United States Department of Labor
Employees' Compensation Appeals Board

W.G., Appellant	)	
and	)	**Docket No. 21-0675**
	)	**Issued: December 28, 2021**
DEPARTMENT OF THE TREASURY, BUREAU OF ENGRAVING & PRINTING, Washington, DC, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On March 23, 2021 appellant filed a timely appeal from an October 22, 2020 merit decision and a February 26, 2021 nonmerit 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 to consider the merits of this case.[2]

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than 13 percent permanent impairment of the left lower extremity and 4 percent permanent impairment

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that, following the February 26, 2021 decision, OWCP received additional evidence and appellant submitted additional evidence on appeal. 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*.

of the right lower extremity for which he previously received a schedule award; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On September 26, 2000 appellant, then a 51-year-old electrician, filed a traumatic injury claim (Form CA-1) alleging that, on that date, he sustained a left lower back injury when he lost his footing and fell from a six foot ladder onto the corner of a cardboard box containing computer parts. He stopped work that day. On January 5, 2001 OWCP accepted the claim for thoracic spine fracture and L2 fracture. Appellant returned to light-duty work on May 16, 2001.

By decision dated March 19, 2003, OWCP accepted a recurrence of disability commencing February 28, 2002.

On December 6, 2006 appellant underwent OWCP-approved right shoulder arthroscopy with acromioclavicular resection.

On January 22, 2008 appellant filed a claim for a schedule award (Form CA-7). He submitted a February 5, 2009 impairment rating by Dr. Stephen T. Michaels, a Board-certified orthopedic surgeon, who summarized his history of injury and treatment including physical therapy, epidural injections, and medication. Dr. Michaels noted that an electromyography/nerve conduction velocity (EMG/NCV) study confirmed the presence of left-sided S1 radiculopathy. He opined that appellant had attained maximum medical improvement (MMI) in October 2008. Dr. Michaels diagnosed bilateral lower extremity radiculopathy, which interfered significantly with activities of daily living. Referring to the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] he found 26 percent permanent impairment of the left lower extremity due to weakness in ankle plantar flexion and toe flexion, and sensory losses in the left foot and ankle. Dr. Michaels also found 10 percent permanent impairment of the right lower extremity due to sensory loss with decreased pinprick sensation.

On February 24, 2009 appellant filed a claim for a schedule award (Form CA-7).

On April 6, 2009 OWCP referred the record, including a statement of accepted facts (SOAF), to Dr. Lawrence A. Manning, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), to determine appellant's percentage of permanent impairment and date of MMI. By letter dated April 11, 2009, Dr. Manning noted his review of the medical record, including Dr. Michaels' February 5, 2009 report. He opined that appellant had attained MMI on September 26, 2001, one year from the date of injury. Referring to the fifth edition of the A.M.A., *Guides*, Dr. Manning found eight percent permanent impairment of the left lower extremity and three percent permanent impairment of the right lower extremity based on S1 sensory and motor impairment.

[3] A.M.A., *Guides* (5th ed. 2001).

In an April 14, 2009 report, Dr. Michaels found lower paralumbar tenderness extending into the left lower extremity, numbness extending into the left lower extremity, and good distal strength.

A May 1, 2009 MRI scan of the lumbar spine demonstrated L3-4 disc desiccation, a small concentric L3-4 disc protrusion, very small right-sided L5-S1 disc protrusion, and mild lower lumbar facet joint arthropathy.

In a report dated November 3, 2009, Dr. Michaels referred generally to the sixth edition of the A.M.A., *Guides*[4] to find 13 percent permanent impairment of the right upper extremity, a 9 percent permanent impairment of the right lower extremity, and 21 percent permanent impairment of the left lower extremity.

