United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 22-0605**
	)	**Issued: September 19, 2024**
DEPARTMENT OF VETERANS AFFAIRS, VA MEDICAL CENTER, Oklahoma City, OK, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On March 17, 2022 appellant filed a timely appeal from a March 10, 2022 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 to consider the merits of this case.

ISSUE

The issue is whether appellant has greater than 11 percent permanent impairment of his right lower extremity and 12 percent permanent impairment of his left lower extremity, for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board on a different issue.[2] The facts and circumstances of the case as set forth in the Board's prior order are incorporated herein by reference. The relevant facts are as follows.

On November 28, 2016 appellant, then a 47-year-old supervisory police officer, filed a traumatic injury claim (Form CA-1) alleging that on November 3, 2016 he injured his lower back and right leg during his annual medical examination and stress test while in the performance of duty. He stopped work on November 4, 2016 and performed light-duty work four hours a day from March 1 through May 26, 2017. On November 30, 2017 OWCP accepted the claim for dislocation of the L4-5 lumbar vertebra. It subsequently expanded the acceptance of the claim to include intervertebral disc disorders with lumbar radiculopathy.[3] OWCP paid appellant wage-loss compensation on the supplemental rolls effective March 1, 2017.

The record reflects that appellant underwent OWCP-authorized L4-5 bilateral hemilaminotomies, medial facetectomies, and foraminotomies with a microdiscectomy on the right, and an L5-S1 unilateral hemilaminotomy, medial facetectomy, and foraminotomy on the right on September 15, 2017 performed by Dr. Benjamin White, a Board-certified neurosurgeon. The operative report noted a preoperative diagnosis of lumbar ruptured disc with lumbar radiculopathy and low back pain. OWCP paid appellant wage-loss compensation for total disability from May 26 through October 15, 2017. Appellant returned to full duty on April 10, 2018. The employing establishment terminated his employment on September 11, 2019.

On September 30, 2019 appellant filed a claim for compensation (Form CA-7) for a schedule award.

Appellant provided a September 25, 2019 impairment evaluation report from Dr. John W. Ellis, a Board-certified family practitioner, who reviewed appellant's medical records and noted that he underwent spine surgery on September 15, 2017. Dr. Ellis applied the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[4] and *The Guides Newsletter*, *Rating Spinal Nerve Impairment Extremity Impairment Using the Sixth Edition* (July/August 2009) (*The Guides Newsletter*) to his findings and determined that appellant had 21 percent right lower extremity permanent impairment and 18 percent left lower extremity permanent impairment extremity due to his spinal injuries. He also noted that appellant continued to have 12 percent permanent impairment of the left ankle due to fracture of the fibula in accordance with the diagnosis-based impairment (DBI) estimates of the A.M.A., *Guides*, Table 16-2, page 503. Dr. Ellis combined appellant's left lower extremity impairment ratings and found

[2] *Order Remanding Case*, Docket No. 21-0671 (issued December 14, 2021).

[3] OWCP assigned the present claim OWCP File No. xxxxxx297. Under OWCP File No. xxxxxx089, it accepted that appellant sustained a closed fracture of the left ankle during a January 23, 2015 training accident. OWCP granted him a schedule award for 12 percent of the left lower extremity on February 26, 2020.

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

28 percent permanent impairment of the left lower extremity. He opined that appellant reached maximum medical improvement (MMI) on that date.

Appellant filed another Form CA-7 schedule award claim on March 5, 2020.

On March 13, 2020 OWCP forwarded the medical record, including Dr. Ellis' report and statement of accepted facts (SOAF), to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA).

In a March 20, 2020 report, Dr. Harris opined that Dr. Ellis' report provided insufficient explanation for his calculation of spinal nerve impairments as there was only limited information regarding the physical findings and functional limitations. He requested a supplemental report from Dr. Ellis.

On June 25, 2020 OWCP again forwarded Dr. Ellis' September 25, 2019 report, the medical record, and a SOAF to Dr. Harris as the DMA.

In a July 1, 2020 supplemental report, Dr. Harris reiterated that Dr. Ellis' report was insufficient as there was only limited information regarding appellant's physical findings and functional limitations. He recommended a second opinion evaluation to determine permanent impairment.

