United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 24-0844**
	)	**Issued: November 21, 2024**
U.S. POSTAL SERVICE, POST OFFICE, Kansas City, MO, 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 August 8, 2024 appellant filed a timely appeal from July 11, 2024 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 July 24, 2024 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 his burden of proof to establish greater than 21 percent total permanent impairment of his left leg and 21 percent total permanent impairment of his right leg, for which he previously received schedule award compensation.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances of the case as set forth in the Board's prior decisions are incorporated herein by reference. The relevant facts are as follows.

On August 24, 1963 appellant, then a 23-year-old distribution clerk, filed a traumatic injury claim (Form CA-1) alleging that he had reinjured his back following a September 1962 employment injury.[4] He retired from the employing establishment in 1995. OWCP initially accepted the claim for lumbosacral sprain and authorized medical treatment, including surgical procedures in 1964, 1965, 1994, 1998, 2012, and 2013. By decision dated December 17, 2014, it expanded the acceptance of the claim to include a 1998 lumbar wound infection, pseudo-arthritis at L4-5, lumbar postlaminectomy syndrome at L4-S1, lumbar radiculopathy, and nonunion of fracture.

By decision dated February 26, 2015, OWCP granted appellant a schedule award for 10 percent permanent impairment of his right lower extremity (leg) and 0 percent permanent impairment of his left lower extremity (leg). The award ran for 28.8 weeks for the period November 13, 2014 through March 7, 2015.

On January 20, 2016 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

By decision dated June 13, 2018, OWCP granted appellant an additional schedule award for 3 percent permanent impairment of the right lower extremity (leg), for 13 percent total permanent impairment of the right lower extremity, and 0 percent permanent impairment of the left lower extremity (leg). The award ran for 8.64 weeks for the period February 13 through April 14, 2017.

On October 9, 2018 appellant appealed to the Board. By decision dated June 21, 2019,[5] the Board set aside OWCP's June 13, 2018 decision and remanded the case for further development. The Board found that there was an unresolved conflict in the medical evidence

[3] Docket No. 19-0063 (issued June 21, 2019); Docket No. 22-0301 (issued July 25, 2022); Docket No. 23-0600 (issued September 20, 2023).

[4] On September 7, 1962 appellant filed a Form CA-1 alleging that on that date he sustained an acute lumbosacral sprain when bending over and repositioning mail trays while in the performance of duty. OWCP assigned that claim OWCP File No. xxxxxx227. These claims have been administratively combined by OWCP with the current file, OWCP File No. xxxxxx452, serving as the master file.

[5] Docket No. 19-0063 (issued June 21, 2019).

between Dr. Kevin Komes, a Board-certified physiatrist and second opinion physician, and Dr. M. Stephen Wilson, appellant's treating orthopedic surgeon, regarding the extent of permanent impairment of appellant's lower extremities due to his accepted conditions. Thus, the Board remanded the case for referral to an impartial medical examiner (IME) to resolve the conflict in medical opinion evidence, pursuant to 5 U.S.C. § 8123(a).

On March 4, 2021 OWCP referred appellant, along with an August 17, 2016 statement of accepted facts (SOAF) and the medical record, to Dr. William Hopkins, a Board-certified orthopedic surgeon, for an impartial medical examination. The August 17, 2016 SOAF noted appellant's accepted condition only as acute lumbosacral strain.

In a March 9, 2021 report, Dr. Hopkins opined, based on a September 2, 2022 electromyography (EMG) test, that appellant was at maximum medical improvement (MMI). Utilizing the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[6] he opined that appellant had 27 percent permanent impairment of the whole body due to his August 24, 1963 work injury.

On July 9, 2021 OWCP routed the August 17, 2016 SOAF, the medical record, and a list of questions, to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, serving as a district medical adviser (DMA). In a July 9, 2021 report, Dr. Harris reviewed the August 17, 2016 SOAF and the medical record. He reported that Dr. Hopkins' examination of appellant demonstrated diffuse decreased sensation and weakness in the bilateral lower extremities in a nonanatomic distribution. Using Dr. Hopkins' examination findings and *The Guides Newsletter, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*), Dr. Harris opined that appellant had zero percent bilateral lower extremity permanent impairment for lumbar radiculopathy.

By decision dated July 22, 2021, OWCP denied appellant's request for an increased schedule award. It accorded the weight of the medical evidence to the July 9, 2021 report of Dr. Harris, the DMA.

