United States Department of Labor
Employees' Compensation Appeals Board

B.B., Appellant	)	
and	)	**Docket No. 22-1068**
	)	**Issued: June 13, 2023**
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
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On July 5, 2022 appellant filed a timely appeal from an April 13, 2022 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]

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the April 13, 2022 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*.

ISSUE

The issue is whether appellant has met her burden of proof to establish more than nine percent permanent impairment of the left lower extremity and zero percent permanent impairment of the right lower extremity for which she previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board regarding appellant's schedule award claims.[3] The facts and circumstances as set forth in the Board's prior decisions 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 lower back and left shoulder injuries when placing 50-pound boxes into a cart while in the performance of duty. OWCP accepted the claim 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 appellant filed a claim for compensation (Form CA-7) for a schedule award due to her accepted November 30, 2009 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 based upon appellant's distal clavicle resection. By decision dated June 19, 2015, it granted her a schedule award for an additional three percent permanent impairment of the left upper extremity. 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. 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 of the merits of her claim, finding that the evidence submitted was either repetitious or irrelevant.

[3] Docket No. 20-1187 (issued November 18, 2021); 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 xxxxx845 have been administratively combined by OWCP, with OWCP File No. xxxxxx704 serving as the master file.

By decision dated October 16, 2018, the Board set aside OWCP's April 6 and August 25, 2017 decisions.[5] In pertinent part, the Board found that OWCP failed to develop the evidence regarding whether appellant had established permanent impairment of her lower extremities as a result of her accepted lumbar conditions and remanded the case for OWCP to obtain a second opinion impairment evaluation to determine the extent of appellant's lower extremity permanent impairment, if any, under the A.M.A., *Guides*.[6]

Appellant's treating physician, Dr. Samuel J. Chmell, a Board-certified orthopedic surgeon, submitted 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.

On remand, OWCP referred appellant to Dr. Kanayo K. Odeluga, a Board-certified occupational medicine physician, for a second opinion permanent 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, and xxxxxx845.

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. Dr. Odeluga set forth his impairment calculations under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[7] for both the upper and lower extremities. Regarding the lower extremities, Dr. Odeluga found an essentially normal examination with full range of motion (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 Class 1, grade C or five percent default lower extremity impairment. He found a grade modifier for functional history (GMFH) of 0 and grade modifier for clinical studies (GMCS) of 1, from findings on a June 23, 2016 electromyogram/nerve conduction velocity (EMG/NCV) study. Applying the grade modifiers resulted in a Class 1, grade B impairment and equaled three percent lower extremity impairment for L5 motor deficit. Dr. Odeluga also indicated that after applying the grade modifiers of GMFH

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

[6] The Board also 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, finding 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*) regarding the proper use of either the diagnosis-based impairment (DBI) or range of motion (ROM) methodologies in assessing the extent of permanent impairment.

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

0, GMCS 1 to appellant's grade C sensory deficit, appellant had five percent L4, five percent L5, and three percent S1 sensory deficits. 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.

On June 25, 2019 OWCP requested that Dr. Odeluga provide a supplemental report to include impairment ratings for appellant's right upper and right lower extremities. It noted that appellant may be reexamined if necessary. OWCP also issued a new SOAF, dated August 2, 2019, which included the accepted conditions under all of the combined OWCP files.

In his August 20, 2019 report, Dr. Odeluga indicated his examination findings and impairment calculations for both the upper and lower extremities. In relevant part, the examination of appellant's bilateral lower extremities were 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. Dr. Odeluga opined that appellant reached MMI as August 20, 2019.[8] He indicated, based on his evaluation, that there was no observed impairment of the right lower extremity originating in the back or spine. Dr. Odeluga found no sign of right lumbar radiculopathy despite appellant's complaint of radicular pain into her right buttock and groin. He 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 OWCP's district medical adviser (DMA). In a January 15, 2020 report, Dr. Harris provided findings with regard to appellant's right and left upper extremities. He opined that appellant reached MMI on August 20, 2019, the date of Dr. Odeluga's examination. 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 indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method for the accepted diagnosis.

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.

[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.

