United States Department of Labor
Employees' Compensation Appeals Board

Y.L., Appellant	)	
and	)	**Docket No. 13-1857**
	)	**Issued: February 5, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Palatine, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On August 6, 2013 appellant filed a timely appeal from a May 29, 2013 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 the case.

ISSUE

The issue is whether appellant has more than two percent permanent impairment of the right leg for which she received a schedule award.

FACTUAL HISTORY

On January 4, 2009 appellant, then a 38-year-old mail handler, was injured when a bundle of magazines fell on her right foot. OWCP accepted the claim for contusion of the right foot; contusion of the right toe; a bone cyst, right side; other disorders of the bone and cartilage

[1] 5 U.S.C. §§ 8101-8193.

on the right; ganglion and cyst of synovium, tendon and bursae on the right; right tarsal tunnel syndrome; and temporary aggravation of intervertebral disc disease. Appellant stopped work on January 5, 2009 and returned to full-time limited duty on August 2, 2009.[2]

A February 11, 2009 right foot magnetic resonance imaging (MRI) scan revealed osseous contusion on the dorsal medial aspect of the first metatarsal head without gross cortical offset and no fracture through the shaft of the metatarsal. Appellant was treated by Dr. Jesse Plasencia, a podiatrist, from February 26 to May 21, 2009, for right foot pain in the anterior joint space medial to the tibialis anterior tendon after a work-related injury. Dr. Plasencia noted lateral x-rays revealed joint space narrowing and no obvious fracture with bone cysts. On May 11, 2009 he performed an authorized excision of cystic bone, first metatarsal head of the right foot and diagnosed bone cyst, first metatarsal with hypertrophic first metatarsal head of the right foot.

Dr. Malcolm Herzog, a podiatrist, also treated appellant for the work injury. He noted appellant had a compensatory gait, but excellent range of motion dorsally and plantarly of the first metatarsophalangeal joint. On July 14, 2009 Dr. Herzog noted a cystic lesion on the plantar aspect of the first metatarsal head of the right foot and diagnosed fibroma, ganglion cyst. On February 25, 2010 he performed an authorized excision of a mass on the plantar aspect of the right foot.

Appellant came under the treatment of Dr. Robert J. Fink, a Board-certified orthopedic surgeon, from July 31, 2010 to August 11, 2011. Dr. Fink diagnosed tarsal tunnel syndrome and recommended surgery to release the serpiginous varicosities around the medial plantar nerve and tarsal tunnel of the right ankle. On December 16, 2010 he performed an authorized tarsal tunnel release of the right ankle and ligation of varicose veins of the right ankle and diagnosed tarsal tunnel syndrome of the right foot and varicose veins of the right foot.[3]

Appellant was treated by Dr. Anatoly Rozman, a Board-certified physiatrist, on September 24, 2012 and February 1, 2013 for low back pain radiating into her legs which developed while she was working. Dr. Rozman noted that appellant had surgery for a foot cyst, ganglion cyst and tarsal tunnel syndrome. He opined that the MRI scan revealed sciatica and

[2] On June 29, 2010 appellant injured her right foot which was accepted for right tarsal tunnel syndrome, File No. xxxxxx075. On September 18, 2005 she injured her right shoulder which was accepted for right shoulder strain, File No. xxxxxx216. These claims are consolidated with the current claim before the Board.