On December 15, 2021 appellant appealed to the Board. By decision dated July 25, 2022,[7] the Board set aside OWCP's July 22, 2021 decision and remanded the case for further development as there remained an unresolved conflict in the medical evidence. The Board found that the August 17, 2016 SOAF, which both Dr. Hopkins, the IME, and Dr. Harris, the DMA, utilized was deficient as it did not list appellant's additional conditions of a 1998 lumbar wound infection, pseudo-arthritis at L4-5, lumbar postlaminectomy syndrome at L4-S1, and lumbar radiculopathy, or indicate that he had previously received a schedule award for permanent impairment of his right lower extremity. The Board instructed OWCP to refer appellant and an updated SOAF to Dr. Hopkins for a supplemental report to resolve the existing conflict regarding the extent of permanent impairment of appellant's bilateral lower extremities due to his accepted conditions.

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

[7] Docket No. 22-0301 (issued July 25, 2022).

On August 2, 2022 OWCP routed an August 2, 2022 SOAF, the medical record, and a list of questions, to Dr. Hopkins with a request to reexamine appellant and render a supplemental impairment report to resolve the existing conflict as to the extent of permanent impairment of appellant's bilateral lower extremities due to his accepted conditions. It requested that he rate appellant's lower extremity permanent impairment pursuant to *The Guides Newsletter*.

In an October 11, 2022 supplemental report, Dr. Hopkins reviewed the August 2, 2022 SOAF and the medical record. Based on appellant's August 30, 2022 examination findings, he indicated that appellant continued to have bilateral lower extremity pain with loss of sensation and loss of strength.[8] Dr. Hopkins reported that appellant had sensory loss in both feet medially and laterally, and in his calf and thigh medially and laterally with loss of muscle strength bilaterally without loss of inguinal or abdominal sensation. He found that appellant's complaints and physical findings were sciatic in nature with generalized weakness in his hip, thigh, and calf muscle groups. Dr. Hopkins indicated that appellant had a 33 percent permanent impairment of the whole body, pursuant to Table 16-2 on page 535 of the A.M.A., *Guides*. He related that appellant's impairment stemmed from the peripheral nerve and that the previous right knee replacement was not a contributing factor to the lack of ability, strength, and sensation in his bilateral lower extremities. Dr. Hopkins opined that appellant reached MMI on May 5, 2022, and that appellant's total permanent impairment included the previous award for 13 percent permanent impairment.

On November 17, 2022 OWCP routed the August 2, 2022 SOAF, the medical record, and a list of questions, to Dr. Harris, again serving as the DMA, for a permanent impairment rating.

In a November 22, 2022 report, Dr. Harris reviewed the August 2, 2022 SOAF and Dr. Hopkins October 11, 2022 supplemental report, which he indicated demonstrated bilateral sensory loss in the L5 and S1 dermatomes with generalized weakness in the lower extremities without specific muscle weakness consistent with lumbar radiculopathy. He opined that appellant reached MMI on August 30, 2022, the date of Dr. Hopkins' impairment evaluation, as the case file did not contain any medical records prior to that date which documented that appellant had reached MMI. Dr. Harris indicated that while Dr. Hopkins had calculated the impairment for appellant's residuals problems with radiculopathy utilizing the charts for peripheral nerve impairment, FECA utilizes *The Guides Newsletter* for rating permanent impairment of the lower extremities based upon a permanent impairment originating in the spine. For both the right and left lower extremities, he utilized the diagnosis-based impairment (DBI) method to render an impairment rating as the A.M.A., *Guides* did not allow for range of motion methodology for the lower extremities/lumbar spine. Using Dr. Hopkins' August 30, 2022 examination findings, Dr. Harris found the class of diagnosis (CDX) for the right L5 lumbar radiculopathy resulted in a Class 1 impairment for six percent impairment of the lower extremity for residual problems with severe pain/impaired sensation. He also found a CDX of 1 for the right S1 lumbar radiculopathy for four percent impairment for residual problems with severe pain/impaired sensation. Dr. Harris indicated that this resulted in 10 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity. He opined that there was no increase

[8] A copy of the August 30, 2022 examination was not of record.

in the right lower extremity impairment as appellant had previously been awarded schedule award compensation for 13 precent permanent impairment of the right lower extremity.

