United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 16-0502**
	)	**Issued: June 13, 2016**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Austin, TX, Employer	)	

Appearances:
Thomas Mann, Jr., Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 19, 2016 appellant, through counsel, filed a timely appeal from a December 31, 2015 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.

ISSUE

The issue is whether appellant met his burden of proof to establish greater than 10 percent permanent impairment of the left lower extremity for which he received schedule awards.

On appeal counsel asserts that Dr. William Nemeth, a Board-certified orthopedic surgeon who provided a second opinion evaluation for OWCP, did not examine appellant. As such his

[1] 5 U.S.C. § 8101 *et seq.*

opinion is of no probative value, and appellant should be referred to another qualified physician for examination and an impairment evaluation.

FACTUAL HISTORY

On February 12, 2009 appellant, then a 49-year-old clerk,[2] filed a traumatic injury claim (Form CA-1) alleging that on January 26, 2009 he injured his left leg, arm, neck, and left shoulder when he slipped and fell on slick pavement while walking near the security entrance at work. He did not stop work.

In merit decisions dated August 24, 2009, February 6, 2010, and February 25, 2011, OWCP denied the claim finding no injury resulting from the January 26, 2009 employment incident. On February 8, 2012 it accepted that the January 26, 2009 employment incident caused thoracic or lumbosacral neuritis or radiculitis, not otherwise specified.

A December 16, 2009 electrodiagnostic study of the left lower extremity was normal. A January 5, 2010 magnetic resonance imaging (MRI) scan of the lumbar spine demonstrated degenerative disc and joint changes at L5-S1 with a synovial cyst versus disc fragment. A March 29, 2012 MRI scan of the lumbar spine demonstrated moderate-to-severe narrowing of both foramina which could displace the S1 nerve root, a synovial cyst at L5-S1, and milder degenerative changes at L4-5.

On December 4, 2012 appellant filed a schedule award claim (Form CA-7). He submitted an October 26, 2012 report in which Dr. Michael S. Perkins, Board-certified in occupational medicine, noted a history that, as a result of the 1979 injury, appellant had ongoing right leg spasticity with right foot drop and numbness of the entire left leg. Appellant described the January 26, 2009 employment injury and noted the March 29, 2012 MRI scan findings. Physical examination demonstrated right lower extremity spasticity. Dr. Perkins advised that unsteadiness prevented lumbar motion measurements, and lower extremity spasticity prevented straight leg raising. He diagnosed herniated lumbar disc. Dr. Perkins advised that appellant had reached maximum medical improvement as of October 15, 2012 and, in accordance with Table 17-4 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] appellant had a class 2 impairment. He applied the net adjustment formula and concluded that appellant had 12 percent whole person impairment. In a November 12, 2012 supplementary report, Dr. Perkins advised that, in accordance with Table 16-10, 12 percent whole person impairment equaled 31 percent lower extremity impairment.

On December 14, 2012 Dr. Ronald Blum, an OWCP medical adviser, who is a Board-certified orthopedic surgeon, reviewed the record, including Dr. Perkins' reports. He noted that the spine is not a scheduled member and Dr. Perkins did not describe specific lower extremity

[2] On July 22, 1979 appellant, then 19 years old, was in a nonemployment-related motor vehicle accident and fractured his spine at C7 with resulting quadriparesis. He underwent cervical interbody fusion and had some return of movement of the left leg.

[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009).

sensory and motor deficits. As such, Dr. Perkins' report was invalid and inadequate. He recommended referral to an appropriate physician for an impairment evaluation in accordance with the proper tables of the A.M.A., *Guides*.