[3] Also submitted were reports of diagnostic testing. A July 1, 2010 right ankle MRI scan revealed serpiginous varicosities in the tarsal tunnel consistent with early tarsal tunnel syndrome. A July 1, 2010 electrophysiologic study of the peroneal nerves on both sides were normal, findings suggest mild focal entrapment of the right tibial nerve above the tarsal ligament with no evidence of peripheral neuropathy. An August 5, 2010 electromyogram (EMG) and nerve conduction studies revealed of bilateral superficial and sural nerves revealed spared peak latencies and reduce amplitude, more on the left side. Motor nerve conduction studies of bilateral common peroneal and tibial nerves were normal. The EMG revealed mild spontaneous denervating activity in the bilateral gastrocnemius muscles and mild spontaneous denervating activity at L5-S1 bilaterally. A July 29, 2011 nerve conduction study revealed right lower lumbar radiculopathy at L5-S1, left lower lumbar radiculopathy at L5, decreased amplitude of the tibial nerve, right tarsal tunnel syndrome, no response on stimulation of the medial plantar nerve and decreased amplitude of the lateral plantar nerve on the same side and mild to moderate left tarsal tunnel syndrome. A December 27, 2010 lumbar MRI scan showed lumbar spondylosis, mild bilateral neural foramen stenosis due to a disc bulge at L4-5 and L5-S1.

L5-S1 radiculopathy which he opined was related to repetitive lifting and physical stress to her back performing her job as a mail clerk. Dr. Rozman stated that appellant reached maximum medical improvement.

On April 11, 2013 appellant filed a claim for a schedule award.

On April 18, 2013 OWCP requested that appellant submit a rating of permanent impairment pursuant to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[4] (A.M.A., *Guides*).

In a March 25, 2013 report, Dr. Rozman advised that appellant reached maximum medical improvement on February 25, 2013. He noted pain on palpation of the first metatarsal joint with deformities, positive Tinel's sign, right tarsal tunnel syndrome with decreased sensation in the distribution of the median and plantar nerve, no significant motor deficit, positive straight leg testing bilaterally, decreased sensation at L4-5 with antalgic gait on the right side due to tarsal tunnel syndrome. Dr. Rozman referenced Table 17-4, page 570, Lumbar Spine Regional Grid, of the A.M.A., *Guides* and noted appellant was a class 2 with intervertebral disc herniation for 12 percent whole person impairment. He applied grade modifiers and used the net adjustment formula to find 14 percent whole person impairment. For the bone cyst, Dr. Rozman rated appellant pursuant to Table 16-2, page 501, Foot and Ankle Regional Grid, noting appellant was a class 1 with a default value C, for one percent impairment of the lower extremity. He noted applying the grade modifiers, pursuant to Table 16-6, he found a grade modifier 2 for moderate problems for Functional History (GMFH), grade modifier 2 for Physical Examination (GMPE), pursuant to Table 16-7, and grade modifier 1 for Clinical Studies (GMCS), pursuant to Table 16-8. Dr. Rozman utilized the adjustment formula to find a net adjustment of 2 which yielded three percent permanent impairment of the leg. He noted the impairment rating for right tarsal tunnel syndrome, Table 16-12, page 536, Peripheral Nerve Impairment -- Lower Extremity Impairment, appellant was a class 1, with a default value C for two percent impairment of the lower extremity. Dr. Rozman noted no significant motor deficit. He noted applying grade modifiers, he found GMCS of one, a GMFH of two and a GMPE of two (moderate problems). Dr. Rozman utilized the net adjustment formula to find a net adjustment of two, which yielded a grade E impairment of four percent right lower extremity impairment.

In an April 28, 2013 report, OWCP's medical adviser reviewed Dr. Rozman's report. He noted that appellant underwent a tarsal tunnel release and a ganglion cyst removal on December 16, 2010. The surgical report noted the ganglion cyst was in reality a varicose vein which could have contributed to the tarsal tunnel syndrome and was routinely removed during the tunnel release. Therefore, the medical adviser noted that the ganglion cyst would not be rated. He noted that, while Dr. Rozman rated impairment due to degeneration of the lumbar/lumbosacral intervertebral disc, whole person spinal impairment was not permissible under OWCP regulations. The medical adviser noted that the contusions of the right toe and foot resolved and were class zero diagnoses with no permanent impairment. He noted that appellant had right ankle pain and functional deficits with sensory losses in the branches of the posterior tibial nerve distribution. On examination, appellant had full range of motion of the ankle with

