United States Department of Labor
Employees' Compensation Appeals Board

STEPHEN BOYLE, Appellant	)	
and	)	**Docket No. 04-1168**
	)	**Issued: October 29, 2004**
DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL BASE, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On March 30, 2004 appellant, through his attorney, filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated November 25, 2003 which denied his claim for a schedule award and a March 15, 2004 hearing representative's decision affirming the denial of his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the schedule award decisions.

ISSUE

The issue is whether appellant is entitled to a schedule award for a permanent impairment to his lower extremities or penis.

FACTUAL HISTORY

On March 14, 1989 appellant, then 23-year-old mechanical engineer, filed a claim for compensation for a traumatic injury occurring on that date in the performance of duty. The Office accepted appellant's claim, assigned file number A03-0143253, for cervical spine strain,

cervical disc disease and a herniated disc at C5-7. On June 18, 1992 appellant underwent an anterior fusion at C5-6 and C6-7 with a right iliac crest bone graft.[1] Appellant sustained intermittent periods of disability from work following his injury.

On October 12, 1995 the Office reduced appellant's compensation to zero on the grounds that his actual earnings as a mechanical engineer effective January 16, 1995 fairly and reasonably represented his wage-earning capacity.

The Office further accepted that appellant sustained an employment-related herniated disc at C4-5 in an injury sustained on September 26, 1996. The Office subsequently accepted neurotic depression. The Office assigned the claim file number A03-0224745. Appellant stopped work on October 18, 1996.[2] The Office began paying appellant compensation for temporary total disability beginning November 20, 1996.[3]

By decision dated August 3, 2001, the Office reduced appellant's compensation to zero on the grounds that his actual earnings as a business analyst effective May 29, 2001, fairly and reasonably represented his wage-earning capacity.[4]

In an unsigned letter dated January 10, 2002, Dr. William C. Murphy, a Board-certified osteopath, noted that appellant had reached maximum medical improvement. He indicated that he had referred appellant to Dr. George L. Rodriguez, a Board-certified physiatrist, for an impairment evaluation.

In an impairment rating evaluation dated March 6, 2002, Dr. Rodriguez discussed appellant's history of injury and cervical spinal fusions at C5-7. He noted that appellant experienced pain in his neck "radiating into the bilateral trapezii." Dr. Rodriguez stated:

> "Furthermore, [appellant] notes that[,] pursuant to the fusion surgery of 1992, he had to undergo a bone gra[f]ting procedure from his right iliac crest, which has left him with a zone of numbness in this region. He describes that this numbness causes him to have sexual dysfunction with his significant other. He notes that his sexual pleasure has been reduced by no less than 40 [percent]. [Appellant] has been notified by Dr. Murphy that the area of numbness overlying the right iliac crest is larger than would normally be expected, due to the fact that he suffered from a post-grafting infection…. [He] notes that this area of numbness is

[1] On July 11, 1992 appellant underwent an incision and drainage with irrigation of the right iliac crest bone graft donor site due to a wound infection.

[2] The record indicates that appellant was suspended when his security clearance was revoked. Appellant resigned from the employing establishment on February 21, 1997 citing as the reason his cervical spine problems.

[3] By decision dated April 10, 1997, the Office denied appellant's claim for continuation of pay on the grounds that he did not file written notice of his claim within 30 days. In a decision dated April 22, 1999, the Board affirmed the Office's April 10, 1997 decision. *Stephen Boyle*, Docket No. 97-2436 (issued April 22, 1999).

[4] In a decision dated April 2, 2003, the Office denied reimbursement of the expenses appellant incurred earning a Masters in Business Administration. By decision dated April 16, 2003, a hearing representative reversed the Office's April 2, 2003 decision.

approximately [four] [inches] in diameter. It spans to the area of the inguinal canal. He notes that, as such, the numbness affects his ability to become excited and in some regards aware of the physical presence of his sexual partner."

Dr. Rodriguez diagnosed herniated cervical discs at C4-5, C5-6 and C6-7, bilateral cervical radiculopathy, sexual dysfunction and chronic muscle pain. He found that appellant had a one percent impairment of both the right and left upper extremity due to radiculopathy according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (5th ed. 2001).[5] He further found that appellant had a three percent impairment due to pain[6] and a nine percent impairment due to sexual dysfunction from intermittent numbness.[7]

An Office medical adviser reviewed Dr. Rodriguez' report on July 3, 2002 and opined that appellant had a two percent permanent impairment of both the right and left upper extremity. He further found that Dr. Rodriguez did not provide sufficient rationale supporting his finding that appellant had "permanent damage to the penis from the cervical herniated discs."