On March 2, 2010 OWCP referred the record and an updated SOAF to Dr. Manning to determine the appropriate percentage of permanent impairment. By letter dated March 13, 2010, Dr. Manning reviewed the medical record and SOAF. Referring to Table 15-5, page 403 (Shoulder Regional Grid) of the sixth edition of the A.M.A., *Guides*, he found 10 percent impairment of the right upper extremity due to distal clavicle resection. He opined that the right upper extremity had attained MMI on December 6, 2007, one year after the arthroscopic procedure. Dr. Manning found 13 percent permanent impairment of the left lower extremity based on the default rating for sciatic nerve impairment with a mild-to-moderate sensory deficit and mild motor deficit with a Class 1 diagnosis-based impairment. He also found four percent permanent impairment of the right lower extremity due to mild-to-moderate sensory deficit in the sciatic nerve with mild motor deficit.

By decision dated April 26, 2010, OWCP granted appellant a schedule award for 13 percent permanent impairment of the left lower extremity, 4 percent permanent impairment of the right lower extremity, and 10 percent permanent impairment of the right upper extremity. The award ran for 80.16 weeks, from December 6, 2007 through June 9, 2009.

On April 29, 2011 appellant underwent OWCP-authorized right shoulder arthroscopic subacromial decompression and distal clavicle excision.

In a July 10, 2017 report, Dr. Christopher M. Magee, a Board-certified orthopedic surgeon, diagnosed cervical radiculopathy, right subacromial bursitis, and right acromioclavicular arthritis. He administered a right subacromial injection.

On October 12, 2017 OWCP expanded its acceptance of the claim to include post-traumatic osteoarthritis of the right shoulder, right shoulder impingement syndrome, right rotator cuff and upper arm sprain, lumbar sprain, lumbosacral joint and ligament sprain, closed fracture of lumbar vertebra without spinal cord injury, and thoracic or lumbosacral neuritis or radiculitis.

On November 9, 2017 appellant underwent OWCP-authorized right shoulder arthroscopy with subacromial decompression and distal clavicle excision.

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

On January 16, 2018 appellant filed a claim for an additional schedule award (Form CA-7).

In a development letter dated January 17, 2018, OWCP requested an impairment rating based on the A.M.A., *Guides*, which provided appropriate measurements, findings, and a recommended percentage of permanent impairment of the affected member or members based on the applicable tables of the A.M.A., *Guides*. It afforded 30 days for appellant to submit the requested evidence.

In response, appellant submitted a May 9, 2018 report by Dr. Magee, who noted the September 26, 2000 employment injury and subsequent treatment. Dr. Magee noted that appellant continued to exhibit consistent signs of left S1 radiculopathy, including intermittent weakness and diminished sensation in the left lower extremity proximally and occasionally extending into the calf. He opined that, based on these consistent findings, appellant had radicular symptoms in both lower extremities, which interfered with activities of daily living. Dr. Magee found that appellant had attained MMI. He noted a 26 percent permanent impairment of the left lower extremity due to weakness in the ankle plantar flexion and toe flexion as well as sensory losses in his left foot and ankle. Dr. Magee also found 10 percent permanent impairment of the right lower extremity based on diminished pinprick sensation.