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

slightly decreased sensation along the posterior tibial nerve distribution, positive Tinel's sign over the tarsal tunnel and increasing antalgic gait. The medical adviser noted that, under Table 16-12, A.M.A., *Guides*, Peripheral Nerve Impairment -- Lower Extremity Impairments, appellant had a class 1 diagnoses, tibial nerve entrapment with mild sensory deficit, which yielded a default grade C impairment of two percent. He applied grade modifiers, finding GMFH of 1, pursuant to Table 16-6, (for a limp) for a mild problem; and a GMPE of 1 at Table 16-7, for a mild problem (neutral alignment, full range of motion with minimal palpatory findings). He advised that clinical studies were not applicable. The medical adviser utilized the net adjustment formula to find a net adjustment of zero correlated to two percent impairment of the right leg.

On May 29, 2013 appellant was granted a schedule award for two percent impairment of the right leg. The period of the award was March 10 to April 19, 2013.

LEGAL PRECEDENT

The schedule award provision 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. 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions after February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8] For decisions issued beginning May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[9]

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).[10] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] The grade modifiers are used on the net adjustment formula described above to calculate a net adjustment. The final impairment grade is

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003).

[9] FECA Bulletin No. 09-03 (issued March 15, 2009).

[10] A.M.A., *Guides*, 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

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

[12] *Id.* at 521.

determined by adjusting the grade up or down the default value C, by the calculated net adjustment.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical consultant for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical consultant providing rationale for the percentage of impairment specified.[14]

ANALYSIS

The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments be classified by diagnosis which is then adjusted by grade modifiers according to the formula noted above.[15] Appellant's accepted conditions include contusion of the right foot, contusion of the right toe, cyst of bone, right side, other disorders of the bone and cartilage on the right, ganglion and cyst of synovium tendon and bursae on the right, right tarsal tunnel syndrome and temporary aggravation of intervertebral disc disease. OWCP authorized a May 11, 2009 excision of cystic bone, first metatarsal head of the right foot and a December 16, 2010 tarsal tunnel release of the right ankle and ligation of varicose veins of the right ankle. On May 29, 2013 appellant was granted a schedule award for two percent permanent impairment of the right lower extremity using the sixth edition of the A.M.A., *Guides*.

The Board has carefully reviewed Dr. Rozman's report of March 25, 2013 and notes that he did not adequately explain how his rating was reached in accordance with the relevant standards of the A.M.A., *Guides*.[16] Dr. Rozman noted that appellant had 14 percent whole person impairment due to her lumbar spine condition. However, for rating impairment of the upper or lower extremities caused by a spinal injury, lower extremity impairments are generally rated as provided in Exhibit 4 of section 3.700 of OWCP's procedures which identifies proposed Table 2 of *The Guides Newsletter*, July/August 2009 which is to be used in rating lower extremity impairments caused by spinal nerve injury.[17] Dr. Rozman provided a spinal impairment rating for the whole person, however, such impairment is not allowed under FECA.[18] He rated appellant for a ganglion bone cyst pursuant to Table 16-2, page 501, Foot and Ankle Regional Grid, noting she was a class 1 with a default value C, for one percent impairment of the lower extremity. Dr. Rozman noted applying the grade modifier for functional history, physical examination and clinical studies which yielded three percent permanent impairment of the lower

[13] *Id*. at 497.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[15] *Supra* notes 11, 12.

