United States Department of Labor
Employees' Compensation Appeals Board

W.G., Appellant	)	
and	)	**Docket No. 17-1258**
	)	**Issued: July 12, 2018**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, SOUTHERN NEVADA HEALTHCARE SYSTEM, Las Vegas, NV, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 19, 2017 appellant, through counsel, filed a timely appeal from a March 20, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

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 the claim.[3]

ISSUE

The issue is whether appellant has met his burden of proof to establish more than four percent permanent impairment of his bilateral lower extremities, for which he previously received schedule awards.

FACTUAL HISTORY

On August 21, 2013 appellant, then a 52-year-old registered nurse, filed an occupational disease claim (Form CA-2) alleging bilateral foot problems which resulted from the performance of his nursing duties on a medical surgical floor. OWCP accepted the claim for the bilateral foot conditions of plantar fibromatosis, other valgus deformities, hallux valgus (acquired), and aggravation of acquired equinus. It authorized September 11, 2013 right foot surgery, which was performed by Dr. Anthony Ricciardi, a podiatrist.[4] Appellant received wage-loss compensation on the supplemental rolls, commencing September 12, 2013, and returned to part-time, restricted-duty work on February 3, 2014.

On December 10, 2014 appellant filed a claim for compensation and requested a schedule award (Form CA-7).

In an undated letter, received December 22, 2014, Dr. Ricciardi indicated that he had treated appellant since 2012 and performed the corrective surgery on his right foot in 2013. He opined that appellant had reached maximum medical improvement (MMI). Dr. Ricciardi described the symptoms appellant experienced regarding the right foot and opined that continuation of appellant's current work as a medical surgical floor nurse could cause further damage. He also indicated that appellant's ability to turn the foot inward or outward was reduced by 30 percent and that appellant's great toe had lost 90 percent flexibility.

By development letter dated December 31, 2014, OWCP requested that appellant provide an impairment rating from his treating physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*).[5] Appellant was afforded 30 days to submit the requested evidence.

In a January 6, 2016 report, Dr. Ricciardi advised that appellant had not reached MMI of his right lower extremity. He indicated that appellant's compensation of the contralateral limbs

[2] 5 U.S.C. § 8101 *et seq.*

[3] The record provided to the Board includes evidence received after OWCP issued its March 20, 2017 decision. The Board's jurisdiction is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

[4] Appellant underwent a right foot calcaneus Evans osteotomy and a first metatarsal osteotomy with hallux osteotomy.

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

had caused more aggravation of the left extremity and significant debilitating pain, which prevented him from working on his feet. Dr. Ricciardi noted that appellant requested surgical management of his left foot and that he had recommended osteotomy of the first metatarsal, reduction of the talotarsal joint, subluxation of the osteotomy, calcaneus fixation and synovectomy of the subtalar joint and posterior tibial tendon. He indicated that appellant should continue to remain as sedentary as possible at work, with no more than an hour at a time on his feet.

Effective February 9, 2015, appellant retired on medical disability.

By decision dated February 19, 2015, OWCP denied appellant's claim for a schedule award. It found that the medical evidence indicated that appellant's accepted conditions had not yet reached a fixed and permanent state.[6]

Treatment notes from Dr. Ricciardi dated April 8, 2014, September 1, and 29, 2015 were received. In his September 29, 2015 report, Dr. Ricciardi indicated that appellant was at MMI for his right foot. He noted that appellant was able to withstand about 70 percent of normal activities for limited time periods. Dr. Ricciardi described appellant's limitations. He also opined that appellant's continuation in his current position as medical surgical floor nurse could cause further damage and more problems to appellant.