By decision dated December 14, 2022, OWCP granted appellant a schedule award for 10 percent permanent impairment of the left lower extremity (leg) and no additional impairment of the right lower extremity (leg) beyond the 13 percent permanent impairment previously awarded. The award ran for 28.8 weeks for the period August 30, 2022 through March 19, 2023.

On March 14, 2023 appellant appealed to the Board. By decision dated September 20, 2023,[9] the Board set aside OWCP's December 14, 2022 decision and remanded the case for further development. The Board found that in his October 11, 2022 supplemental report, Dr. Hopkins, the IME, did not specifically rate appellant's permanent impairment pursuant to *The Guides Newsletter* and thus, his supplemental opinion was not entitled to the special weight of the medical opinion evidence. The Board therefore found that an unresolved conflict in medical opinion remained and remanded the case for referral to a new IME for purposes of obtaining a rationalized medical opinion regarding any employment-related permanent impairment of the lower extremities, pursuant to *The Guides Newsletter*.

On October 30, 2023 OWCP routed an October 17, 2023 SOAF, the medical record, and a list of questions to Dr. Robert Tomlinson, a sports medicine orthopedic surgeon specialist, for an impartial medical examination. The October 17, 2023 SOAF indicated that the case was accepted for sprain of other parts of lumbar spine and pelvis; infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts; postlaminectomy syndrome; lumbar radiculopathy; and nonunion of fracture (L4-5 pseudo arthritis).[10]

In a January 3, 2024 report, Dr. Tomlinson reviewed the October 17, 2023 SOAF and the medical record. He noted his January 2, 2023 examination findings, which included a mild antalgic gait to the right and mild tenderness to palpation of the paraspinous muscles L1 to S3. Dr. Tomlinson indicated that appellant had active movement against resistance with some resistance at 4/5 strength and that the clinical presentation was consistent with MRI scan and EMG findings consistent with radiculopathy at the L4, L5, and S1 nerve roots for both mild sensory and mild motor deficits. He opined that appellant had reached MMI as of January 2, 2024. Based on appellant's January 2, 2023 examination findings, Dr. Tomlinson opined that appellant had 21 percent permanent impairment for both the right and left lower extremities. He indicated that appellant had L4, L5, and S1 mild sensory and L4, L5, and S1 mild motor radiculopathies for both the right and left lower extremities. Under the standards of *The Guides Newsletter*, Dr. Tomlinson identified the CDX for L4 radiculopathy with a Class 1 default value of one percent for the mild sensory deficit and 5 percent for the mild motor deficit. He found that the grade modifier for functional history (GMFH) was 1; the grade modifier for physical examination (GMPE) was 1; and the grade modifier for clinical studies (GMCS) was 2. Dr. Tomlinson applied the net

[9] Docket No. 23-0600 (issued September 20, 2023).

[10] On September 27, 2023 OWCP indicated that the current accepted conditions were sprain of other parts of lumbar spine and pelvis; infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants, and grafts; postlaminectomy syndrome; and radiculopathy, lumbar region. It did not contain the diagnosis of nonunion of fracture (L4-5 pseudo arthritis), which was included in the October 17, 2023 SOAF.

adjustment formula and found a net adjustment of 1, which changed the grade of C to D for both lower extremities. Thus, for the L4 radiculopathy, this resulted in two percent mild sensory deficit and seven percent mild motor deficit for both lower extremities. For the CDX relating to the L5 radiculopathy, Dr. Tomlinson identified a Class 1 with a default value of one percent for the mild sensory deficit and five percent for the mild motor deficit. He applied the net adjustment formula using the above modifiers and found a net adjustment of 1, which resulted in a grade D or two percent mild sensory deficit and seven percent mild motor deficit for both lower extremities. For the CDX relating to the S1 radiculopathy, Dr. Tomlinson found a Class 1 with a default value of one percent for the mild sensory deficit and three percent for mild motor deficit. He again applied the net adjustment formula using the above modifiers and found a net adjustment of 1, which resulted in a grade D or one percent mild sensory deficit and four percent mild motor deficit for both lower extremities. Dr. Tomlinson added the mild sensory and mild motor deficits of each nerve to find nine percent impairment associated with L4 radiculopathy; nine percent impairment associated with L5 radiculopathy; and five percent impairment associated with S1 radiculopathy. He then used the Combined Values Chart on page 604 of the A.M.A., *Guides* and found that 9 percent impairment for L4 radiculopathy plus 9 percent impairment for L5 radiculopathy plus 5 percent impairment for S1 radiculopathy equaled 21 percent lower extremity impairment for both lower extremities.

