File Number:
HR11-D-H

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U.S. DEPARTMENT OF LABOR

DFELHWC-FECA, PO Box 8311
LONDON, KY 40742-8311
Phone: (202) 693-0045

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Date of Injury:
Employee:

Dear

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A preliminary review has been completed, and it has been determined that the case is not in posture for a hearing at this time. The decision of the Office has been vacated and returned to the office for further action as explained in the attached Remand Order.

Your case file has been returned to your assigned Claims Examiner. You may contact that office by writing to our Central Mail Roorn at the fo!lowing address:

US DEPARTMENT OF LABOR
DFELHWC-FECA, PO Box 8311
LONDON, KY 40742-8311

Sincerely,

Federal Employees Program

PAUL H FELSER, ESQ
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, December 17, 2020

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et. seq. of
Claimant; Employed by the

Merit Consideration of the case file was completed on). Based on the review, the decision of the Office dated (is set aside for the reasons set forth below.

The issue for determination is whether the Office properly adjudicated the claim for a schedule award by decision dated

born is employed as a f with the . She filed Form CA-1 for a Traumatic Injury alleged to have occurred on On that date she picked up a heavy package. The case was approved for displacement of lumbar intervertebral disc without myelopathy. Appropriate medical and wage loss benefits were paid.

According to the evidence of record, the claimant stopped work on or around and underwent L4-5 and L5-S1 laminectomy. She returned to full duty on or around However, she suffered recurrent disability on On a diagnostic spinal cord stimulator trial placement was done.

On he Office received Form CA-7 which had been filed for a schedule award. In support of this, an impairment rating report dated was received from M.D. He indicated that he examined the claimant on for schedule award purposes and obtained EMG/NCV testing due to the claimant's lumbar disc displacement and peripheral spinal nerve impingement. He attached a copy of the study, performed by , D.O. He proceeded to document the claimant's complaints and perform a review of relevant medical records. On physical exam, he first assessed the neck, documenting decreased range of motion in the *cervical spine*. He noted that gentle pressure on the trapezius muscles increased numbness down the arms, although it did not reproduce tingling she experienced in the thumbs and fingers. Dr. described decreased sensation to light touch, pin prick, two point discrimination and monofilament testing in the thumb and fingers of both hands. Grip strength was very weak. Dr. proceeded to address the lumbar spine and described tightness and tenderness in the paraspinous muscles. Pressure on the right buttock reproduced tingling in the back of the right thigh which was consistent with mild lumbosacral plexus impingement but it did not cause radiculopathy. A sensory examination was performed relative to the lower extremities and Dr. described decreased sensation to pin prick, light touch, monofilament and 2 point discrimination. He also described weakness on toe and heel walking, dorsiflexion of the big toes and plantar flexion of the feet. Straight leg raising and Bragard's sign was weak in both lower extremities. The claimant was said to have an antalgic gait due to weakness of the L4, L5, and S1 spinal nerve motor function. It was Dr. opinion that had reached maximum medical improvement (MMI) as of Impairment was assessed in accordance

Washington DC, December 17, 2020

with the Sixth Edition of the AMA Guides and the Guides Newsletter July/August 2009. A total of 18% impairment was assigned for the right lower extremity based upon spinal nerve impairment at L4, L5, and S1. For the left lower extremity, a total of 10% was assigned based upon spinal nerve impairment at L4, L5 and S1.

On the Office wrote to the claimant acknowledging receipt of the CA-7 as well as Dr. report. However, they proceeded to outline the requirements necessary to establish schedule award entitlement. The claimant was to ensure that the report he supplied adhered to these guidelines. Thirty days were afforded for the submission of additional evidence in support of the claim.

Concurrently, the Office forwarded the report of Dr. to the District Medical Advisor (DMA) for review. A response dated April 4, 2019 was received from M.D. He acknowledged the impairment rating offered by Dr. but indicated that his findings on exam appeared to be in conflict with other documentation in the file. He made reference to records from Dr. who described sensation "within normal limits" with no motor deficits recorded. This was in contrast to the multilevel deficits described in each extremity by Dr. . Given this, the DMA recommended that the claimant be referred for a second opinion evaluation.