On May 12, 2020 appellant filed an appeal to the Board. By decision dated November 18, 2021, the Board affirmed in part and set aside in part OWCP's February 20, 2020 decision.[9] The Board found that appellant had not met her burden of proof to establish permanent impairment of her right lower extremity due to her accepted lumbar conditions. The Board further found that the case was not in posture for decision regarding the permanent impairment of her left lower extremity due to her accepted lumbar conditions. The Board explained that there was no indication that the DMA had reviewed Dr. Odeluga's March 26, 2019 left lower extremity impairment rating. The Board remanded 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.

Dr. Chmell continued to submit progress reports. In a January 6, 2022 report, he set forth examination findings which included marked tenderness of the left sciatic nerve and positive straight leg raising on the left and right side with diminished strength and sensation at both ankles and feet. In relevant part, Dr. Chmell diagnosed lumbar sprain and L4-5 disc herniation with left L5 radiculopathy.

In a January 13, 2022 report, Dr. Chmell disagreed with the DMA's impairment findings regarding appellant's lower extremities as appellant had diagnostic evidence of bilateral lower extremity neurologic involvement. This included the 2016 EMG/NCV study, which indicated bilateral L4-5 and L5-S1 radiculopathy, and the recent September 22, 2021 lumbar spine MRI scan, which demonstrated greater nerve root impingement on right side than left. Dr. Chmell indicated that appellant's bilateral lower extremity radiculopathy has deteriorated with time, which is often the case with a permanent low back injury affecting the lower extremity nerves. He therefore recommended that she undergo a repeat evaluation as to the permanent neurologic impairment in her lower extremities as a result of her accepted work-related low back injury. A copy of the September 22, 2021 lumbar spine MRI scan was submitted along with copies of May 27, 2015 and November 7, 2017 lumbar spine MRI scans.

In a January 21, 2022 report, Dr. Scott E. Glaser, a Board-certified anesthesiologist and pain medicine specialist, noted that a work event was the precipitating factor of appellant's bilateral lower back pain and bilateral buttock and leg/feet pain. He diagnosed lumbar radiculopathy "as deteriorated," noting examination findings of limited rotation and extension which produced bilateral lumbar spine pain and bilateral straight leg raising which elicited calf pain. Dr. Glaser provided a bilateral L3-4 and L4-5 transforaminal epidural steroid injection on February 18, 2022.

OWCP continued to receive progress reports from Dr. Chmell and Dr. Glaser.

On March 16, 2022 OWCP requested an addendum report from the DMA, Dr. Harris, regarding whether appellant had a left lower extremity permanent impairment based upon her accepted lumbar spine condition as outlined in Dr. Odelunga's March 26, 2019 report.

[9] Docket No. 20-1187 (issued November 18, 2021). The Board found that appellant had 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.

In a March 17, 2022 report, Dr. Harris, the DMA, noted that the medical record, in pertinent part, established the diagnoses of lumbar disc bulging L4-5 with protrusion L2-3; and lumbar radiculopathy. He reviewed Dr. Odeluga's March 26, 2019 report and indicated that appellant reached MMI on March 26, 2019, the date of Dr. Odeluga's examination. Dr. Harris noted that while Dr. Odeluga found that appellant had impairment to his left L4, L5, and S1 dermatomes, his examination only demonstrated diminished sensation in the L5 dermatome. Utilizing *The Guides Newsletter*, Dr. Harris rated appellant's bilateral lower extremity permanent impairments. For the right lower extremity, he found that appellant did not have any neurologic deficit in the 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*. He indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method. For the left lower extremity, Dr. Harris opined that appellant had nine percent total permanent impairment due to the L5 lumbar radiculopathy. This was comprised of six percent impairment for severe pain/impaired sensation due to class of diagnosis (CDX), left L5 lumbar radiculopathy, a Class 1, grade C, and three percent impairment for mild motor weakness due to left L5 lumbar radiculopathy, a Class 1 grade B impairment. Dr. Harris indicated that the A.M.A., *Guides* did not allow for an impairment rating under the ROM method.

