United States Department of Labor
Employees' Compensation Appeals Board

K.W., Appellant	)	
and	)	**Docket No. 17-0864**
	)	**Issued: June 21, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Portland, OR, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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 March 10, 2017 appellant, through counsel, filed a timely appeal from a January 25, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 met his burden of proof to establish more than two percent permanent impairment of his left lower extremity, for which he received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on April 21, 2012 appellant, then a 51-year-old food service worker, sustained a left ankle sprain while pushing a cart at work. Appellant stopped work on April 22, 2012 per the recommendation of Dr. Colene Andersen, an attending Board-certified internist. He received intermittent disability compensation on the daily rolls and returned to light-duty work on May 8, through July 16, 2012.

Appellant participated in OWCP-authorized physical therapy sessions during which he reported tenderness to palpation of his left ankle and increased pain upon exercise.

Appellant was terminated from the employing establishment effective August 10, 2012 while he was in a probationary period. He reported to his attending physicians that he was experiencing continued left ankle pain. On May 30, 2013 Dr. Edward Tierney, an attending podiatrist, indicated that May 13, 2013 left ankle x-rays revealed a resolution of previously noted ankle effusion and soft tissue swelling overlying the medial malleolus with no underlying displaced fractures or dislocations.

On September 23, 2015 appellant filed a claim for a schedule award (Form CA-7).

In a February 12, 2015 decision, OWCP denied appellant's claim for work-related permanent impairment noting that he had failed to submit sufficient medical evidence to establish permanent impairment due to his April 21, 2012 left ankle injury.

In an April 13, 2015 report, Dr. William Leonetti, an attending podiatrist, discussed appellant's factual and medical history, including the nature of his April 21, 2012 left ankle injury. He noted that a December 4, 2014 left ankle magnetic resonance imaging scan showed thickening of the mid Achilles tendon, unremarkable lateral and medial ligaments, unremarkable sinus tarsi, plantar calcaneal spur with thickening of the plantar fascia, four millimeter articular body anterior to the anterior talar dome with cartilage fissuring of the anterior talar dome, and minimal osteophyte formation at the tibia anteriorly. Dr. Leonetti indicated that there was no ankle joint effusion and no significant arthritic change of the subtalar joint. He advised that appellant reported that the majority of his pain was over the posterolateral and posteromedial aspect of his left ankle joint. Dr. Leonetti reported the findings of his physical examination on April 13, 2015, noting that there were no signs of complex regional pain syndrome/reflex sympathetic dystrophy.

Range of motion (ROM) testing for the left ankle revealed that dorsiflexion was less than 5 degrees, plantarflexion was 30 to 40 degrees, inversion was less than 10 degrees, and eversion was 0 degrees. Dr. Leonetti indicated that appellant exhibited 4/5 strength in his right lower extremity and 2/5 strength in his left lower extremity, but noted there were no measurable signs of atrophy to account for the early breakaway weakness on the left side. He determined that, under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009) (A.M.A., *Guides*), and using the ROM method of rating including Tables 16-20 and 16-22 on page 549, appellant would qualify for a permanent impairment rating based on weakness, instability, and loss of ROM, specifically in dorsiflexion and inversion. Dr. Leonetti concluded that appellant had 12 percent permanent impairment of his left lower extremity.

In December 2016 OWCP referred the case record to a medical adviser, Dr. Arnold T. Berman, a Board-certified orthopedic surgeon, for review and an opinion regarding the permanent impairment of appellant's left lower extremity under the standards of the sixth edition of the A.M.A., *Guides*.

In a February 16, 2016 report, Dr. Berman indicated that Dr. Leonetti's April 13, 2015 impairment rating was not carried out in accordance with the standards of the sixth edition of the A.M.A., *Guides.* He indicated that as a general matter under the A.M.A., *Guides*, Dr. Leonetti was not qualified to make a permanent impairment calculation. He went on and noted that Dr. Leonetti utilized ROM as the primary method to rate the permanent impairment of appellant's left lower extremity and indicated that this method was not consistent with the A.M.A., *Guides* because it should not be used except in rare instances. Dr. Berman advised that ROM is reflected in the grade modifiers. He noted that, under Table 16-2 (Foot and Ankle Regional Grid) on page 502 of the sixth edition of the A.M.A., *Guides,* he applied the diagnosis-based impairment (DBI) rating method and chose the diagnosis of traumatic joint instability/ligamentous laxity. Dr. Berman determined that this was the appropriate diagnosis because the diagnoses found on page 501 were related to soft tissue conditions for which appellant did not qualify. He found that, under Table 16-2, appellant's left ankle condition fell under class 1 (clinical instability) and would be assigned the default value of one percent permanent impairment of the left lower extremity. Dr. Berman noted that appellant did not meet the next subcategory of class 1, mild ligamentous laxity, because that would require anteroposterior stress radiographs of two to three millimeters of excess opening or five degrees of varus compared to the normal side.

Dr. Berman further noted that, under Table 16-6 on page 516, appellant had a functional grade modifier of 2 due to a moderate problem and that, under Table 16-7 on page 517, he had a physical examination grade modifier of 2 due to moderate palpatory findings consistently documented and supported by observed abnormalities, including moderately decreased ROM. Under Table 16-8 on pages 519-20, appellant had a clinical grade modifier of 2 due to a moderate pathology. Dr. Berman applied the net adjustment formula to yield a result of +2 and noted that, under Table 16-2, the class 1 default value of one percent impairment of the left lower extremity, grade C, was increased by two grades to the grade E value of two percent impairment. He concluded that appellant had a total permanent impairment of the left lower extremity of two percent. Dr. Berman indicated that, because the ROM method was not appropriate in appellant's case, Dr. Leonetti's recommendation of 12 percent permanent impairment was improper. He noted that appellant's date of maximum medical improvement was April 13, 2015, the date of Dr. Leonetti's examination.