Ms. was subsequently referred for a second opinion evaluation which took place on with board certified orthopedist M.D. He documented the history of injury and performed a review of the medical records supplied to him. Following a physical exam, he addressed the questions posed by the Office relative to impairment. Referencing the Sixth Edition of the AMA Guides, he assigned 12% whole person impairment. This was calculated based on a disc herniation at a single level with documented residual radiculopathy. Attached to this report was a addendum within which Dr. assigned 6% right lower extremity impairment. This was based upon a motor deficiency in the right tibial nerve and sensory deficiencies in the right superficial peroneal and right sural nerves. In another addendum of Dr. assessed impairment using the Guides Newsletter, July/August 2009. For the left, he assigned 1% impairment for a mild sensory deficit at the L4 level. There was no motor deficit. At the L5 level, 1% impairment was assigned for a mild sensory deficit and 5% for a mild motor deficit. At the S1 level, there was 1% impairment for a mild sensory deficit and no motor deficit. For the right lower extremity, the claimant had 3% impairment secondary to a moderate sensory deficit and no motor deficit at the L4 level. At L5, there was 1% impairment for a mild sensory deficit and 5% for a mild motor deficit. At the S1 level, there was 4% impairment for a sensory deficit and no motor deficit. Final left lower extremity impairment was 8% and right lower extremity impairment was 13%.

The report of Dr. was forwarded to the DMA for review. A response dated was received from Dr. However, he recommended that the Office contact Dr. for a supplemental opinion due to inconsistencies/conflicts in his prior reports. He stated,

> "In his initial examination of 11/6/19, he notes "no significant focal motor weakness is noted on ankle plantar flexion and dorsiflexion, knee and extension and flexion, or hip flexion bilaterally."
>
> He also states, "Sensory examination shows decreases sensation in the right foot compared to the left."
>
> In his calculation of impairment using Table 16-12 (Peripheral Nerve Impairment); he only determines impairment of the right lower extremity, implying no impairment of the LLE, yet he subsequently calculates 8% LLE for nerve deficits in his later reports."

Based upon this, the DMA stated that the impairment rating was not consistent with his prior exam or reports.

Based upon the above, the Office wrote to second opinion examiner Dr. on for a supplemental opinion. They explained that the DMA had pointed to several inconsistencies relative to his reports of

An addendum dated was received from Dr. . He stated that his exam noted increased abnormalities in the right lower extremity compared to the left however he did not state that the left lower extremity was normal. Further, the claimant was intermittently symptomatic in her lower extremities and this was considered in assessing impairment. However. he went on to state that he did not recall the exact questions that were answered in his communication but he believed that it concerned the right lower extremity and this is why the left was not mentioned.

The Office forwarded the above addendum to the DMA and a response dated was received from Dr. . In that report, he concurred with the rating offered by Dr. . Specifically, he agreed with an 8% rating relative to the left lower extremity and 13% of the right lower extremity. He opined that Dr. s report should be given more weight than Dr. as he is a board certified orthopedic surgeon.

On the Office processed a schedule award for 8% impairment of the left lower extremity and 13% of the right lower extremity. The date of maximum medical improvement was The weight of medical evidence was afforded to the second opinion examiner.

The claimant disagreed with this decision and an oral hearing was requested. In accordance with this request, I have conducted an initial review of the file and find that the case is not in posture for a hearing at this time.

Based on my review of the file, the decision of the Office should be *SET ASIDE* and the case *REMANDED* for further development.

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1]

The Employees' Compensation Appeals Board has held that, for consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Board has concluded with the Office's decision to adopt the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA Guides) for determining the extent of permanent impairments.[2]

Section 8107 of the Federal Employees' Compensation Act[3] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss

[1] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).
[2] *James E. Archie*, 43 ECAB 180 (1991).
[3] 5 USC § 8107.

or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., Guides.[4] The OWCP adopted the Third Edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised Third Edition of the Guides effective September 1, 1991; the Fourth Edition effective November 1, 1993; the Fifth Edition effective February 1, 2001; and the Sixth Edition effective May 1, 2009.[5]

The Sixth Edition of the AMA *Guides* does not provide a separate mechanism for rating spinal nerve injuries for extremity impairments. Recognizing that certain jurisdictions, such as FECA, mandate ratings for extremities and preclude ratings for the spine, the AMA *Guides* has offered an approach to rating spinal nerve impairments consistent with Sixth Edition methodology, pursuant to the AMA *Guides* Newsletter, July/August 2009. OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[6]

The issue for determination is whether the Office properly adjudicated the claim for a schedule award by decision dated

On review, I find that the decision of the Office must be set aside. As outlined above, had filed Form CA-7 for a schedule award and supplied a rating report from Dr. within which he assigned 18% impairment of the right lower extremity and 10% of the left lower extremity. This report was reviewed by the DMA however it was recommended that the Office refer the claimant for a second opinion evaluation given the fact that the exam findings of Dr. were inconsistent with additional evidence of record. Therefore, the claimant was referred for a second opinion exam which took place on with Dr. Following receipt of his original report and 3 addendums, his opinion was afforded the weight of medical evidence and a schedule award was issued on for 13% right lower extremity impairment and 8% left lower extremity impairment.

