United States Department of Labor
Employees' Compensation Appeals Board

B.C., Appellant	)	
and	)	**Docket No. 17-1617**
	)	**Issued: January 8, 2018**
DEPARTMENT OF THE AIR FORCE, AIR EDUCATION & TRAINING COMMAND, LACKLAND AIR FORCE BASE, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On July 21, 2017 appellant filed a timely appeal from a January 23, 2017 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 lower extremity permanent impairment due to his accepted lumbar condition, warranting a schedule award.

FACTUAL HISTORY

On August 6, 2015 appellant, then a 58-year-old information technology (IT) specialist, filed a traumatic injury claim (Form CA-1) for lower back and left leg conditions he alleged arose in the performance of duty on July 28, 2015. He and a coworker were moving a loaded

[1] 5 U.S.C. § 8101 *et seq.*

metal cart down a ramp when it started to veer off the ramp. Appellant indicated that they struggled to regain control of the cart and he injured his back. He did not stop work around the time he filed his claim.[2]

A September 3, 2015 lumbar x-ray revealed degenerative disc and joint disease at L4-5 and L5-S1, without evidence of fracture or destructive lesion.

In a September 3, 2015 report, Dr. Jose V. Vela, an attending Board-certified internist and family practitioner, noted that appellant complained of low back and radiating left leg pain. He reported findings on physical examination and diagnosed lumbar strain.

OWCP initially accepted that appellant sustained a lumbar sprain. It later expanded the accepted conditions to include lumbar intervertebral disc displacement.

A December 9, 2015 lumbar magnetic resonance imaging (MRI) scan contained an impression of left paracentral disc herniation at L5-S1 with impingement of the exiting left L5 nerve root and traversing left S1 nerve root, and a broad-based disc bulge at L2-3 with mild impingement of the anterior thecal sac. There was no fracture, tumor, abscess, sequestered, or extruded disc fragment, osteomyelitis, discitis, or retroperitoneal aneurysm. The findings showed mild degenerative disc and joint disease consistent with age, involving both the anterior and posterior elements of the lumbar spine. There was no evidence of dysmorphism, fracture, mass, tumor, retroperitoneal lesion, aneurysm, or suggestion of inflammatory change.

In a July 27, 2016 report, Dr. Vela reported the findings of his physical examination of that date. He indicated that appellant exhibited mild tenderness to palpation of the lumbar paraspinal muscles and noted that straight leg raise testing in both legs was negative.

On November 4, 2016 appellant filed a claim for a schedule award (Form CA-7).

Appellant submitted an August 23, 2016 report in which Dr. Mark Mason, an attending Board-certified occupational medicine physician, discussed his factual and medical history and reported the findings of the physical examination he performed on that date. Dr. Mason noted that no electrodiagnostic studies were performed. He observed that appellant transitioned from one position to another with minimal difficulty. Dr. Mason noted that straight leg testing was tolerated to 40 degrees and that there were no distal symptoms with maximum tolerated straight leg raising. He advised that it was reasonable to say that appellant reached maximum medical improvement on July 27, 2016, the date that appellant last saw Dr. Vela, having completed all of the diagnostic workup and treatment. Dr. Mason indicated that no further material recovery from or lasting improvement to the compensable work condition could reasonably be anticipated from further treatment that appellant was interested in pursuing. He noted that, according to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent*

[2] Beginning on October 18, 2015, appellant received wage-loss compensation on the daily roll for intermittent work stoppages. Some of these work stoppages were due to his attendance at physical therapy sessions to treat his work-related condition.

Impairment (A.M.A., *Guides*),[3] appellant qualified for a left lower extremity permanent impairment rating of 14 percent due to his work injury.

Dr. Mason indicated that he used *The Guides Newsletter*, "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" (July/August 2009) (*The Guides Newsletter*) to assign the permanent impairment rating for the lumbar radiculopathies affecting appellant's left lower extremity.[4] For the L5 nerve, appellant qualified for a moderate sensory loss according to Table 17-7 and this qualified for a range of impairment between two and five percent of the left lower extremity with a grade C default value (within class 1) of three percent impairment. Dr. Mason indicated that, for the motor component of the L5 nerve, appellant qualified for mild motor deficit using Table 17-7 for physical examination, and qualified for range of impairment between zero and nine percent of the left lower extremity using proposed Table 2. The default grade C default value (within class 1) was five percent. Hence, the default rating for sensory loss was three percent of the left lower extremity and the default rating for motor loss was five percent of the left lower extremity. Dr. Mason indicated that these were modified by the grade modifiers for functional history and clinical studies. For functional history, using Table 17-6, appellant qualified under modifier 2 which resulted in a modifier adjustment of +1 (grade modifier 3 minus class 1 equaled adjustment 1). For clinical studies, using Table 17-9, he qualified for grade modifier 2 and an adjustment of +1 (grade modifier 2 minus class 1 equaled modifier adjustment +1). Hence, the grade modifier adjustment under the net adjustment formula was +2. This moved appellant from the grade C default value (within class 1) to the maximum grade E value (within class 1). For the sensory component of the nerve, this qualified for five percent permanent impairment of the left lower extremity. For the motor component, appellant qualified for a maximum of nine percent permanent impairment of the left lower extremity. Dr. Mason concluded that these values combined to equal 14 percent permanent impairment of the left lower extremity.

In November 2016, OWCP referred appellant's case to Dr. Arthur S. Harris, an attending Board-certified orthopedic surgeon serving as an OWCP medical adviser, and requested that he evaluate the permanent impairment of appellant's lower extremities.