OWCP referred appellant to Dr. Jerome O. Carter, a Board-certified orthopedic surgeon, in January 2013. In a March 25, 2013 report, Dr. Carter described the work injury, his review of the medical record including diagnostic study reports, and appellant's complaints of constant pain in the left hip, left knee, left ankle, left leg, and left foot with weakness in the left leg and burning with sudden jerks and agitations. He reported findings, noting moderately decreased sensation in the femoral, obturator, superior gluteal, interior gluteal, lateral femoral cutaneous, posterior femoral cutaneous, saphenous, lateral plantar, medial plantar, sural, superficial peroneal, common peroneal, and sciatic nerves on the left with decreased pinwheel sensation of the entire left leg. The right was within normal limits. Bilateral strength testing showed spasticity, right greater than left, which made it difficult to assess motor strength. Appellant was unable to heel or toe walk. Dr. Carter advised that appellant reached maximum medical improvement on October 12, 2012. He found that, under July/August 2009 *The Guides Newsletter*, using proposed Table 2, appellant had class 1 moderate sensory deficits in the left L5 and S1 distributions. Dr. Carter applied the net adjustment formula to each nerve root, and concluded that appellant had three percent left leg impairment due to L5 sensory loss, and two percent for S1 sensory loss, for a total of five percent left leg impairment.

Dr. Michael M. Katz, a Board-certified orthopedic surgeon and OWCP medical adviser, reviewed the record, including Dr. Carter's report. He agreed with Dr. Carter's findings, concluding that appellant had five percent left lower extremity impairment, with maximum medical improvement reached on March 25, 2013.

On June 18, 2013 OWCP granted appellant a schedule award for five percent left lower extremity impairment, for 14.4 weeks, to run from March 25 to July 3, 2013. He timely requested a review of the written record by an OWCP hearing representative.

In a December 12, 2013 decision, the OWCP hearing representative found that, as Dr. Perkins did not evaluate appellant's impairment in accordance with the July/August 2009 *The Guides Newsletter*, his opinion was of no probative value. He nonetheless found that Dr. Carter, the OWCP referral physician, did not address whether appellant had additional left lower extremity impairment due to the preexisting cervical injury and fusion surgery. The hearing representative vacated the June 18, 2013 schedule award decision and remanded the case to OWCP to obtain a supplemental report from Dr. Carter and for reexamination if required.

On remand, OWCP referred appellant for reexamination with Dr. Carter, with an appointment scheduled for March 17, 2014. Appellant appeared for the appointment, but there was a disagreement with the staff concerning cell phone usage, and appellant left. He was then scheduled for a second opinion evaluation with Dr. William Nemeth, a Board-certified orthopedic surgeon. In a May 27, 2014 report, Dr. Nemeth noted the 1979 cervical spine injury, the employment injury, and appellant's complaint of dull, achy, stabbing pain in the thigh area.

He advised that appellant had difficulty with activities of daily living due to spasticity and stiffness in both lower extremities, and that he walked with a crutch. Dr. Nemeth stated:

> "On exam[ination], [appellant] has a paraparetic spastic gait, walks slowly with knees and hips flexed. He is somewhat difficult to examine because of the previous C7 spinal cord injury. [Appellant] does have interosseous atrophy of both hands, right worse than left. He has spasticity of the right upper extremity, of the right lower extremity, and left lower extremity. I cannot do straight leg raises because of that. [Appellant] has hyperreflexic deep tendon reflexes at the knee jerk, 3+ but symmetrical, ankle 2+ and symmetric. His heel cords are right. [Appellant] has decreased extensor hallucis strength on the left side. He has decreased sensation in the superficial femoral nerve on the left side, and hyperalgesia and hypesthesia in the area of the superficial femoral nerve."

Dr. Nemeth diagnosed C7 spastic quadriplegia with lower extremity involvement, nonwork-related, preexisting, and meralgia paraesthetica, left, from contusion and neuropractic injury of the superficial femoral nerve, not L5 and S1 nerve roots. Dr. Nemeth advised that Dr. Perkins did not use the proper methodology for rating appellant's left leg impairment. He advised that, based on his physical examination findings, under Table 16-12, Peripheral Nerve Impairment, of the A.M.A., *Guides*, appellant had a grade C superficial femoral nerve impairment which yielded seven percent permanent impairment of the left lower extremity.

In a June 26, 2014 report, Dr. Blum, the OWCP medical adviser, reviewed Dr. Nemeth's report. He advised that Dr. Nemeth erroneously identified the nerve as the superficial femoral when it should have been the lateral femoral cutaneous nerve. Dr. Blum further noted that, while Dr. Nemeth found 7 percent permanent impairment using the middle value for the range 1 to 13 percent under Table 16-12, the specific range for sensory loss in the lateral femoral cutaneous nerve is identified as 1 to 5 percent in Table 16-12. He recommended the middle value, grade C, or three percent impairment.