In a January 25, 2017 decision, OWCP granted appellant a schedule award for two percent permanent impairment of his left lower extremity. The award ran for 5.76 weeks from April 13 to May 23, 2015 and was based on the impairment rating of Dr. Berman, the OWCP medical adviser.

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.[3] FECA,

[3] 5 U.S.C. § 8107(c).

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 A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[4] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2nd prtg. 2009).[5]

ANALYSIS

OWCP accepted appellant's traumatic injury claim for left ankle sprain. In a March 7, 2016 decision, it granted a schedule award for two percent permanent impairment of the left lower extremity. By decision dated January 25, 2017, OWCP's hearing representative affirmed the March 7, 2016 left lower extremity schedule award. He relied on the DMA's February 16, 2016 impairment rating, which was based on a diagnosis of left ankle joint instability/ ligamentous laxity -- traumatic.

In determining lower extremity permanent impairment under Chapter 16, A.M.A., *Guides* (6th ed. 2009), an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the ankle, the relevant portion of the lower extremity for the present case, reference is made to Table 16-2, Foot and Ankle Regional Grid, A.M.A., *Guides* 501-07 (6th ed. 2009).[6] After determining the Class of Diagnosis (CDX), including identification of a default grade ("C"), the evaluator assigns appropriate grade modifiers for Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The next step is to calculate the net adjustment based on the identified grade modifiers, and then make any appropriate adjustments (-/+) to the previously identified CDX default grade.[7]

Chapter 16 provides that the DBI method is the primary basis for calculating lower extremity permanent impairment. Most impairment ratings are based on the DBI methodology where impairment class is determined by the diagnosis and specific criteria, then adjusted by nonkey factors (grade modifiers), which may include functional history, physical examination, and clinical studies.[8] The grade modifiers, or nonkey factors, are considered only if they are determined to be reliable and associated with the diagnosis.[9] Chapter 16 further provides: "Alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and [ROM]."[10] However, ROM is

[4] 20 C.F.R. § 10.404.

[5] *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 and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[6] *See* A.M.A., *Guides* 501-07 (6th ed. 2009).

[7] Net Adjustment = (GMFH -- CDX) + (GMPE -- CDX) + (GMCS -- CDX). *See* Section 16.3d, A.M.A., *Guides* 521 (6th ed. 2009).

[8] Section 16.2, A.M.A., *Guides* 497 (6th ed. 2009).

[9] *Id.*

[10] *Id.*

"primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment."[11] Lastly, a rating based on loss of ROM cannot be combined with other approaches.[12]

As noted, OWCP granted appellant a left lower extremity schedule award for two percent permanent impairment. Appellant submitted an April 13, 2015 report from Dr. Leonetti, who opined that he had 12 percent permanent impairment to the left lower extremity. Dr. Leonetti used the ROM method and reported that he was applying Table 16-20 and Table 16-22 on page 549 of the sixth edition of the A.M.A., *Guides*. The first question presented is whether the ROM method is appropriate in this case.

Under Chapter 16 the DBI method is the primary basis for determining lower extremity permanent impairment. The ROM method is used to determine actual impairment values of the lower extremities only when it is not possible to otherwise define impairment.[13] Dr. Leonetti failed to explain why the percentage of impairment could not be defined under Table 16-2 (Foot and Ankle Regional Grid) beginning on page 501 of the sixth edition of the A.M.A., *Guides*.

In his December 16, 2016 report, Dr. Berman, the OWCP medical adviser, identified left ankle joint instability/ligamentous laxity under Table 16-2. The Board finds that the medical adviser properly determined the left lower extremity impairment should be evaluated using the DBI method.[14]

Dr. Berman identified class 1 (mild problem) for appellant's left ankle condition with clinical instability.[15] This is consistent with the findings of Dr. Leonetti. Dr. Berman noted that the grade C (default) impairment was one percent under Table 16-2 on page 503. He then applied the net adjustment formula and found an adjustment to a grade E impairment of two percent.[16] This adjustment was based on grade modifiers for functional history (2), physical examination (2), and clinical studies (2).[17]

The Board finds that the opinion of Dr. Berman represents the weight of the medical evidence with respect to appellant's left lower extremity permanent impairment. Dr. Berman properly applied the A.M.A., *Guides* using the DBI method, finding that the left lower extremity permanent impairment was, in fact, two percent. The probative evidence does not establish more than two percent permanent impairment of appellant's left lower extremity.

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[11] *Id.*

[12] *Id.*

[13] *E.M.,* Docket No. 14-0311 (issued July 8, 2014).

[14] *See P.M.,* Docket No. 16-0367 (issued March 27, 2017).

[15] A.M.A., *Guides* 502 (6th ed. 2009), Table 16-2.

[16] *See supra* note 7. The Board notes that calculation of the Net Adjustment Formula would actually yield a result of +3, rather than +2 as reported by Dr. Berman. However, this is harmless error as, under Table 16-2, both the +2 and the +3 adjustment figures would result an adjustment to a grade E impairment of two percent permanent impairment of the left lower extremity.

[17] A.M.A., *Guides* 516-17, 519-20 (6th ed. 2009), Table 16-6, Table 16-7, and Table 16-8.

Appellant may request an increased schedule award at any time 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 did not meet his burden of proof to establish more than two percent permanent impairment of his left lower extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the January 25, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 21, 2017
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