In a letter dated July 27, 2020, OWCP referred appellant, the December 12, 2019 SOAF, the medical records, and a series of questions to Dr. Michael S. Brown, a Board-certified physiatrist, for a second opinion permanent impairment evaluation.

Dr. Brown completed a report on September 8, 2020 and related appellant's history of injury and accepted conditions. On physical examination he found reduced range of motion (ROM) of the lumbar spine, tenderness to palpation over the lumbar paraspinal musculature, and spasm with ROM. Neurological examination revealed weakness of the right anterior tibialis and the right extensor hallucis longus both graded 4/5 and weakness of the right gastric soleus graded 3/5. Appellant demonstrated reduced sensation to light touch in the right L5 and S1 dermatomes, and hypoactive deep tendon reflexes at the knee and ankle. Dr. Brown referred to the sixth edition of the A.M.A., *Guides* and *The Guides Newsletter*, finding that appellant had no impairment of the left lower extremity as appellant had no focal myotomal or dermatomal sensory deficits as a result of his diagnosed spinal conditions. However, he found evidence of right L5 and S1 radiculopathies. Dr. Brown utilized Table 2, page 6 of *The Guides Newsletter* for the L5 spinal nerve level. He assigned mild motor and moderate sensory deficits, which were rated as Class 1 class of diagnosis (CDX). Dr. Brown assigned a grade modifier for functional history (GMFH) of 1 under Table 16-6, page 516, and a grade modifier for clinical studies (GMCS) of 0 under Table 16-8, page 519, as the electrodiagnostic studies did not show evidence of reduced recruitment and demonstrated normal motor unit action potentials. In his application of the grade modifiers for the sensory component, he found that rating moved to Grade A position for moderate sensory deficit or a two percent permanent impairment for the L5 sensory component deficit. Dr. Brown's calculation of the grade modifiers for the motor component moved to the position of Grade B for three percent permanent impairment for the L5 nerve root. He found combined L5 motor and sensory deficits of five percent permanent impairment of the right lower extremity. Dr. Brown

conducted similar calculations for the S1 spinal nerve level, finding moderate sensory and motor deficits, with application of the grade modifiers resulting in grade A or one percent permanent impairment for the S1 sensory deficit and five percent permanent impairment for the S1 motor deficit, combined to reach six percent right lower extremity impairment based on the S1 nerve root. He then combined appellant's spine nerve root right lower extremity impairments to reach 11 percent permanent impairment of the right lower extremity. Dr. Brown found that appellant had reached MMI.

On November 10, 2020 OWCP referred the medical record, including Dr. Brown's second opinion report and a SOAF to Dr. Harris, as the DMA. In a November 16, 2020 report, Dr. Harris found that due to impairment of the L5 nerve root appellant had two percent impairment of the right lower extremity due to sensory deficits and three percent impairment of the lower extremity due-to-mild motor weakness. He found five percent impairment due-to-mild motor weakness attributed to the S1 nerve root and one percent impairment due-to-moderate sensory deficit of that nerve root. Dr. Harris found that appellant had 11 percent permanent impairment of his right lower extremity due to his accepted lumbar conditions. He noted that appellant was previously awarded 12 percent left lower extremity impairment due to appellant's accepted left ankle fracture and that there was no increase in his left lower extremity impairment.

By decision dated March 3, 2021, OWCP granted appellant a schedule award for 11 percent permanent impairment of his right lower extremity and no additional impairment of his left lower extremity. The award ran for 31.68 weeks from September 8, 2020 through April 17, 2021.

Appellant appealed this decision to the Board. By a December 14, 2021 order, the Board set aside the March 3, 2021 decision and ordered OWCP to administratively combine the files and issue a *de novo* decision.[5]

On February 2, 2022 OWCP created an amended SOAF which included the injuries sustained on both January 23, 2015 and November 3, 2016. It then referred the medical record, including Dr. Brown's second opinion report and an amended SOAF to the DMA, Dr. Harris. In a February 5, 2022 report, he again found that appellant had no more than 11 percent permanent impairment of the right lower extremity.