On February 16 and May 9, 2024 OWCP requested that Dr. Tomlinson clarify whether the percentage of permanent impairment set forth in his January 3, 2024 report included or excluded the prior award for 13 percent permanent impairment of the right lower extremity and 10 percent permanent impairment of the left lower extremity.

In a July 1, 2024 addendum report, Dr. Tomlinson indicated that his ratings of 21 percent permanent impairment for both the right and left lower extremities were not in addition to any previous impairment determinations.

By *de novo* decision dated July 11, 2024, OWCP granted appellant a schedule award for an additional 11 percent permanent impairment of his left leg, for a total permanent impairment of 21 percent, and an additional 8 percent permanent impairment of his right leg, for a total permanent impairment of 21 percent. The period of the award was for 54.04 weeks and ran from January 2, 2024 through January 19, 2025. OWCP accorded special weight to the opinion of Dr. Tomlinson, the IME.

LEGAL PRECEDENT

The schedule award provisions of FECA[11] and its implementing regulations[12] 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 to all claimants, OWCP has adopted the A.M.A., *Guides* as

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.404.

the uniform standard applicable to all claimants.[13] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[14]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.[15] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment of the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[16] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[17] The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory deficit, and loss of strength.[18]

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.[19] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[20] 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.[21]

In addressing upper or lower extremity impairment due to peripheral or spinal nerve root involvement, the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter* require

[13] *Id*. *See also T.T.*, Docket No. 18-1622 (issued May 14, 2019).

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

[15] A.M.A., *Guides* 3, section 1.3.

[16] *Id*. at 493-556.

[17] *Id*. at 521.

[18] *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *E.B.*, Docket No. 10-0670 (issued October 5, 2010); *Robert V. Disalvatore*, 54 ECAB 351 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[19] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.D.*, Docket No. 20-0553 (issued April 19, 2021); *A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[20] *See supra* note 14 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5c(3) (March 2017).

[21] *Id*. at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

identifying the impairment CDX, which is then adjusted by the GMFH and the GMCS. The effective net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[22]

Section 8123(a) of FECA provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[23] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[24]

ANALYSIS

The Board finds appellant has not met his burden of proof to establish greater than 21 percent total permanent impairment of his left lower extremity and 21 percent total permanent impairment of his right lower extremity, for which he previously received schedule award compensation.

Preliminarily, the Board notes that it is unnecessary for the Board to consider the evidence appellant submitted prior to the issuance of OWCP's December 14, 2022 decision because the Board considered that evidence in its September 20, 2023 decision. Findings made in prior Board decisions are *res judicata* absent further review by OWCP under section 8128 of FECA.[25] The Board, therefore, need not review the evidence addressed on prior appeal.

In the prior appeal, the Board indicated that to address the unresolved conflict in the medical opinion evidence, OWCP would need a referral to a new IME for the purpose of obtaining a rationalized medical opinion regarding any employment-related permanent impairment of the lower extremities, pursuant to *The Guides Newsletter*. On remand OWCP properly referred appellant to Dr. Tomlinson for an impartial medical evaluation, pursuant to 5 U.S.C. § 8123(a), as the supplemental report of Dr. Hopkins, the original IME, was found to be insufficient to carry the special weight of the medical opinion evidence and a conflict in medical evidence remained unresolved.

In a January 3, 2024 report, Dr. Tomlinson reviewed the October 17, 2023 SOAF and the medical record and noted his January 2, 2023 examination findings, which included mild sensory radiculopathies at L4, L5, and S1 and mild motor radiculopathies at L4, L5, and S1 for both the right and left lower extremities. Based on appellant's January 2, 2023 examination findings, Dr. Tomlinson opined that appellant had 21 percent permanent impairment for both the right and

[22] *The Guides Newsletter*; A.M.A., *Guides* 430.

[23] 5 U.S.C. § 8123(a).

[24] *See A.D.*, *supra* note 19; *L.L.*, Docket No. 19-0214 (issued May 23, 2019); *D.M.*, Docket No. 18-0476 (issued November 26, 2018); *R.H.*, 59 ECAB 382 (2008); *Raymond A. Fondots*, 53 ECAB 637, 641 (2002); *James P. Roberts*, 31 ECAB 1010 (1980).