By decision dated April 13, 2022, OWCP granted appellant nine percent permanent impairment of the left lower extremity and zero percent permanent impairment of the right lower extremity. The period of the award ran for 25.92 weeks from March 26 to September 13, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA,[10] and its implementing federal regulations,[11] 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.[12] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[13]

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.[14] However, a schedule award is permissible where the employment-related spinal condition affects the upper

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] *Id*. at § 10.404(a).

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

[14] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see T.W.*, Docket No. 20-0119 (issued January 12, 2021); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

and/or lower extremities.[15] 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. 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.[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision.

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's February 20, 2020 merit decision because the Board considered that evidence in its November 18, 2021 decision. Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[18]

On prior appeal, the Board remanded the case to OWCP so that its DMA, Dr. Harris, could review Dr. Odeluga's March 26, 2019 report with regard to a left lower extremity impairment based upon a spine condition. Based on Dr. Odeluga's March 26, 2019 examination findings and *The Guides Newslette*r, Dr. Harris opined, in his March 17, 2022 report, that appellant had nine percent permanent impairment of the left lower extremity and zero percent permanent impairment for the right lower extremity. In its April 13, 2022 decision, OWCP granted appellant a schedule award for nine percent permanent impairment of the left lower extremity and zero percent permanent impairment of the right lower extremity.

The evidence of record received prior to Dr. Harris' March 17, 2022 report, however, reflects evidence of recent sensory or motor loss which could possibly affect the current schedule award to the left and right lower extremities. Dr. Chmell opined that appellant's bilateral lower extremity radiculopathy had deteriorated and recommended a repeat impairment evaluation. In his January 6, 2022 report, he noted examination findings included positive straight leg raising on left and right side with diminished strength and sensation at both ankles and feet. He further noted,

[15] *Supra* note 13 at Chapter 2.808.5c(3) (March 2017).

[16] *Supra* note 13 at Chapter 3.700, Exhibit 4 (January 2010); *see N.G.*, Docket No. 20-0557 (issued January 5, 2021).

[17] *Supra* note 13 at Chapter 2.808.6f (March 2017).

[18] *See D.M.*, Docket No. 21-1209 (issued March 24, 2022); *T.R.*, Docket No. 20-0588 (issued June 25, 2021); *A.G.*, Docket No. 18-0329 (issued July 26, 2018); *Clinton E. Anthony, Jr.*, 49 ECAB 476 (1998).

in his January 13, 2022 report, that the recent September 22, 2021 lumbar spine MRI scan demonstrated nerve root impingement on both the right and left sides. Further, in his January 21, 2022 report, Dr. Glaser, diagnosed lumbar radiculopathy and noted that the condition had deteriorated. Thus, the record contains medical evidence of bilateral sensory or motor loss which may constitute an increased basis for a schedule award based on *The Guides Newsletter*.[19]

The Board notes that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[20] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case. Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[21] It issued its April 13, 2022 schedule award decision without consideration of the additional medical evidence received from Dr. Chmell and Dr. Glazer, by Dr. Harris. Therefore, the case must be remanded to OWCP for further development.[22]

The Board will, therefore, set aside OWCP's April 13, 2022 decision and remand the case to OWCP for referral of the entire case record to Dr. Harris for further review. After such other further development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for a bilateral lower extremity schedule award.

CONCLUSION

The Board finds that this case is not in posture for decision.

[19] 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 in which 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. *Supra* note 14 at Chapter 3.700, Exhibit 4 (January 2010); *see T.W., supra* note 15; *B.M.*, Docket No. 19-1069 (issued November 21, 2019).

[20] *See T.C.*, Docket No. 19-0771 (issued March 17, 2021); *E.W.*, Docket No. 17-0707 (issued September 18, 2017).

[21] *See T.K.*, Docket No. 20-0150 (issued July 9, 2020); *T.C.*, Docket No. 17-1906 (issued January 10, 2018).

[22] *See T.C., id.*; *X.Y.*, Docket No. 19-1290 (issued January 24, 2020); *K.G.*, Docket No. 17-0821 (issued May 9, 2018).

ORDER

IT IS HEREBY ORDERED THAT the April 13, 2022 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 13, 2023
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board