OWCP forwarded a copy of the medical adviser's report to Dr. Nemeth who responded on January 30, 2015. Dr. Nemeth advised that he agreed with Dr. Blum that he used the wrong range on Table 16-12. However, he opined that appellant had a very severe deficit of the cutaneous nerve which he characterized as class 1, severe, under Table 16-12, for five percent left lower extremity impairment.

On February 20, 2015 Dr. Blum, the medical adviser, reviewed Dr. Nemeth's January 30, 2015 report and agreed that appellant had five percent left lower extremity impairment. OWCP then asked Dr. Blum if appellant, who had previously received a schedule award for five percent left lower extremity impairment, was entitled to an additional award. In a March 9, 2015 response, he indicated that appellant was entitled to an additional award because the loss described by Dr. Nemeth was separate from the loss initially identified. Dr. Blum concluded that the 5 percent losses should be combined, which yielded a total left lower extremity impairment of 10 percent.

By decision dated March 12, 2015 appellant was granted a schedule award for an additional five percent left lower extremity impairment, to run for 14.4 weeks, from May 27 to September 4, 2014.

On August 11, 2015 appellant, through counsel, requested reconsideration. Counsel asserted that Dr. Nemeth did not examine appellant, and attached a signed and notarized affidavit dated August 4, 2015. In the affidavit, appellant attested that when he saw Dr. Nemeth on May 27, 2014:

> "The doctor asked me to sit on a table with my legs dangling. I began to express to him what was going on with my L-5 nerve injury and [thigh] pain. He did not regard it as important, and looked at me for about five minutes. He then made a few statements. One of which was, 'You already have a disability. You have an impairment, but not 31 percent.' He then approached his file folder and glanced at Dr. Perkins' examination and said 'I will have to use this.' He then stated he would fix it for me and that we were finished. However, as I attempted to walk away, I noticed he was watching my [gait] and the fact that I was having trouble with my stride, he then dropped his head, which was to me an indication that it could be as Perkins stated: a 31 percent impairment rating. Dr. Nemeth never touched my body. He did not physically examine me. He did not ask me any substantial questions."

Appellant then described his physical condition, describing continued intense pain, difficulty sleeping, mental anguish, and lower extremity weakness. He concluded that he was required to use a wheelchair at work.

In a merit decision dated December 31, 2015, OWCP denied modification of the March 12, 2015 decision because the evidence submitted did not support an additional impairment.

LEGAL PRECEDENT

It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of any employment injury.[4]

The schedule award provision of FECA,[5] and its implementing federal regulation,[6] 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

[4] *See Tammy L. Meehan*, 53 ECAB 229 (2001).

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is to be used.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[9] Under the sixth edition, for upper extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11] The sixth edition of the A.M.A., *Guides* also provides that, under certain circumstances, range of motion may be selected as an alternative approach in rating impairment. An impairment rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.[12]

Although the A.M.A., *Guides* includes guidelines for estimating impairment due to disorders of the spine, under FECA a schedule award is not payable for injury to the spine.[13] In 1960, amendments to FECA modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. Therefore, as the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[14]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. The A.M.A., *Guides* for decades has offered an alternative approach to rating spinal nerve impairments.[15] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures, which memorializes proposed tables outlined in a

[7] 20 C.F.R. § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.* at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[9] A.M.A., *Guides*, *supra* note 3 at 3, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[10] *Id*. at 385-419.

[11] *Id*. at 411.

[12] *Id*. at 390. The A.M.A., *Guides* explains that diagnoses in the grid that may be rated using range of motion are followed by an asterisk.

[13] *Pamela J. Darling*, 49 ECAB 286 (1998).

[14] *Thomas J. Engelhart*, 50 ECAB 319 (1999).

[15] *Rozella L. Skinner*, 37 ECAB 398 (1986).

