx845 have been administratively combined by OWCP, with file xxxxxx704 serving as the master file.

May 28, 2014. The rating was based upon evidence in master OWCP File No. xxxxxx704 and subsidiary OWCP File Nos. xxxxxx544 and xxxxxx845.

On July 3, 2015 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review, which was held telephonically on October 28, 2015. OWCP received additional evidence.

By decision dated January 14, 2016, the hearing representative affirmed OWCP's June 19, 2015 decision, finding that appellant had not established additional permanent impairment of the upper or lower extremities.

On December 19, 2016 appellant requested reconsideration. By decision dated April 6, 2017, OWCP denied modification of its January 14, 2016 decision.

On May 31, 2017 appellant requested reconsideration. By decision dated August 25, 2017, OWCP denied her request for reconsideration, finding that the evidence submitted was either repetitious or irrelevant.

On September 18, 2017 appellant appealed to the Board. By decision dated October 16, 2018, the Board set aside OWCP's April 6 and August 25, 2017 decisions.[5] The Board found that OWCP had inconsistently applied Chapter 15 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[6] regarding the proper use of either the diagnosis-based impairment (DBI) or range of motion (ROM) methodologies in assessing the extent of permanent impairment. The Board remanded the case for OWCP to issue a *de novo* decision following development of a consistent method for calculating permanent impairment of the upper extremities. The Board also found that OWCP failed to develop the evidence regarding whether she had established permanent impairment of her lower extremities as a result of her accepted lumbar conditions. The Board remanded the case for OWCP to obtain a second opinion impairment evaluation followed by a proper analysis under the A.M.A., *Guides* to determine the extent of appellant's lower extremity impairment, if any.

Appellant's treating physician, Dr. Samuel J. Chmell, a Board-certified orthopedic surgeon, continued to submit progress reports regarding appellant's conditions. In a February 28, 2019 report, he reported that a February 6, 2019 magnetic resonance imaging (MRI) scan demonstrated significant multi-level degenerative changes in the lumbar spine, most notably at L4-5.[7]

On remand, OWCP referred appellant to Dr. Kanayo K. Odeluga, a Board-certified occupational medicine physician, for a second opinion impairment evaluation of both upper and lower extremities due to her accepted work-related injuries. A November 29, 2018 statement of accepted facts (SOAF) noted the accepted conditions under OWCP File Nos. xxxxxx704, xxxxxx544, xxxxxx845, and xxxxxx514. OWCP also noted that appellant previously received

[5] *Supra* note 3.

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

[7] The results of a left hip MRI scan, also performed on February 6, 2019 were also discussed.

schedule awards for 13 percent permanent impairment of the left upper extremity and 10 percent permanent impairment of the right upper extremity.

In a March 26, 2019 report, Dr. Odeluga reviewed the November 29, 2018 SOAF and set forth his examination findings. He opined that appellant reached maximum medical improvement (MMI) on March 26, 2019. Regarding the upper extremities, Dr. Odeluga found an essentially normal examination with full ROM in each joint, grade 5/5 strength in all major muscle groups, and normal sensations and muscle reflexes. For the accepted left shoulder sprain class of diagnosis (CDX), he found, under Table 15-5, a Class 1 impairment with midrange default of 1 percent upper extremity impairment. Dr. Odeluga assigned a grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 0, and a grade modifier for clinical studies (GMCS) of 2, under Table 15-7, Table 15-8 and Table 15-9, respectively. He found that the net adjustment within the diagnostic class was 1, which resulted in Grade D or two percent left upper extremity permanent impairment for the accepted left shoulder sprain.

