United States Department of Labor
Employees' Compensation Appeals Board

Y.O., Appellant	)	
and	)	**Docket No. 14-1179**
	)	**Issued: September 5, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Capitol Heights, MD, Employer	)	

Appearances:
Alan J. Shapiro, *Esq*., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 21, 2014 appellant, through counsel, timely appealed the February 27, 2014 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.

ISSUE

The issue is whether appellant has greater than one percent permanent impairment of the left lower extremity.

FACTUAL HISTORY

Appellant, a 49-year-old mail carrier, has an accepted traumatic injury claim for left ankle deltoid ligament sprain, which occurred on July 1, 2009.[2] OWCP approved an October 19,

[1] 5 U.S.C. §§ 8101-8193 (2006).

[2] Appellant was walking through grass delivering mail when she stepped on a rock and twisted her left ankle.

2009 left ankle arthroscopic procedure, which included debridement of a partial tear of the deltoid ligament. Appellant received wage-loss compensation for temporary total disability. On August 10, 2010 she returned to work in a light-duty capacity. Appellant subsequently filed a claim for a schedule award (Form CA-7).

Dr. Uchenna R. Nwaneri, a Board-certified orthopedic surgeon, provided an August 18, 2011 impairment rating under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2008).[3] He diagnosed a partial tear of the left deltoid ligament, which was causally related to appellant's July 1, 2009 employment injury. According to Dr. Nwaneri, appellant had reached maximum medical improvement (MMI). He calculated a combined 42 percent left lower extremity (LLE) impairment. Dr. Nwaneri's rating included 25 percent impairment under "Table 15-2."[4] He also found 10 percent peripheral nerve impairment (medial plantar nerve) under Table 16-12, A.M.A., *Guides* 536 (6th ed. 2008). Lastly, Dr. Nwaneri found seven percent impairment for loss of range of motion (ROM) under Table 16-22, A.M.A., *Guides* 549 (6th ed. 2008). He explained that appellant had restricted motion on eversion as well as dorsiflexion of the ankle. Dr. Nwaneri also noted that he reviewed an August 18, 2011 left ankle x-ray, which showed some joint space narrowing.[5]

On June 16, 2012 Dr. Lawrence A. Manning, the district medical adviser (DMA) reviewed Dr. Nwaneri's impairment rating and recommended that OWCP refer appellant for further evaluation. He noted several deficiencies in Dr. Nwaneri's report, which included the absence of ROM measurements and no description of his sensory examination. The DMA also noted that Dr. Nwaneri impermissibly combined a diagnosis-based impairment with a stand-alone ROM impairment. Moreover, he indicated that Dr. Nwaneri did not combine the three identified impairments utilizing the Combined Values Chart, but instead added them (25 + 10 + 7) to arrive at 42 percent.

OWCP subsequently referred appellant to Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, for a second opinion. In a report dated September 27, 2012, Dr. Gordon found one percent LLE impairment under Table 16-2, Foot and Ankle Regional Grid (LEI), A.M.A., *Guides* 502 (6th ed. 2008). He indicated that appellant reached MMI in June 2010. Dr. Gordon's rating was based on a diagnosis of joint instability/ligamentous laxity -- traumatic. He found class 1 impairment (CDX 1) for clinical instability, with a default (grade c) lower extremity impairment of one percent. With respect to grade modifiers, Dr. Gordon assigned a value of 1 for Functional History (GMFH 1), Physical Examination (GMPE 1) and Clinical Studies (GMCS 1), which resulted in a net adjustment of zero (0).[6] He further noted that there

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[3] Dr. Nwaneri performed appellant's October 19, 2009 left ankle arthroscopy.

[4] Table 15-2, Digit Regional Grid (Upper Extremity), A.M.A., *Guides* 391-94 (6th ed. 2008).

[5] Dr. Craig A. Campbell, a Board-certified diagnostic radiologist, reviewed the August 18, 2011 x-ray and noted no evidence of acute fracture, bone lesion, or dislocation. He further noted that the ankle mortise was intact and the soft tissues were normal. Dr. Campbell's diagnostic impression was no acute bony abnormality.

[6] Net Adjustment (0) = (GMFH 1 - CDX 1) + (GMPE 1 - CDX 1) + (GMCS 1 – CDX 1). *See* Section 16.3d, A.M.A, *Guides* 521 (6th ed. 2008).

was no evidence of sensory or motor deficit, no evidence of loss of motion and no evidence of joint space narrowing apart from Dr. Nwaneri's finding.

The DMA reviewed the record on October 20, 2012 and concurred with Dr. Gordon's one percent LLE impairment rating. According to him, appellant reached MMI on October 19, 2010; one year from the date of her left ankle surgery.