On review, I find that Dr. opinion was improperly afforded the weight and further development must be initiated to properly assess schedule award entitlement. First and foremost, it appears that despite the Office's instruction in their eferral, Dr. was not clear at the time he actually examined the claimant, as to how impairment stemming from the spine was to be assessed under the FECA. In his initial report, he rated impairment to the *lumbar spine itself* secondary to a disc herniation with residual radiculopathy. This is improper as FECA does not allow payment for impairment to the spine. However, a schedule award can be paid for the extremities if a spinal injury leads to impairment of the arms or legs. Impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July/August 2009 edition of The Guides Newsletter published by the AMA.[7] Dr. also provided a whole person rating of 12%. However, no claimant may receive a schedule award for permanent impairment of the whole person.[8] It is well established that neither FECA nor its regulations provide for a schedule award for impairment to the back, spine or to the body as a whole.[9] The issue is whether the medical evidence

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[4] 20 CFR § 10.404 (2002).
[5] Federal Employees' Compensation Act Procedure Manual 2-1601-8(c).
[6] Federal (FECA) Procedure Manual, Part 3 -- Medical, Schedule Awards, Chapter 3.700 (January 2010) (Exhibits 1, 4). See also E.P., Docket No. 11-614 (issued November 2, 2011); P.M., Docket No. 11-1072, (issued November 23, 2011).
[7] Chapter 2-0808(5)(c,3) of the FECA Procedure Manual.
[8] Tania R. Keka, 55 ECAB (Docket No. 04-177, issued February 27, 2004).
[9] *See James E. Jenkins*, 39 ECAB 860 (1988); 5 U.S.C. § 8101(20).

establishes any permanent impairment to the claimant's lower extremities based on the accepted lumbar condition.

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* provides a specific methodology for rating spinal nerve extremity impairment. It was designed for situations where a particular jurisdiction, such as FECA, mandated ratings for extremities and precluded ratings for the spine. 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 OWCP's procedures.[12]

In an attached addendum of Dr. proceeded to offer a rating which differed from his original report. Specifically, he calculated impairment based upon a motor deficiency in the right tibial nerve and sensory deficiencies in the right superficial peroneal and right sural nerves. However, the instant case is approved for a spinal (lumbar) condition and the question is whether the claimant has impairment stemming from this condition which extends in to the extremities. Specifically, the issue is whether the claimant has any sensory or motor deficits stemming from the spinal nerve roots. While impairment must reflect the total loss of the extremity at the time of the rating exam, there must be some impairment attributable to the work injury in order for any other impairment to be considered.[13] Additionally, it is important to note (as the DMA did), that in this ıddendum, Dr. only addressed the right lower extremity, not left. This was erroneous.

Yet another addendum dated vas received from Dr. N and this was the first report received which made reference to the Guides Newsletter July/August 2009. As noted above, this is to be used for rating impairment to the upper or lower extremities caused by a spinal injury. He proceeded to offer an impairment rating of 13% for the right lower extremity and 8% for the left lower extremity. However, I find that he failed to provide an adequate explanation to support how he arrived at this rating. The physical examination section of his original report has been reviewed. Relative to motor deficits, he states that there was *no* significant focal motor weakness on ankle plantar flexion and dorsiflexion, knee extension and flexion or hip flexion bilaterally. He documented weakness of toe raising on the right compared to left although he went on to state that this was questionable weakness versus pain. However, in his addendum of he included a rating of 5% on the right for a mild L5 motor deficit and 5% on the left for a mild L5 motor deficit. It is unclear what exam finding(s) this was based upon.

Additionally, Dr. assigned impairment on the left for mild sensory deficits at L4, L5 and S1. On the right, he assigned impairment for a *moderate* sensory deficit at L4 and for a *mild* sensory deficit at L5. He also assigned impairment for a sensory deficit at S1 although he failed to specify whether this was mild, moderate, severe, etc. Further, and most importantly, he failed to discuss the specific sensory testing he performed (i.e. two-point discrimination, Semmes Weinstein Monofilament testing, etc.) and

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[10] 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see C.S.*, Docket No. 19-0851 (issued November 18, 2019).

