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
Case No.

Merit consideration of the case file was completed in Washington, DC. Based on this review, the decision of the District Office is vacated for the reasons set forth below.

The claimant, born , has been employed by the . He filed a timely workers' compensation claim, and the District Office of Workers' Compensation Programs accepted the claim for lumbar strain, displacement of lumbar intervertebral disc without myelopathy, and thoracic or lumbosacral neuritis or radiculitis, unspecified.

He sustained an injury in the performance of his duties on

On the claimant filed a claim for Schedule Award. Effective the claimant elected to receive retirement benefits in lieu of wage loss compensation.

The claimant's physician, Dr. MD, provided an impairment rating on Dr. assessed the claimant at 28.8% lower extremity impairment. He conferred impairment for motor and sensory loss to the peroneal and sural nerves as follows:

8.4% right peroneal
1.2% right sural
1.2% left sural
3% right superficial peroneal
3% left superficial peroneal

Dr. also conferred impairment for dysesthesia:

3% right sural
3% left sural
3% right superficial peroneal
3% left superficial peroneal

The Office's District Medical Director (DMD) reviewed the record on . He averred that Dr. had not properly utilized the American Medical Association *Guides to the Evaluation of Permanent Impairment*, Fifth Edition. He explained that to determine any extremity impairment associated with the claimant's accepted condition, the spinal nerves must be identified and graded, and they must be anatomically related to the accepted condition.

The Office then wrote to Dr on to request that he provide the necessary information for an impairment evaluation. Dr responded with an undated report, received in the Office on . The doctor wrote:

> "The patient underwent EMG-NCV testing on . The results of the testing have been sent previously. It shows that Mr. has Neurological Impairments to his lower extremities bilaterally. His lower extremity symptoms are consistent with the damage shown on the EMG-NCV. The EMG-NCV shows he has damage to the right and left peroneal, right and left sural, right and left superficial peroneal and the right and left tibial nerves. Based on these objective findings as well as his subjective neurological findings, and the AMA Guide, 5th Edition as a reference source, Mr has approximately 18% whole body impairment.
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> "Using the guidelines for the spinal nerve impairment rating Section 15.12 on page 423, items 1 through 4 and tables 15-15, 15-16, 15-17, and 15-18 we come to calculate his impairment as follows. For sensory nerve impairment he would fall under Grade 2 classification, decreased superficial cutaneous pain and tactile sensibility with abnormal sensations or moderate pain that may prevent some activities. Since the EMG-NCV findings reveal involvement of both L5 and S1 nerve roots, the maximum impairment of 80% x 5% (maximum % loss of function due to sensory deficit) equals 4% for each nerve root. According to the objective testing there are four nerve roots involved (L5 and S1 on both sides) which brings the total percentage to 16.
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> "In regards to determining impairment due to loss of power and motor deficits, Table 15-16 reveal Mr is classified under grade 4, which is active movement against gravity with some resistance. Grade 4 is 25% motor deficit. Table 15-18, unilateral spinal nerve root impairment affecting the lower extremity, shows that this patient has roughly 28% loss of function due to strength (37% of L5 and 20% for S1). Therefore, if we do the calculation for each nerve root, 25% x 28% =7% x 4 nerves (L5 and S1 bilaterally) = 28%.
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> "Finally, if we now calculate the total percentage disability of sensory plus motor deficits, 16% + 28% = 44%. Permanent partial disability lower extremity is

44%. If we use table 17-3 on page 527, we can calculate his whole person impairment value from lower extremity impairment. His whole person impairment value is 18%."

The DMD again reviewed the record on . He opined that the claimant had no impairment to the lower extremities. He referenced a functional capacity evaluation that was found in the record. He made no reference whatsoever to Dr. most recent report.

The Office denied the claim for Schedule Award on . The claimant's attorney, Paul Felser, requested an oral hearing on the claimant's behalf. After reviewing the case record, however, I find that the case is not in posture for a hearing.

The schedule award provision of the FECA and its implementing regulations set forth the number of weeks of compensation to be paid for permanent loss, or loss of use, of body members listed in the schedule. The Act, 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 to all claimants, good administrative practice necessitates the use of a single set of tables to calculate schedule awards so that there may be uniform standards applicable to all claimants. The Office has adopted, and the Board has approved, the use of the American Medical Association, Guides to the Evaluation of Permanent Impairment, as an appropriate standard for evaluating schedule losses. Andrew Aaron, Jr., 48 ECAB ___ (Docket No. 95-1827, issued October 23, 1996); Richard Larry Enders, 48 ECAB ___ (Docket No. 95-452, issued November 14, 1996).

In the instant case Dr. indicates that the claimant has sustained permanent impairment to the lower extremities as an effect of his back injury. He has explained how he used the AMA Guides to arrive at his impairment rating. The record does not reflect that the DMD considered Dr. most recent report. Rather, he simply reaffirmed his position that the claimant had not sustained ratable lower extremity impairment. On remand, the Office should ensure that the DMD reviews Dr. most recently submitted report. He should discuss the doctor's rating and explain any disagreements he might have with it. When the DMD's report is received and after any other case development that may become necessary, the Office should issue a *de novo* decision.

JUL 14 2005

DATED:
WASHINGTON, DC

Hearing Representative
for
Director, Office of Workers'
Compensation Programs