On June 20, 2018 OWCP referred appellant to Dr. Easton L. Manderson, a Board-certified orthopedic surgeon, for a second opinion evaluation of appellant's permanent impairment of the bilateral lower extremities due to spinal nerve root compromise. In a report dated July 18, 2018, Dr. Manderson reviewed his history of injury and the medical record. On physical examination, he noted surgical scars on the right shoulder, good range of motion of the right shoulder, bilaterally negative straight leg raising tests, and bilateral iliolumbar tenderness. Dr. Manderson diagnosed right rotator cuff tendinitis, status post arthroscopic surgery times three, lumbar strain, and lumbar radiculopathy by MRI scan, but "not by physical examination." He opined that appellant had attained MMI as of September 26, 2001, one year following the employment injury. Referring to *The Guides Newsletter*, *Rating Spinal Nerve Extremity Impairment using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Dr. Manderson assessed a severe or very severe motor deficit as appellant reported that muscle use when driving generated severe lower extremity discomfort. Dr. Manderson found Class 1 sensory and motor deficits, with a default grade of C, equaling 5 percent permanent impairment of the lower extremity due to sensory deficit and a 13 percent permanent impairment of the lower extremity for motor deficit. Referring to Table 16-6, page 516 (Functional History Adjustment – Lower Extremities) of the A.M.A., *Guides*, he assigned a grade modifier for functional history (GMFH) of 2 due to documented L5 and S1 nerve root compression causing severe deficits. Dr. Manderson found that a grade modifier for physical examination (GMPE) was not applicable. He assigned a grade modifier for clinical studies (GMCS) of 3 according to Table 16-8, page 519 (Clinical Studies Adjustment – Lower Extremities) due to intolerable sensory discomfort into the bilateral lower extremities with abnormal sensation. Applying the net adjustment formula, (GMFH - CDX) + (GMCS - CDX) = (2-1) + (3-1) = +3, moved the default grade upward from C to E. Dr. Manderson therefore found 5 percent permanent impairment of the left lower extremity for sensory deficit and 13 percent permanent impairment of the left lower extremity for motor deficit. Utilizing the Combined Values Chart at page 604 of the A.M.A., *Guides*, he found 17 percent permanent impairment of the left lower extremity due to S1 nerve root impairment. Applying the same calculation to the L5 nerve root, Dr. Manderson found 2 percent permanent impairment due to L5 sensory deficit and 9

percent impairment due to L5 motor deficit, combined to equal 11 percent permanent impairment of the left lower extremity. He again utilized the Combined Values Chart to combine the 17 percent S1 impairment and 11 percent L5 impairment to yield a final 26 percent permanent impairment of the left lower extremity. Dr. Manderson noted that appellant had no permanent impairment of the right lower extremity.

On September 20, 2018 OWCP referred the record and an updated SOAF to Dr. Kenechukwu Ugokwe, a Board-certified orthopedic surgeon serving as DMA, to determine the appropriate percentage of permanent impairment of the bilateral lower extremities. By letter dated October 9, 2018, Dr. Ugokwe opined that appellant had a zero percent permanent impairment of the lower extremities as the motor and sensory deficits noted by Dr. Manderson were based on subjective symptoms and not objective test results.

By decision dated October 10, 2018, OWCP denied appellant's claim for an additional schedule award for permanent impairment of the bilateral lower extremities, based on Dr. Ugokwe's opinion that the medical evidence of record did not demonstrate permanent impairment greater than that previously awarded.

On August 7, 2020 appellant again filed a claim for an additional schedule award (Form CA-7). In support of his claim, he provided a May 6, 2020 report by Dr. Magee, finding a 26 percent permanent impairment of the left lower extremity due to weakness in ankle plantar flexion and toe flexion as well as sensory loss in his left ankle and foot. Dr. Magee also found 10 percent permanent impairment of the right lower extremity due to sensory loss with diminished pinprick sensation.

On October 14, 2020 OWCP referred the record and an updated SOAF to Dr. Ugokwe in his role as DMA to determine the appropriate percentage of permanent impairment of the bilateral lower extremities. By letter dated October 20, 2020, Dr. Ugokwe reiterated that appellant had no permanent impairment of either lower extremity as there were no physical examination findings by Dr. Magee or Dr. Manderson to support spinal nerve root impairment.

By decision dated October 22, 2020, OWCP denied appellant's claim for an additional schedule award for permanent impairment of the bilateral lower extremities, based on Dr. Ugokwe's opinion as the weight of the medical evidence.