In a decision dated September 10, 2002, the Office granted appellant a schedule award for a four percent combined impairment of the right and left upper extremity. The period of the award ran for 12.48 weeks from March 6 to June 1, 2002.

On September 17, 2002 appellant, through his representative, requested a review of the written record. In a decision dated January 9, 2003, a hearing representative affirmed the September 10, 2002 decision.[8] The hearing representative noted, however, that the Office should further develop the record to determine whether appellant had an impairment to either his lower extremities or penis due to his 1989 and 1996 employment injuries.

In a clinic note dated March 5, 2003, Dr. James F. Bonner, a Board-certified physiatrist, stated that appellant had intermittent complaints involving the cervical spine with problems sleeping and limitations in his physical activities and concluded that appellant had a 25 to 28 percent whole person impairment.

On March 20, 2003 an Office medical adviser reviewed the March 6, 2002 report of Dr. Rodriguez, in connection with the hearing representative's instructions to consider whether appellant had an impairment of the lower extremities. He found that Dr. Rodriguez did not adequately describe the "precise location and extent of the numbness over the iliac crest." The Office medical adviser noted that the iliohypogastric nerve provided the "cutaneous sensation" and was not a nerve listed in Table 17-37 on page 552 of the A.M.A., *Guides*. He further found that Table 15-18 on page 424 of the A.M.A., *Guides*, relevant to determining the extent of the

[5] A.M.A., *Guides* 482, 489, Tables 16-10 and 16-13.

[6] *Id*. at 573.

[7] *Id*. at 342, Table 13-21.

[8] The cover letter accompanying the Office's January 9, 2003 decision is dated December 9, 2003; however, it is apparent that this is a typographical error.

lower extremity impairment due to spinal nerve root impairments, did not apply because the root of the nerve was not affected. The Office medical adviser additionally found that the L1 nerve root, the source of the iliohypogastric nerve, was not ratable. The Office medical adviser noted that appellant's infection following his cervical spinal fusion surgery complicated the situation and indicated that the ilioinguinal nerve "which goes to the dorsal root of the penis is anatomically often near the course of the iliohypogastric" nerve but that any nerve irritation should have been temporary. He recommended a second opinion evaluation.

By letter dated August 15, 2003, the Office referred appellant for an impairment evaluation with a neurologist for a determination of whether he had a permanent impairment of the lower extremities and with a urologist for a determination of whether he had a permanent impairment of the penis. In a report dated September 30, 2003, Dr. Marvin H. Marx, a Board-certified urologist, discussed appellant's history of injury and medical treatment received. On physical examination, he noted that appellant had "loss of touch [and] [two] point pin prick over 10 [centimeters] radius around the right iliac scar area extending to the penile/scrotal/inguinal angle." Dr. Marx stated:

> "A neck injury resulting from a blow to his hard hat was surgically treated in 1992 by a bone graft fusion using the right anterior iliac bone. An infection of this site shortly ensued requiring further surgery for drainage. An area of par[e]sthesia resulted around the area down to the genitalia but not including them. This has persisted more than [10] years later with no improvement, affecting his psychological but not his physical sexual activity. He feels he is distracted by the numbness giving him an unnatural and [e]erie sensation affecting the quality of his sexual activity as well as his partner's.
>
> "A loss of sensory sensation around the anterior hip area resulted and remains to the present time. This has reduced the quality of sexual activity between him and his sex partner more in a psychological way in that his genital and penile activity with sensation is normal. Maximum medical improvement (MMI) has reached the maximum at this time."

Dr. Marx diagnosed "[p]ost-operative cicatrix pare[s]thesia, right ilia-inguinal nerve injury" and "[p]sychological sexual dysfunction." He found that appellant had an 8 percent whole person impairment according to Table 7-5 on page 156 of the A.M.A., *Guides*, which provides the criteria for rating a permanent impairment due to penile disease.

By letter dated October 14, 2003, the Office requested a supplemental report from Dr. Marx regarding whether appellant had a permanent loss of function of the penis. The Office further noted that the Federal Employees' Compensation Act did not provide for a whole person impairment rating.