[25] *F.H.*, Docket No. 21-0579 (issued December 9, 2021); *D.A.*, Docket No. 19-1965 (issued February 10, 2021); *G.B.*, Docket No. 19-1448 (issued August 21, 2020); *Clinton E. Anthony, Jr.*, 49 ECAB 476, 479 (1998).

left lower extremities. Under the standards of *The Guides Newsletter*, he identified the CDX for each nerve root, found grade modifiers and applied the net adjustment formula. The L4 radiculopathy with a Class 1 had a default value of one percent for the mild sensory deficit and five percent for the mild motor deficit. Dr. Tomlinson found that the GMFH was 1; the GMPE was 1; and the GMCS was 2. He applied the net adjustment formula and found a net adjustment of 1, which changed the grade of C to D for both lower extremities or two percent mild sensory deficit and seven percent mild motor deficit for the L4 radiculopathy. For the L5 radiculopathy, Dr. Tomlinson identified a Class 1 with a default value of one percent for the mild sensory deficit and five percent for the mild motor deficit. Application of the net adjustment formula using the above modifiers resulted in a net adjustment of 1, which resulted in a grade D or 2 percent mild sensory deficit and seven percent mild motor deficit for both lower extremities. For the S1 radiculopathy, Dr. Tomlinson found a Class 1 with a default value had one percent for the mild sensory deficit and three percent for mild motor deficit. Application of the net adjustment formula using the above modifiers resulted in a net adjustment of 1, which resulted in a grade D or one percent mild sensory deficit and four percent mild motor deficit for both lower extremities. Dr. Tomlinson properly added the mild sensory and mild motor deficits of each nerve to find nine percent impairment associated with L4 radiculopathy; nine percent impairment associated with L5 radiculopathy; and five percent impairment associated with S1 radiculopathy. He then properly used the Combined Values Chart on page 604 of the A.M.A., *Guides* and found that 9 percent impairment for L4 radiculopathy plus 9 percent impairment for L5 radiculopathy plus 5 percent impairment for S1 radiculopathy equaled 21 percent lower extremity impairment for both lower extremities. In his July 1, 2024 addendum report, Dr. Tomlinson indicated that his 21 percent permanent impairment rating to both the right and left lower extremities were not in addition to any previous impairment determinations.

The Board finds that Dr. Tomlinson's opinion constitutes the special weight of the medical opinion evidence and is sufficient to establish that appellant is entitled to an additional schedule award for the accepted lumbar conditions.[26] When a case is referred to an IME to resolve a conflict, the resulting medical opinion, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[27] Dr. Tomlinson provided a well-reasoned opinion based on a proper factual and medical history. He also accurately summarized the relevant medical evidence and provided thorough physical examination findings. Dr. Tomlinson provided detailed findings and medical rationale supporting his opinion, based upon the entire medical record, and found that appellant had 21 percent permanent impairment of the right lower extremity and 21 percent permanent impairment of the left lower extremity.

The Board further finds that OWCP properly awarded appellant the additional 11 percent permanent impairment of his left lower extremity, for a total permanent impairment of 21 percent, and the additional 8 percent permanent impairment of his right lower extremity, for a total permanent impairment of 21 percent. OWCP's procedures provide that a previous impairment to a member is included in ascertaining the percentage of loss except if the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the

[26] *See B.T.*, Docket No. 24-0736 (issued August 23, 2024); *A.P.*, Docket No. 24-0348 (issued June 7, 2024).

[27] *A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001); *James P. Roberts, supra* note 24.

total percentage of impairment.[28] Thus, OWCP properly subtracted the prior award of 13 percent permanent impairment of the right lower extremity from the current impairment rating of 21 percent permanent impairment of the right lower extremity and properly subtracted the prior award of 10 percent permanent impairment of the left lower extremity from the current 21 percent permanent impairment of the left lower extremity to find that appellant was entitled to the additional 11 percent permanent impairment of his left lower extremity, for a total permanent impairment of 21 percent, and the additional 8 percent permanent impairment of his right lower extremity, for a total permanent impairment of 21 percent.

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 or increased permanent impairment.

CONCLUSION

The Board finds appellant has not met his burden of proof to establish greater than 21 percent total permanent impairment of his left leg and 21 percent total permanent impairment of his right leg, for which he previously received schedule award compensation.

[28] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.7(1)(a) (February 2013).

ORDER

IT IS HEREBY ORDERED THAT the July 11, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 21, 2024
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