On November 20, 2012 OWCP granted a schedule award for one percent LLE extremity impairment. The award covered a period of 2.88 weeks from October 19 through November 8, 2010.

Appellant timely requested an oral hearing. She also submitted a January 23, 2013 impairment rating from Dr. Stuart J. Goodman, a Board-certified neurologist. He noted that appellant received an award for one percent LLE impairment, but Dr. Goodman believed she had at least three percent impairment. He stated that appellant "falls into [c]lass 1 with a three percent" impairment of her LLE under Table 16-2, Foot and Ankle Regional Grid (LEI), A.M.A., *Guides* 501-08 (6th ed. 2008). Dr. Goodman did not complain of her foot going to sleep, numbness, difficulty wearing closed shoes, sitting or standing for a prolonged period of time.

By decision dated June 3, 2013, the hearing representative remanded the case to OWCP so that it could refer Dr. Goodman's January 23, 2013 report to the DMA for review.

In a June 22, 2013 report, Dr. Manning, the DMA, found one percent LLE impairment. He indicated that there was no evidence in Dr. Goodman's report that warranted any further impairment above one percent, as previously advised.

In a July 10, 2013 decision, OWCP found that appellant had not established entitlement to additional LLE impairment. It based its decision on the DMA's June 22, 2013 finding of no impairment in excess of the previous one percent LLE award.

Counsel requested another oral hearing, which was held on December 18, 2013.

In a February 27, 2014 decision, the hearing representative affirmed OWCP's July 10, 2013 decision.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[7] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[8]

[7] For complete loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

[8] 20 C.F.R. § 10.404.

Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2008).[9]

ANALYSIS

Appellant's surgeon, Dr. Nwaneri, provided an August 18, 2011 impairment rating that included numerous errors with respect to the application of the A.M.A., *Guides* (6th ed. 2008). First, he purportedly found a diagnosis-based impairment of 25 percent LLE under "Table 15-2." However, the identified table pertains to upper extremity digit impairments.[10] Assuming Dr. Nwaneri intended to cite Table 16-2, Foot and Ankle Regional Grid (LEI), A.M.A., *Guides* 501-08 (6th ed. 2008) rather than "Table 15-2," he still neglected to identify the specific diagnosis and/or diagnostic criteria he relied on in finding 25 percent LLE impairment. Dr. Nwaneri also found impairment due to loss of ankle range of motion under Table 16-22, A.M.A., *Guides* 549 (6th ed. 2008), but failed to provide ROM measurements to support his seven percent LLE impairment rating. Dr. Nwaneri's 10 percent rating for peripheral nerve impairment (medial plantar nerve) under Table 16-12, A.M.A., *Guides* 536 (6th ed. 2008) is similarly deficient because he failed to document specific results of sensory testing. Dr. Nwaneri merely noted that there was "sensory deficit" in the region of the medial arch and great toe. Because of the above-noted deficiencies as identified by the DMA, OWCP referred appellant to Dr. Gordon for further evaluation.

Based on his September 27, 2012 physical examination, the second opinion physician, Dr. Gordon, found no evidence of sensory or motor deficits and no evidence of loss of motion. He rated appellant for joint instability/ligamentous laxity -- traumatic under Table 16-2, Foot and Ankle Regional Grid (LEI), A.M.A., *Guides* 502 (6th ed. 2008). Dr. Gordon identified class 1 impairment for clinical instability. The default lower extremity rating for clinical instability is one percent. Factoring in adjustments for Functional History (GMFH 1), Physical Examination (GMPE 1) and Clinical Studies (GMCS 1), Dr. Gordon calculated a net adjustment of 0, which resulted in no deviation from the default (grade c) rating of 1 percent.[11] The DMA concurred with Dr. Gordon's LLE impairment rating.

The Board finds that Dr. Gordon's September 27, 2012 impairment rating properly conforms to the A.M.A., *Guides* (6th ed. 2008), and thus, represent the weight of the medical evidence regarding the extent of appellant's left lower extremity impairment. Although Dr. Goodman subsequently found "at least a three percent" impairment under Table 16-2, Foot and Ankle Regional Grid (LEI), A.M.A., *Guides* 502 (6th ed. 2008), he did not identify the specific diagnosis and/or diagnostic criteria nor did he further explain his finds. The Board finds that the medical evidence of record does not establish left lower extremity impairment in excess of OWCP's November 20, 2012 award of one percent.

[9] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6a (February 2013).

[10] *See supra* note 4.

[11] *See supra* note 6.

CONCLUSION

Appellant has not demonstrated that she has greater than one percent impairment of the LLE.

ORDER

IT IS HEREBY ORDERED THAT the February 27, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 5, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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