On October 15, 2003 an Office medical adviser reviewed the September 30, 2003 report of Dr. Marx. He noted that Dr. Marx found that appellant had normal sexual and physical function but had "par[es]thesia of the ilioinguinal nerve distribution in the groin area" that did not extend into the sexual organs. The Office medical adviser found that appellant's nerve impairment was not separately ratable according to the A.M.A., *Guides* and did "not involve the

genitalia in this claim." He concluded that, as appellant's "sexual dysfunction was psychological," he did not have a permanent physical impairment as required under Office procedures and thus was not entitled to a schedule award.

In a supplemental report dated October 16, 2003, Dr. Marx related:

> "In response to your inquiry of October 14, 2003 concerning any permanent function loss of the use of the penis I would have to admit that there is no functional loss on a permanent basis based on the work injury and subsequent cervical fusion surgery. However, the psycho/physiological effect of the loss of sensation in the adjacent right groin has reached a level of no change and is a permanent effect on the sexual functioning act."

Dr. Marx again opined that appellant had an eight percent impairment rating.[9]

In an impairment evaluation dated September 9, 2003, Dr. Robert D. Aiken, a Board-certified neurologist, listed findings of normal motor function but "absolute sensory loss in the distribution of the right iliohypogastric nerve." He stated:

> "[Appellant] has had an anterior cervical discectomy at two levels and fusion because of both work and nonwork[-]related cervical spondylolysis with myelopathy. He presently complains of a cutaneous iliohypogastric neuralgia at the iliac crest bone harvest site. The residual numbness is the direct result of his surgery of 1992 and has been static for many years. Although it may be an annoying sensation, it results in no significant quantifiable functional loss. He is able to fully function within all parameters of daily function and work. I do not believe that there is an anatomical explanation for his claim for sexual dysfunction and I suspect that this may be more psychological in nature. Neither do I believe that his claim for sexual dysfunction is due to cervical spinal cord damage."

An Office medical adviser reviewed the report of Dr. Aiken on November 25, 2003. He noted that Dr. Aiken found a sensory deficit in the distribution of the right iliohypogastric nerve but opined that it was not ratable as it was not listed in Table 17-27 on page 552 of the A.M.A., *Guides* and was not "a branch of any of these nerves." The Office medical adviser further noted that Dr. Aiken agreed that appellant's sexual dysfunction was not neurologically based. He concluded that appellant had "no ratable impairment residual from this work injury."

In a decision dated November 25, 2003, the Office denied appellant's claim for a schedule award on the grounds that he had not established a permanent impairment of the lower extremities or penis.

On December 16, 2003 appellant, through his representative, requested a review of the written record. By decision dated March 15, 2004, the hearing representative affirmed the Office's November 25, 2003 decision.

[9] A.M.A., *Guides* 156, Table 7-5.

LEGAL PRECEDENT

The schedule award provision of the Act[10] and its implementing regulation,[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, the Act 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, the Office has adopted the A.M.A., *Guides* as the uniform standards applicable to all claimants.[12] The Office procedures direct the use of the fifth edition of the A.M.A., *Guides*, issued in 2001, for all decisions made after February 1, 2001.[13]

Under section 8107 and its implementing regulations schedule awards provide for payment of compensation for the permanent loss or loss of use of specified members, functions and organs of the body.[14] No schedule award is payable for a member, function or organ of the body that it not specified in the Act or the implementing regulation.[15] The Act identifies members as the arm, leg, hand, foot, thumb and finger, functions as loss of hearing and loss of vision and organs to include the eye.[16] Section 8107(c)(22) of the Act provides for payment of compensation for permanent loss of "any other important external or internal organ of the body as determined by the Secretary of Labor."[17] The Secretary of Labor has made such a determination and, pursuant to the authority granted in section 8107(c)(22), added the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina to the schedule.[18] The Secretary made no provision for impairments of the neck or spine or for whole body impairments.[19]

The statute at section 8107(a) provides a schedule award for "permanent disability involving the loss or loss of use, of a member or function of the body…."[20] The Office's procedures provide, "The phrase 'permanent disability' in 5 U.S.C. § 8107(a) is interpreted to

[10] 5 U.S.C. § 8107.

[11] 20 C.F.R. § 10.404.

[12] 20 C.F.R. § 10.404(a).

[13] *See* FECA Bulletin No. 01-05 (issued January 20, 2001).

[14] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[15] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[16] 5 U.S.C. § 8107(c).

[17] 5 U.S.C. § 8107(c)(22).

[18] 20 C.F.R. § 10.404(a). The Board notes that the Office has awarded schedule awards for conditions which are not covered under the compensation schedule if the condition is shown to have contributed to impairment of a scheduled member.