For the lower extremities, Dr. Odeluga also found an essentially normal examination with full ROM in each joint and grade 5/5 in all major muscle groups except 4/5 in left foot dorsiflexion. Normal sensation was noted in all dermatomes except along the medial aspect of dorsum of the left foot, which was decreased compared to same dermatome on the right. Dr. Odeluga indicated that the weakness of dorsiflexion was attributed to the L5 nerve root. Under Table 16-11, he assigned severity 3 for sensory deficit of L5 nerve root as there was "impaired sharp/dull recognition, but retained protective sensibility" with a motor deficit related to the "weakness of dorsiflexion of 4/5." Under Proposed Table 2 of *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Dr. Odeluga indicated that the mild motor deficit of the L5 nerve root was Grade C or five percent lower extremity impairment. He found a GMFH of 0 and GMCS of 1, using a June 23, 2016 electromyogram/nerve conduction velocity (EMG/NCV) study, which resulted in a Class 1, Grade B impairment which equaled three percent lower extremity impairment for L5 associated motor deficit. Dr. Odeluga also indicated that appellant had five percent L4, five percent L5, and three percent S1 moderate sensory deficits Grade B. He found that she had combined sensory and motor deficit in the left lower extremity of 16 percent permanent impairment. A copy of Dr. Odeluga's impairment worksheets were provided.

In an April 4, 2019 report, Dr. Chmell reported that appellant's recent EMG/NCV study revealed bilateral CTS and cervical radiculopathy. He continued to submit progress reports.

On June 25, 2019 OWCP requested that Dr. Odeluga provide an amended report to include impairment ratings for appellant's right upper and right lower extremities. It noted that she may be reexamined if necessary.

On August 2, 2019 OWCP issued a new SOAF, which included the accepted conditions under OWCP File Nos. xxxxxx704, xxxxxx544, xxxxxx845, and xxxxxx514.

In his August 20, 2019 report, Dr. Odeluga indicated that appellant had essentially normal examination of both upper extremities with left hand grip strength of 4+/5. Both of appellant's lower extremities were also essentially normal except for left foot dorsiflexion of 4/5 strength and decreased sensation along the medial aspect of the dorsum of the left foot. The spinal examination

revealed no anatomic deformity with spinous and paraspinal tenderness noted over her lumbar segment. Appellant had full ROM except for lumbar flexion. The straight leg test was negative on both lower extremities. Dr. Odeluga opined that appellant reached MMI as August 20, 2019.[8] Utilizing appellant's most recent March 5, 2019 EMG/NCV postoperative study, as her symptoms had progressed since her CTS releases in 2010 and 2011, he opined that she had three percent permanent impairment to her left and right upper extremities based on her bilateral CTS diagnosis. Under Table 15-23 of the A.M.A., *Guides*, Dr. Odeluga assigned a grade modifier 1 for test findings, a grade modifier 2 for history, and a grade modifier 1 for physical findings, which yielded a default upper extremity impairment rating of two percent due to entrapment neuropathy. He adjusted the default impairment rating up based on her *Quick*DASH score of 50 to find three percent permanent impairment of each upper extremity. Copies of Dr. Odeluga's permanent impairment worksheets were provided, which indicated his impairment calculation for the left and right CTS.

Dr. Odeluga indicated, based on his evaluation, that there was no observed impairment of the right lower extremity originating in the back or spine. He found no sign of right lumbar radiculopathy despite appellant's complaint of radicular pain into her right buttock and groin. Dr. Odeluga noted that although the 2016 EMG/NCV study was suggestive of L4-5 and L5-S1 active radiculopathy with sensory nerve action potential abnormalities on the right side involving both peroneal and sural nerve sensory fibers, there was no physical evidence of nerve injury on examination such as decreased sensation, reflexes or muscle power.

Dr. Chmell continued to submit progress reports. No right-sided radiculopathy was reported. In an October 21, 2019 letter, Dr. Chmell took issue with Dr. Odeluga's March 26, 2019 impairment ratings.

On January 9, 2020 OWCP referred the medical record, including Dr. Odeluga's reports, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a DMA.

In his January 15, 2020 report, Dr. Harris indicated that appellant did not have any neurologic deficit in the right upper extremity consistent with cervical radiculopathy. Under Table 15-14, he opined that this was consistent with severity 0 and a Class 0 impairment based on Table 1 of *The Guides Newsletter*. Dr. Harris concluded that appellant had zero percent impairment for cervical radiculopathy under *The Guides Newsletter*. He further noted that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method. For appellant's right CTS, Dr. Harris concurred with Dr. Odeluga's rating that she had three percent permanent impairment for the right upper extremity under Table 15-23 for residual problems with mild CTS symptoms status post CTS release (grade modifier 1). He noted that the A.M.A., *Guides* did not allow an impairment rating under the ROM for CTS.