[16] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

[17] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[18] *N.D.*, 59 ECAB 344 (2008).

extremity. However, the Board notes that the December 16, 2010 surgical report notes the ganglion cyst was a varicose vein and therefore it was inappropriate to rate appellant under Table 16-2, Foot and Ankle Grid, for a ganglion cyst. Dr. Rozman also rated a right tarsal tunnel syndrome under Table 16-12, page 536, peripheral nerve. Appellant was class 1, with a default value C for 2 percent impairment of the lower extremity. He noted no significant motor deficit. Dr. Rozman noted applying grade modifiers, he found clinical studies modifier of 1, a functional history modifier of 2 and a physical examination modifier of 2 (moderate problems) to conclude that appellant had four percent impairment. However, he failed to adequately explain how he determined she had a functional history and physical examination modifier of two for a moderate problem. Although appellant had a reported antalgic limp, it was not in the presence of objectively defined significant pathology and she had no reported external orthotic device, routine use of a single gait aid or positive Trendelenburg's test. Therefore, the selected modifier was inappropriate. Further, Dr. Rozman noted a physical examination modifier of 2 but he failed to explain his determination in light of findings of neutral alignment, full range of motion and minimal palpatory findings. Therefore the Board finds that he did not adequately follow the A.M.A., *Guides* and his report is of diminished probative value where the A.M.A., *Guides* were not properly followed.[19]

On April 28, 2013 OWCP's medical adviser reviewed Dr. Rozman's report. He noted that appellant underwent a tarsal tunnel release and a ganglion cyst removal on December 16, 2010. The medical adviser explained that the operative report noted the ganglion cyst was in reality a varicose vein such that the ganglion cyst would not be rated as it was an incorrect diagnosis. While Dr. Rozman rated whole person impairment for appellant's lumbar condition, the medical adviser explained that this was not ratable under OWCP standards. He noted that the contusions of the right toe and foot had resolved and thus were not ratable. For right tarsal tunnel syndrome, the medical adviser noted that appellant had right ankle pain and functional deficits with sensory losses in the branches of the posterior tibial nerve distribution. He noted on physical examination, she had full range of motion of the ankle with slightly decreased sensation along the posterior tibial nerve distribution, positive Tinel's sign over the tarsal tunnel and increasing antalgic gait. Under Chapter 16 of the sixth edition of the A.M.A., *Guides*, appellant had two percent impairment of the right leg. Using the A.M.A., *Guides*, the medical adviser properly found that, in accordance with Table 16-12, A.M.A., *Guides*, for peripheral nerve impairment, appellant had a class 1 diagnosis, tibial nerve entrapment with mild sensory deficit, which yielded a default grade C impairment of two percent. He applied the modifiers for functional history, physical examination and clinical studies found in Table 16-6, Table 16-7 and Table 16-8.[20] The medical adviser applied grade modifiers, finding a grade 1 for functional history, pursuant to Table 16-6, (for a limp) for a mild problem; a grade 1 for physical examination at Table 16-7, for a mild problem (neutral alignment, full range of motion with minimal palpatory findings) and with clinical studies not applicable. The medical adviser utilized the net adjustment formula to find a net adjustment of zero which yielded a grade C modifier or two percent impairment of the right lower extremity.

[19] *See Paul R. Evans, Jr.*, 44 ECAB 646 (1993); *John Constantin*, 39 ECAB 1090 (1988) (medical report not explaining how the A.M.A., *Guides* are utilized is of little probative value).

[20] *Id*. at 516-19.

OWCP's medical adviser properly utilized and explained his calculations under the sixth edition of the A.M.A., *Guides*. The Board finds that the weight of medical evidence establishes two percent permanent impairment of appellant's right leg. This rating was based on the applicable protocols and tables of the sixth edition of the A.M.A., *Guides.* There is no evidence in accordance with the A.M.A., *Guides* which supports that appellant sustained a higher impairment.

On appeal, appellant argues that she sustained a greater impairment than that determined by OWCP's medical adviser. She asserts that Dr. Rozman properly calculated a higher impairment of the lower extremity. However, as noted above, Dr. Rozman failed to adequately explain how his determination was reached in accordance with the relevant standards of the A.M.A., *Guides*.[21] Additionally, as noted, the record does not contain any probative medical evidence to establish greater impairment under the sixth edition of the A.M.A., *Guides.*

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has two percent impairment of the right lower extremity, for which she received a schedule award.

[21] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

ORDER

IT IS HEREBY ORDERED THAT the May 29, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board