In a November 22, 2016 report, Dr. Harris determined that appellant did not have permanent impairment of his lower extremities under the standards of the sixth edition of the A.M.A., *Guides.* He noted that appellant was seen for evaluation on August 23, 2016 by Dr. Mason who documented his ongoing symptoms. Dr. Mason documented that a December 9, 2015 MRI scan of appellant's lumbar spine demonstrated a disc herniation at L5-S1 and a bulging disc at L2-3. Dr. Harris noted that Dr. Mason found that appellant had 14 percent permanent impairment of his left lower extremity for problems associated with L5 radiculopathy. He advised that, from review of the medical record, a lumbar disc herniation at L5-S1 had been established. Dr. Harris indicated that, although Dr. Mason found in his August 23, 2016 report that appellant had 14 percent left lower extremity impairment due to an L5 radiculopathy, his examination did not demonstrate any neurologic deficit in either lower extremity. He found that, as appellant did not have documented neurologic deficits, he was not entitled to a permanent impairment rating based on the sixth edition of the A.M.A., *Guides*. Dr. Harris concluded that, for purposes of

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

[4] *See infra* notes 12 through 14.

calculating a schedule award utilizing the sixth edition of the A.M.A., *Guides*, appellant had zero percent permanent impairment of either lower extremity.

By January 23, 2017 decision, OWCP determined that appellant had not met his burden of proof to establish permanent impairment of his lower extremities due to his accepted employment condition. It based its determination on Dr. Harris' November 22, 2016 report which evaluated the August 23, 2016 findings of Dr. Mason.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.[5] FECA, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[6] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[7]

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.[8] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[9] The sixth edition of the A.M.A., *Guides* (2009) provides a specific methodology for rating spinal nerve extremity impairment.[10] 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 procedure manual.[11]

In addressing lower extremity impairments, due to peripheral or spinal nerve root involvement, the sixth edition requires identifying the impairment for the Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on grade modifier for

[5] 5 U.S.C. § 8107(c). For a total or 100 percent loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

[6] 20 C.F.R. § 10.404.

[7] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[8] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[9] *Supra* note 7 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6a(3) (February 2013).

[10] The methodology and applicable tables were initially published in *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009).

[11] *See supra* note 6 at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4.

Functional History (GMFH) and, if electrodiagnostic testing was done, grade modifier for Clinical Studies (GMCS).[12] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[13]

ANALYSIS

OWCP accepted appellant's traumatic injury claim for lumbar sprain and expanded to include lumbar intervertebral disc displacement. Appellant filed a claim for a schedule (Form CA-7) and, in a May 30, 2017 decision, OWCP determined that appellant did not meet his burden of proof to establish permanent impairment of his lower extremities due to his accepted employment injury. OWCP based its determination on the November 22, 2016 report of Dr. Harris, OWCP's medical adviser, who reviewed the August 23, 2016 findings of Dr. Mason, an attending physician.

Dr. Mason indicated that he applied the standards of the sixth edition of the A.M.A, *Guides*, including *The Guides Newsletter.* He determined that appellant had 14 percent permanent impairment of the left lower extremity due to sensory and motor deficits associated with the L5 nerve root.

In his November 22, 2016 report, Dr. Harris, OWCP's medical adviser, properly determined that appellant did not have permanent impairment of his lower extremities under the standards of the sixth edition of the A.M.A., *Guides.* He discussed Dr. Mason's August 23, 2016 evaluation noting that, although Dr. Mason found in his August 23, 2016 report that appellant had 14 percent left lower extremity impairment due to left L5 radiculopathy, his examination did not demonstrate a neurologic deficit in either lower extremity. It is noted that Dr. Mason reported on August 23, 2016 that straight leg testing was tolerated to 40 degrees and that there were no distal symptoms with maximum tolerated straight leg raising. Dr. Harris acknowledged that a December 9, 2015 lumbar MRI scan demonstrated a disc herniation at L5-S1, but he correctly found that an L5 radiculopathy had not been established. The Board finds that Dr. Harris properly opined that, as appellant did not have documented neurologic deficits, he was not entitled to any permanent impairment rating based on the sixth edition of the A.M.A., *Guides*. In his August 23, 2016 report, Dr. Mason specifically indicated that electrodiagnostic studies were not performed. As noted above, a schedule award is not payable under FECA for injury to the spine or back and *The Guides Newsletter* is designed to evaluate peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries.[14] Dr. Harris properly concluded that, for purposes of calculating a schedule award utilizing the sixth edition of the A.M.A., *Guides*, appellant had zero percent permanent impairment of either lower extremity.

On appeal appellant contends that the opinion of Dr. Harris should not have been accepted over that of Dr. Mason. In some instances, OWCP's medical adviser's opinion can constitute the weight of the medical evidence. As long as OWCP's medical adviser explains his or her opinion, shows values and computation of impairment based on the A.M.A., *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the

[12] A.M.A., *Guides* 515-21, 533.

[13] *Id.* at 521.

[14] *See supra* notes 8 through 12.

weight of the medical evidence.[15] As explained above, Dr. Harris, OWCP's medical adviser, identified the errors in Dr. Mason's impairment rating and then properly applied the standards of the sixth edition of the A.M.A., *Guides* to find that appellant had no lower extremity permanent impairment.

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.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish lower extremity permanent impairment due to his accepted employment injury.

ORDER

IT IS HEREBY ORDERED THAT the January 23, 2017 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 8, 2018
Washington, DC

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

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

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

[15] If the attending physician misapplied the A.M.A., *Guides*, no conflict would exist because the attending physician's report would have diminished probative value and the opinion of OWCP's medical adviser would constitute the weight of medical opinion. *Supra* note 6 at Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.8j (September 2010); *M.P.*, Docket No. 14-1602 (issued January 13, 2015).