For the left upper extremity, Dr. Harris indicated that appellant did not have any neurologic deficits in the upper extremity consistent with cervical radiculopathy. Under Table 15-14, he opined this was consistent with severity 0 and a Class 0 impairment based on Table 1 of *The Guides Newsletter*. Dr. Harris noted that the A.M.A., *Guides* did not allow for the impairment to be

[8] Dr. Odeluga indicated that August 20, 2019 was the date of his first examination of appellant. The record reflects that he first examined her on March 26, 2019.

calculated under the ROM method. He concluded that appellant had zero percent impairment for cervical radiculopathy under *The Guides Newsletter*. For the left shoulder, Dr. Harris opined that under Table 15-5, she had 10 percent upper extremity impairment for having undergone excision of distal clavicle. As appellant had full ROM she had 0 percent impairment under the ROM methodology. Dr. Harris opined that the DBI rating should be used as it represented the greater impairment. For the left CTS, he noted his concurrence with Dr. Odeluga's rating that appellant had three percent permanent impairment for the left upper extremity under Table 15-23 for residual problems with mild CTS symptoms status post CTS release (grade modifier 1). Dr. Harris noted that the A.M.A., *Guides* did not allow an impairment rating under the ROM methodology for CTS. Utilizing the combined values of 10 percent permanent impairment for excision of distal clavicle and 3 percent permanent impairment for CTS, he found a total of 13 percent permanent impairment of the left upper extremity.

For the lower extremities, Dr. Harris indicated that appellant did not have any neurologic deficit in either the left or right lower extremity consistent with lumbar radiculopathy. This was consistent with severity 0 under Table 16-11 and a Class 0 impairment based on Table 2 of *The Guides Newsletter*. Dr. Harris concluded that this resulted in zero percent permanent impairment for lumbar radiculopathy in either the left or right lower extremity based on the methodology described in *The Guides Newsletter*. He indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method.

Dr. Harris opined that appellant reached MMI August 20, 2019, the date of Dr. Odeluga's examination. As appellant was previously awarded 10 percent right upper extremity permanent impairment and 13 percent left upper extremity permanent impairment, the DMA concluded that there was no increase in either the right or left upper extremities.

By decision dated February 20, 2020, OWCP denied appellant's claim for an increased schedule award. It relied on the medical opinion of its DMA, Dr. Harris, to establish that there was no additional permanent impairment that would justify an increased schedule award.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[9] and its implementing regulations[10] 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 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 adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[11] As of May 1, 2009, schedule awards are determined in

[9] 5 U.S.C. § 8107.

[10] 20 C.F.R. § 10.404.

[11] *Id.*; *see also, Ronald R. Kraynak*, 53 ECAB 130 (2001).

accordance with the sixth edition of the A.M.A., *Guides* (2009).[12] 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.[13]

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.[14] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[15] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[16]

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 determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s)."[17]

FECA Bulletin further 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.)[18]

The Bulletin also advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id*. Chapter 2.808.5.a. (March 2017).

[13] *M.D.*, Docket No. 20-0007 (issued May 13, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[14] *M.D.*, *id*.; *T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[16] *Id*. at 411.

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

[18] *Id*.

should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[19]

Impairment due to CTS is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[20] In Table 15-23, grade modifier levels (ranging from zero to four) are described for the categories of test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities (*Quick*DASH).[21]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[22]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish more than 13 percent permanent impairment of her left upper extremity and 10 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation.

Following the Board's October 16, 2018 decision, OWCP referred appellant's schedule award claim to Dr. Odeluga, serving as an OWCP second opinion physician, to provide a permanent impairment examination and rating of her left and right upper and lower extremities in accordance with the A.M.A., *Guides* and FECA Bulletin No. 17-06.