[19] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[20] 5 U.S.C. § 8107(a).

mean 'permanent physical impairment.' The same standards for evaluating such impairment are applied in all cases."[21]

ANALYSIS

In a report dated July 3, 2002, Dr. Rodriguez noted that appellant had numbness over the right iliac crest and determined that he had a nine percent permanent impairment due to sexual dysfunction. An Office medical adviser reviewed Dr. Rodriguez' report and found that he did not precisely describe the location of appellant's numbness. He also indicated that the iliohypogastric nerve, which caused appellant's numbness, was not a nerve listed in the appropriate table of the A.M.A., *Guides* relevant to nerve impairments of the lower extremity.

The Office referred appellant for second opinion evaluations to determine whether he had any permanent impairment of his lower extremities or penis due to his accepted cervical condition and resulting cervical fusion. Dr. Marx, a Board-certified urologist, in an impairment evaluation dated September 30, 2003, noted that subsequent to appellant's spinal surgery he experienced a sensory loss "around the anterior hip area" which impaired sexual function "more in a psychological way in that his genital and penile activity with sensation is normal." He opined that appellant had an 8 percent whole person impairment due to impaired sexual function according to Table 7-5 on page 156 of the A.M.A., *Guides*. In a supplemental report dated October 16, 2003, Dr. Marx indicated that appellant had "no functional loss" of the penis but had a "loss of sensation in the adjacent right groin" which caused an impairment. He again opined that appellant had an eight percent whole person impairment.

An Office medical adviser noted that Dr. Marx found that appellant had normal sexual function and that his loss of sensation did not extend to the sexual organs. He indicated that, as discussed above, the Office procedures require that an appellant sustain a permanent physical impairment for entitlement to a schedule award.[22] The Office medical adviser determined that, as appellant did not have a permanent impairment or loss of sensation of the penis, he was not entitled to a schedule award for the penis. The Board notes that neither the Act nor the implementing regulation separately lists sexual function as a specified member, function or organ.[23] Instead, the regulation provides for a permanent impairment of the penis.[24] While Dr. Marx found that appellant had sensory loss in the ilioinguinal nerve distribution, the area of the sensory loss was in the groin rather than the sexual organs. As Dr. Marx found that appellant had no loss of sensation or functional impairment of the penis, appellant is not entitled to a schedule award for a permanent impairment of the penis.[25]

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[21] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

[22] *Id*.

[23] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[24] 20 C.F.R. § 10.404(a).

[25] Additionally, as noted above, the Act does not provide for whole person impairments *See Jay K. Tomokiyo*, *supra* note 19.

Dr. Aiken, a Board-certified neurologist, provided an impairment evaluation on September 9, 2003. He found that appellant's complaints of "cutaneous iliohypogastric neuralgia at the iliac crest bone harvest site" was the "direct result of his surgery of 1992…." Dr. Aiken concluded that appellant had no functional loss resulting from the altered sensation or loss of sexual function.

An Office medical adviser reviewed Dr. Aiken's report on November 25, 2003. He determined that, while Dr. Aiken found a loss of sensation in the distribution of the right iliohypogastric nerve, it was not ratable because it was not listed in Table 17-37 on page 552 of the A.M.A., *Guides*, which provides impairments due to nerve deficits of the lower extremity. He further noted that it was not a branch of any of the nerves identified by the table. The Board finds that the Office medical adviser properly applied the A.M.A., *Guides* in finding that appellant was not entitled to a schedule award for a loss of sensation of the right iliohypogastric nerve as it was not identified in the appropriate table providing impairments of the lower extremity due to nerve deficits and was not a branch of an identified nerve. There is no other medical evidence of record showing that appellant has a ratable permanent impairment of the lower extremities in accordance with the A.M.A., *Guides*. Appellant submitted a report from Dr. Bonner finding that he had a 25 to 28 percent whole person impairment, however, the Act does not provide a schedule award for whole person impairments.[26] Furthermore, Dr. Bonner did not reference any particular section of the A.M.A., *Guides* in reaching his conclusions. Appellant, consequently has not met his burden of proof to establish entitlement to a schedule award.

CONCLUSION

The Board finds that the Office properly determined that appellant was not entitled to a schedule award for a permanent impairment of the penis or the lower extremities.

[26] *See James E. Mills*, 43 ECAB 215 (1991) (neither the Act nor its implementing regulation provide for a schedule award for impairment to the body as a whole).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 25, 2003 is affirmed.

Issued: October 29, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member