[11] Federal (FECA) Procedure Manual, Chapter 2.808.5(c)(3) (March 2017).

[12] Federal (FECA) Procedure Manual, Chapter 3.700, Exhibit 4 (January 2010); *see B.M.*, Docket No. 19-1069 (issued November 21, 2019).

[13] While non-work related impairments are to be included in calculating impairment to a scheduled member, when a claimant does not demonstrate any permanent impairment caused by the accepted employment injury, the claim is not ripe for consideration of non-work related impairment. *Thomas P. Lavin*, 57 ECAB 353 (2006); *B.M.*, Docket No. 13-691, issued September 12, 2013.

the specific findings of such testing. He only stated "Sensory examination notes decreased sensation in the right foot compared to the left." Therefore, it is unclear how he arrived at the above conclusions. Additionally, in a worksheet which accompanied his addendum, Dr. assigned Grade Modifiers for Functional History and Clinical Studies, although he failed to identify the basis for his assignment.

The Sixth Edition of the AMA *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[14] Under the Sixth Edition, the evaluator identifies the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). *Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.*[16]

Also, the DMA pointed to the inconsistencies between Dr. reports of and and so the Office wrote to him again for clarification. A response dated August 5, 2020 was received however deficiencies remain. He references "increased abnormalities" in the right lower extremity compared to the left, but noted that the left lower extremity was not normal. He further stated that the claimant was "intermittently symptomatic" in the lower extremities and this was considered in assessing impairment. While Dr. opinion is noted, non-specific references to increased abnormalities and intermittent symptoms is insufficient to determine whether impairment was properly calculated. The above issues as it relates to sensory and motor testing remains.

Additionally, in Dr report he noted that EMG/NCV testing had been performed on Given that the issue on appeal is lower extremity impairment stemming from a spinal condition, it is imperative that the examining official be afforded the opportunity to consider this report. The file has been reviewed and it appears that only page 2 of the EMG/NCV study was received in April 2019. Therefore, the Office must request a *complete* copy of the report before initiating further medical development.

In the instant case, the Office had referred Ms. for a second opinion examination to assess impairment, per the recommendation of the DMA. This was because the findings documented by Dr. were in conflict with other exam findings in file. The claimant was evaluated by Dr. and to date he has supplied an original report of November 6, 2019 along with 3 addendums datec [17] However, deficiencies remain for the reasons outlined above. Given this, I find that a new second opinion examination is warranted in order to properly assess schedule award entitlement.

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[14] AMA *Guides* (6th ed. 2009), page 3, section 1.3, International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[15] AMA *Guides* (6th ed. 2009), pages 494-531.

[16] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[17] If the second opinion specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues, the CE should seek clarification or further rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from its physician upon receiving a report that did not adequately address the issues that the OWCP sought to develop. As such, the CE should seek clarification from the referral physician and request a supplemental report to clarify specifically-noted discrepancies or inadequacies in the initial second opinion report. FECA PM 2-810-9(j).

It is well established that proceedings under the Federal Employees' Compensation Act are not adversarial in nature, and, while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[18]

Upon return of the case file, the Office must write to the claimant and her attorney, requesting a complete copy of the EMG/NCV report from Dr. Upon receipt, they must initiate a referral for a *new* second opinion evaluation with a board certified specialist. The second opinion examiner must then assess impairment based upon the reprinted 2009 version of the Sixth Edition of the AMA Guides and Guides Newsletter July/August 2009. The Office should ask the examiner to cite the applicable sections of the Guides and provide medical rationale with a discussion of the evidence to support all opinions given. Additionally, findings from sensory and motor testing must be clearly documented. The Office should also advise that impairment must reflect the total loss of the affected member at the time of the rating exam. Lastly, the date of maximum medical improvement must be provided along with an explanation to support its selection. Upon receipt, the second opinion report should be forwarded to the DMA for review. Upon completion of any further development action deemed necessary, the Office must issue a *de novo* decision regarding schedule award entitlement.

Consistent with the above findings, the decision of the Office dated is hereby set aside and ***remanded*** for further development. The case file is returned for further processing as noted.

ISSUED:

WASHINGTON, D.C.

Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs

[18] Udella Billups, 41 ECAB 260 (1989).