July/August 2009 *The Guides Newsletter*.[16] Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[17] and upper extremity impairment originating in the spine through Table 15-14.[18]

ANALYSIS

OWCP accepted that a January 26, 2009 employment injury caused thoracic or lumbosacral neuritis or radiculitis, not otherwise specified. On June 18, 2013 OWCP granted appellant a schedule award for 5 percent permanent impairment of the left lower extremity, and on March 12, 2015 he was awarded an additional 5 percent impairment, for a total 10 percent left lower extremity permanent impairment. The Board finds that appellant has not met his burden of proof to establish more than 10 percent permanent impairment of the left lower extremity.

With regard to counsel's assertion on appeal that Dr. Nemeth did not examine appellant, in his May 27, 2014 report the physician described his findings on observation and examination. Moreover, in his January 30, 2015 report, Dr. Nemeth opined that appellant had a very severe nerve deficit, characterized as class 1, severe, and found that he was entitled to five percent left leg impairment, the maximum allowed under Table 16-12.

The October 26, 2012 report from Dr. Perkins, opining that appellant had 31 percent left leg impairment, was not in accordance with the A.M.A., *Guides*. He rated appellant's impairment under Table 17-4, Lumbar Spine Regional Grid.[19] Under FECA a schedule award is not payable for injury to the spine.[20] As noted, the proper mechanism for rating impairment of the upper or lower extremities caused by a spinal injury is provided in section 3.700 of OWCP procedures, which memorializes proposed tables outlined in a July/August 2009 *The Guides Newsletter*.[21] The Board has long held that an opinion which is not based upon the standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's impairment.[22] As such, the Board finds that Dr. Perkins' opinion is of limited probative value regarding appellant's left leg impairment.

However, in the case at hand, both Dr. Nemeth and Dr. Blum, the OWCP medical adviser, identified lower extremity peripheral nerve injuries. Section 16.4 of the A.M.A., *Guides*

[16] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, Chapter 3.700, Exhibit 1, note 5 (January 2010); *The Guides Newsletter* is included as Exhibit 4.

[17] *Supra* note 3 at 533.

[18] *Id*. at 425.

[19] *Id*. at 570.

[20] *Supra* note 13.

[21] *Supra* note 16.

[22] *Carl J. Cleary*, 57 ECAB 563 (2006).

describes the methodology to be followed in rating lower extremity peripheral nerve impairments.[23]

In his May 27, 2014 report, Dr. Nemeth discussed examination findings. In his January 30, 2015 report, he characterized appellant's left leg impairment as class 1, severe, under Table 16-12, for five percent left leg impairment, the maximum allowed.[24] On February 20, 2015 Dr. Blum reviewed Dr. Nemeth's January 30, 2015 report and agreed with his conclusion that appellant had five percent left lower extremity impairment. On March 9, 2015 he indicated that appellant was entitled to an additional award of five percent because the loss described by Dr. Nemeth was separate from the loss initially identified. Dr. Blum concluded that the 5 percent losses should be combined, which yielded a total left leg impairment of 10 percent.

The Board finds that Dr. Nemeth's opinion, as reviewed by Dr. Blum, represents the weight of the medical evidence. The Board has carefully reviewed their reports and finds that their opinions have reliability, probative value, and convincing quality with respect to its conclusions regarding the relevant issue in the present case. Dr. Nemeth's opinion was based on a proper factual and medical history, and he thoroughly reviewed the factual and medical history and accurately summarized the relevant medical evidence.[25] He provided sufficient medical rationale for his opinion by explaining that, after careful review of all medical documentation and his clinical examination of appellant, appellant had five percent left lower extremity impairment due to a peripheral nerve injury. Dr. Blum agreed and advised that this was in addition to the five percent previously awarded. Appellant, therefore, has not established left lower extremity impairment greater than the 10 percent previously awarded.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 10 percent permanent impairment of the left lower extremity, for which he received schedule awards.

[23] *Supra* note 3 at 531-33.

[24] *Id*. at 534-35.

[25] *See D.K.*, Docket No. 15-1312 (issued October 6, 2015).

ORDER

IT IS HEREBY ORDERED THAT the December 31, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 13, 2016
Washington, DC

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

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

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