On February 3, 2021 appellant requested reconsideration of OWCP's October 22, 2020 decision. No additional evidence or argument was received

By decision dated February 26, 2021, OWCP denied appellant's request for reconsideration.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[5] and its implementing federal regulations,[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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.[7] 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.[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): *A Contemporary Model of Disablement*.[9] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX), which is then adjusted by the GMFH, GMPE, and/or GMCS.[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11] Evaluators are directed to provide reasons for their impairment choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[12]

Neither FECA nor its regulations provide for a schedule award for impairment to the back or to the body as a whole.[13] Furthermore, the back is specifically excluded from the definition of organ under FECA.[14] The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as impairments of the extremities. Recognizing that FECA allows ratings for extremities and precludes ratings for the spine, *The Guides Newsletter*

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[5] *Supra* note 1.

[6] 20 C.F.R. § 10.404.

[7] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700, Exhibit 1 (January 2010).

[8] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[9] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3.

[10] *Id.* at 494-531.

[11] *Id.* at 411.

[12] *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[13] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.H.*, Docket No. 19-1788 (issued March 17, 2020); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[14] *See* 5 U.S.C. § 8101(19); *see also G.S.*, Docket No. 18-0827 (issued May 1, 2019); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

offers an approach to rating spinal nerve impairments consistent with sixth edition methodology. For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures indicate that *The Guides Newsletter* is to be applied.[15] The Board has recognized the adoption of this methodology for rating extremity impairment, including the use of *The Guides Newsletter*, as proper in order to provide a uniform standard applicable to each claimant for a schedule award for extremity impairment originating in the spine.[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 impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, OWCP shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[18] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[19]

ANALYSIS -- ISSUE 1

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

The Board finds that there is a conflict in the medical opinion evidence regarding appellant's permanent impairment of the right lower extremity between Dr. Magee, the attending physician, and Dr. Ugokwe, the DMA, which requires further development of the medical evidence.[20]

On May 6, 2020 Dr. Magee opined that appellant had 26 percent permanent impairment of the left lower extremity and 10 percent permanent impairment of the right lower extremity based on consistent signs of bilateral S1 radiculopathy and sensory losses and motor loss in the left foot and ankle.

In contrast, Dr. Ugokwe produced reports in which he provided a conflicting opinion regarding appellant's bilateral lower extremity permanent impairment. OWCP requested that Dr. Ugokwe review the medical record, including the July 18, 2018 second opinion report by Dr. Manderson, who diagnosed lumbar radiculopathy based on October 23, 2000 and May 1, 2009

[15] *Supra* note 7 at Chapter 3.700 (January 2010). *The Guides Newsletter* is included as Exhibit 4.

[16] *L.S.*, Docket No. 10-1730 (issued August 26, 2020); *A.H., supra* note 13.

[17] *See supra* note 7 at Chapter 2.808.6(f) (March 2017).

[18] 5 U.S.C. § 8123(a); *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *M.S.*, 58 ECAB 328 (2007).

[19] 20 C.F.R. § 10.321; *R.M.*, Docket No. 20-0725 (issued May 5, 2021); *P.B.*, Docket No. 20-0984 (issued November 25, 2020); *R.C.*, 58 ECAB 238 (2006).

[20] *Supra* note 17; *R.M., id*.

lumbar MRI scans and an April 22, 2002 EMG/NCV study of the lower extremities. On October 9, 2018 Dr. Ugokwe contended that Dr. Manderson had based his findings of motor and sensory deficits in the bilateral lower extremities on appellant's subjective symptoms and not on objective test results. He opined that appellant had no permanent impairment of either lower extremity. On October 20, 2020 Dr. Ugokwe reiterated that appellant had no objective clinical findings of spinal nerve root impairment affecting either lower extremity.

Consequently, the case must be referred to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding appellant's permanent impairment. On remand, OWCP shall refer appellant, along with the case file and a SOAF, to an appropriate specialist for an impartial medical evaluation for a rating of permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's additional schedule award claim.[21]

CONCLUSION

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

[21] In light of the Board's disposition of Issue 1, Issue 2 is rendered moot.

ORDER

IT IS HEREBY ORDERED THAT the October 22, 2020 and February 26, 2021 decisions of the Office of Workers' Compensation Programs are set aside, and the case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: December 28, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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