In a March 26, 2019 report, Dr. Odeluga reviewed the November 29, 2018 SOAF and set forth his examination findings. He opined that appellant reached MMI on March 26, 2019. For the accepted left shoulder sprain CDX, Dr. Odeluga found, under Table 15-5, a Class 1 impairment with midrange default of 1 percent upper extremity impairment. He assigned a GMFH of 2, GMPE of 0, and a GMCS of 2, under Table 15-7, Table 15-8 and Table 15-9, respectively. Dr. Odeluga found that the net adjustment within the diagnostic class was 1, which resulted in Grade D or two percent left upper extremity permanent impairment for the accepted left shoulder sprain.

In his August 20, 2019 report, Dr. Odeluga opined that appellant reached MMI as of August 20, 2019.[23] Utilizing appellant's most recent March 5, 2019 EMG/NCV postoperative

[19] *Id*.

[20] A.M.A., *Guides* 449.

[21] *Id*. at 448-49.

[22] *See supra* note 12 at Chapter 2.808.6(f) (February 2013). *See also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[23] Dr. Odeluga indicated that August 20, 2019 was the date of his first examination of appellant. The record reflects that he first examined her on March 26, 2019.

study, as her symptoms had progressed since her CTS releases in 2010 and 2011, he opined that she had three percent permanent impairment to her left and right upper extremities based on her bilateral CTS diagnosis. Under Table 15-23 of the A.M.A., *Guides*, Dr. Odeluga assigned a grade modifier 1 for test findings, a grade modifier 2 for history, and a grade modifier 1 for physical findings, which yielded a default upper extremity impairment rating of two percent due to entrapment neuropathy. He adjusted the default impairment rating up based on her *Quick*DASH score of 50 to find three percent permanent impairment of each upper extremity. Utilizing the DBI methodology, Dr. Odeluga explained that, according to Table 15-23 of the A.M.A., *Guides*, appellant had a grade modifier 1 for test findings, a grade modifier 2 for history, and a grade modifier 1 for physical findings, which yielded a default upper extremity impairment rating of two percent due to entrapment neuropathy. He adjusted the default impairment rating up based on her *Quick*DASH score of 50 to find three percent permanent impairment of each upper extremity.

Dr. Harris, OWCP's DMA, reviewed and concurred with Dr. Odeluga's three percent impairment rating for the bilateral upper extremities based on the CTS diagnosis. He noted that the A.M.A., *Guides* did not allow an impairment rating under the ROM method for CTS. Dr. Harris further noted that the upper extremity examination failed to reveal any cervical radiculopathy of either extremity. He also noted that Dr. Odeluga related that appellant's left shoulder examination was reported as normal with full ROM. Dr. Harris opined that, under Table 15-5, she had 10 percent left upper extremity impairment for having undergone excision of distal clavicle. As appellant had full ROM he indicated that there was a zero percent impairment under the ROM methodology. Dr. Harris explained that, pursuant to the A.M.A., *Guides*, because the DBI method yielded greater impairment, she had 10 percent permanent impairment of the left upper extremity. He concluded that appellant had 13 percent total left upper extremity permanent impairment based on the distal clavicle excision and left CTS. Dr. Harris also concluded that she had three percent right upper extremity impairment based on right CTS. However, the DMA noted that since appellant was previously awarded 10 percent right upper extremity permanent impairment and 13 percent left upper extremity permanent impairment, no additional upper extremity impairment was established.

The Board finds that the DMA, Dr. Harris, properly applied the A.M.A., *Guides* to the findings of Dr. Odeluga and explained that appellant's current impairment was 13 percent total left upper extremity permanent impairment based on the distal clavicle excision and left CTS and 3 percent right upper extremity impairment based on right CTS. Dr. Harris accurately summarized the relevant medical evidence, provided detailed findings on examination, and reached conclusions about her condition which comported with his findings.[24] In addition, the DMA properly utilized the DBI method and ROM method to rate appellant's accepted upper extremity conditions pursuant to FECA Bulletin No. 17-06. As the DMA's report is detailed, well rationalized, and based on a proper factual background, his opinion represents the weight of the medical evidence.[25] Thus, the Board finds that appellant has not met her burden of proof to establish greater right or left upper extremity permanent impairment than previously awarded.

[24] *See M.D.*, Docket No. 20-0007 (issued May 13, 2020); *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.D.*, *id.*, *D.S.*, Docket No. 18-1816 (issued June 20, 2019).