By decision dated March 10, 2022, OWCP issued a *de novo* decision denying appellant's additional schedule award claim for more than 11 percent permanent impairment of the right lower extremity.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from

[5] *Supra* note 2.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, published in 2009, is used to calculate schedule awards.[9]

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.[10] However, a schedule award is permissible where the employment-related spinal condition affects the upper and/or lower extremities.[11] The sixth edition of the A.M.A., *Guides* (2009) 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.[12]

In addressing 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 identifying the CDX, which is then adjusted by a GMFH and/or GMCS.[13] The net adjustment formula is (GMFH - CDX) + (GMCS - CDX).[14] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[15]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through an OWCP medical adviser for an opinion concerning the nature and

[8] *Id*. at § 10.404 (a); *see also T.T.*, Docket No. 18-1622 (issued May 14, 2019); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also id*. at Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see M.E.*, Docket No. 21-0281 (issued June 10, 2022); *A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000).

[11] *Supra* note 9 at Chapter 2.808.5c(3) (March 2017).

[12] *Supra* note 9 at Chapter 3.700, Exhibit 4 (January 2010); *see L.H.*, Docket No. 20-1550 (issued April 13, 2021); *N.G.*, Docket No. 20-0557 (issued January 5, 2021).

[13] A.M.A., *Guides* 494-531; *The Guides Newsletter*, p.3, (Adjustments are made only for functional history and clinical studies); *see R.V.*, Docket No. 20-0005 (issued December 8, 2020); *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[14] *The Guides Newsletter*, *id*.; A.M.A., *Guides* 521.

[15] A.M.A., *Guides* 23-28.

percentage of impairment in accordance with the A.M.A., *Guides*, with an OWCP medical adviser providing rationale for the percentage of impairment specified.[16]

ANALYSIS

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

The record reflects that Dr. Brown was provided a SOAF dated December 12, 2019, which did not list all of the accepted conditions resulting from the January 23, 2015 and November 3, 2016 employment injuries. At the time, OWCP had not yet administratively combined appellant's claims when it composed the December 12, 2019 SOAF and as such this SOAF did not include his accepted January 23, 2015 closed fracture of the left ankle and February 26, 2020 schedule award for 12 percent of the left lower extremity. The December 12, 2019 SOAF merely listed the accepted conditions resulting from the November 3, 2016 employment injury including dislocation of the L4-5 lumbar vertebra, and intervertebral disc disorders with radiculopathy, lumbar region. It is OWCP's responsibility to provide a complete and proper frame of reference for a physician by preparing a SOAF.[17] OWCP's procedures dictate that, when a DMA, second opinion specialist, or referee physician renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[18] OWCP did not provide the second opinion specialist with an accurate SOAF as it failed to list all of appellant's accepted conditions. As such, the report from Dr. Brown was not based on an accurate factual framework and cannot represent the weight of the medical evidence.

The Board notes that proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[19] Once OWCP undertakes to develop the medical evidence, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.[20]

On remand, OWCP shall list all of the accepted conditions and prepare an updated SOAF. It shall then refer the case record, together with the updated SOAF, to Dr. Brown for a reasoned opinion regarding appellant's permanent impairment in accordance with the A.M.A., *Guides*.

[16] *Supra* note 9 at Chapter 2.808.6(f) (March 2017).

[17] *S.H.*, Docket No. 21-1380 (issued September 22, 2022); *C.E.*, Docket No. 19-1923 (issued March 30, 2021); *B.K.*, Docket No. 19-0976 (issued December 15, 2020); *M.B.*, Docket No. 19-0525 (issued March 20, 2020); *J.N.*, Docket No. 19-0215 (issued July 15, 2019); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[18] *Supra* note 9 at Chapter 3.600.3 (October 1990); *see also C.C.*, Docket No. 19-1948 (issued January 8, 2021); *N.W.*, Docket No. 16-1890 (issued June 5, 2017).

[19] *S.H.*, *supra* note 17; *J.R.*, Docket No. 19-1321 (issued February 7, 2020); *S.S.*, Docket No. 18-0397 (issued January 15, 2019).

[20] *Id.*; *see also R.M.*, Docket No. 16-0147 (issued June 17, 2016).

Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the March 10, 2022 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: September 19, 2024
Washington, DC

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

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board