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.

LEGAL PRECEDENT -- ISSUE 2

Neither FECA nor its implementing regulations provides for the payment of a schedule award for the permanent loss of use of the back/spine or the body as a whole. However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[26] The sixth edition of the A.M.A., *Guides* provides a specific methodology for rating spinal nerve extremity impairment in *The Guides Newsletter*. It was 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 into OWCP's procedures.[27]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[28]

ANALYSIS -- ISSUE 2

The Board finds that this case is not in posture for decision regarding permanent impairment of appellant's left lower extremity due to her accepted lumbar conditions.

The DMA, Dr. Harris, failed to review Dr. Odeluga's March 26, 2019 impairment report. In that report, Dr. Odeluga opined that appellant had 16 percent left lower extremity permanent impairment. He based the impairment rating on combined sensory and motor deficits of the L4, L5, and S1 nerve roots and set forth his impairment calculations. As there is no indication that the DMA reviewed Dr. Odeluga's March 26, 2019 left lower extremity impairment rating, OWCP shall refer the case file back to its DMA, Dr. Harris, to review Dr. Odeluga's March 26, 2019 left lower extremity impairment rating pursuant to its procedures.[29]

In his August 20, 2019 report, Dr. Odeluga discussed appellant's complaints of radicular pain into her right buttock and groin, but indicated that there was no observed impairment of the right lower extremity originating in the back or spine based on his evaluation. He concluded that

[26] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[27] *Supra* note 12 at Chapter 3.700, Exhibit 4 (January 2010); *see E.G.*, Docket No. 19-1081 (issued September 24, 2020).

[28] *See supra* note 12 at Chapter 2.808.6(f) (February 2013). *See also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan*, 57 ECAB 349 (2006).

[29] *See supra* note 17.

there was no sign of right lumbar radiculopathy. Dr. Odeluga noted that although the 2016 EMG/NCV study was suggestive of L4-5 and L5-S1 active radiculopathy with sensory nerve action potential abnormalities on the right side involving both peroneal and sural nerve sensory fibers, there was no physical evidence of nerve injury on examination such as decreased sensation, reflexes or muscle power. While Dr. Chmell noted, in his February 28, 2019 report, that a February 6, 2019 MRI scan demonstrated significant multi-level degenerative changes in the lumbar spine, most notably at L4-5, his subsequent reports failed to diagnose a right lumbar radiculopathy, which is consistent with Dr. Odeluga's findings.

On January 15, 2020 Dr. Harris, OWCP's DMA, reviewed Dr. Odeluga's August 20, 2019 report and opined that appellant did not have any neurologic deficit in either lower extremity consistent with lumbar radiculopathy. He found that this was consistent with severity 0 under Table 16-11 and a Class 0 impairment based on Table 2 of *The Guides Newsletter*. Dr. Harris concluded that this resulted in zero percent permanent impairment for lumbar radiculopathy in either the left or right lower extremity based on the methodology described in *The Guides Newsletter*. He indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method.

The Board further finds that appellant has not met her burden of proof to establish permanent impairment of her right lower extremity due to her accepted lumbar conditions.

With respect to the right lower extremity, the Board finds that Dr. Harris applied the appropriate tables and grade schemes of *The Guides Newsletter* to the examination findings for the right lower extremity. The record contains no medical evidence in accordance with *The Guides Newsletter* demonstrating a permanent impairment of the right lower extremity due to her accepted lumbar conditions.[30]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than 13 percent permanent impairment of her left upper extremity and 10 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation. The Board also finds that the case is not in posture for decision of the permanent impairment of her left lower extremity due to her accepted lumbar conditions. The Board further finds that appellant has not met her burden of proof to establish permanent impairment of her right lower extremity due to her accepted lumbar conditions.

[30] *See E.G.*, Docket No. 19-1081 (issued September 24, 2020); *T.K.*, Docket No. 19-1222 (issued December 2, 2019); *C.S.*, Docket No. 18-0920 (issued September 23, 2019).

ORDER

IT IS HEREBY ORDERED THAT the February 20, 2020 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: November 18, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board