In a January 21, 2016 report, Dr. Demitri A. Adarmes, a Board-certified internist and Board-certified physiatrist, reviewed appellant's medical records and performed a physical examination of appellant's feet. He indicated that appellant had reached MMI on January 21, 2016. Utilizing the sixth edition of the A.M.A., *Guides*, Dr. Adarmes opined that appellant had 14 percent permanent impairment of each lower extremity using the range of motion (ROM) methodology. He indicated that, since Table 16-2, "Foot and Ankle Regional Grid," did not have any condition which described "hallux valgus" and/or consequences of surgery for this disorder, he used Table 16-19, "Greater Toe Impairments." Dr. Adarmes took three active ROM measurements of the great toe, noting that metatarsophalangeal (MTP) joint extension of the right and left great toe were 30, 30, and 30 degrees. Interphalangeal (IP) flexion of the right great toe was 20, 18, and 18 degrees and of the left great toe was 40, 40, and 42 degrees. Under Table 16-19, page 549, Dr. Adarmes found that appellant had two percent right lower extremity great toe impairment of the right foot and two percent left lower extremity impairment of the left foot for restricted ROM of MTP extension. In order to rate the valgus deformity of appellant's feet, he indicated that Table 16-21, "Ankle or Hindfoot Deformity Impairments," was used as Table 16-2 did not contain an adequate description to rate appellant's impairment. Three active ankle ROM measurements were provided. Measurements listed for the right ankle were: inversion of 18, 19, and 18 degrees; eversion of 11, 12, and 12 degrees; plantar flexion of 70, 70, and 70 degrees; and dorsiflexion of 11, 12, and 13 degrees. Measurements listed for the left ankle were: inversion of 11, 10, and 10 degrees; eversion of 12, 14, and 12 degrees, plantar flexion of 70, 70, and 70 degrees; and dorsiflexion of 12, 11, and 12 degrees. Under Table 16-21, Dr. Adarmes found that a valgus deformity of 10 degrees yielded a mild impairment of 12 percent lower extremity

[6] On February 25, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative, which was held on September 10, 2015. During the hearing, counsel requested that appellant's hearing request be dismissed as the issue of MMI had not yet been resolved. By decision dated September 28, 2015, OWCP accepted appellant's petition to withdraw the hearing request.

impairment for the right lower limb and 12 percent lower extremity impairment for the left lower limb. Utilizing the Combined Values Chart on page 604, he found that 12 percent lower extremity impairment combined with 2 percent lower extremity impairment yielded 14 percent impairment for the left lower extremity and 14 percent impairment for the right lower extremity. Dr. Adarmes indicated that no adjustment was done for functional history (FH) as appellant's condition was corrected with orthotics. Copies of diagnostic testing performed on January 21, 2016 were also submitted.

On June 29, 2016 appellant filed an additional claim for a schedule award (Form CA-7).

OWCP subsequently referred a statement of accepted facts (SOAF) and the medical record to its medical adviser to determine appellant's permanent impairment, if any, for schedule award purposes.

In a July 19, 2016 report, an OWCP medical adviser reviewed the SOAF and the case file, including Dr. Adarmes' January 21, 2016 report. He found that appellant had reached MMI on January 21, 2016. However, the medical adviser opined that appellant's permanent impairment of each lower extremity was four percent. He agreed that Dr. Adarmes was correct in applying the stand alone ROM impairments, as the foot and ankle grid did not adequately address the issue of stiffness in appellant's great toe in a nonankylosed state. However, the medical adviser indicated that the calculated impairment was significantly lower as Dr. Adarmes incorrectly rounded his measurement to the nearest whole number and that rounding was not a method used in the lower extremity as reflected in the cutoff values in most tables.

Using Dr. Adarmes' measurements for the right lower extremity, the medical adviser indicated the following: for loss of motion, hindfoot, Table 16-20, page 539, inversion 30 degrees equaled zero percent impairment; eversion 11 degrees equaled zero percent impairment, for total impairment zero percent. For loss of motion, ankle, Table 16-22, page 549, flexion 70 degrees equaled zero percent impairment, extension 12 degrees equaled zero percent impairment for a total impairment zero percent. For loss of motion, great toe, rounded Table 16-19, page 549, flexion 19 degrees equaled two percent impairment, and 30 degrees extension, equaled two percent impairment. The medical adviser totaled the impairments for the hindfoot, ankle, and great toe and found total impairment for the right lower extremity was four percent.

For the left lower extremity, OWCP's medical adviser indicated the following. For loss of motion, hindfoot, Table 16-20, page 539, inversion 10 degrees equaled two percent impairment; eversion 12 degrees equaled zero percent impairment, for total impairment two percent. For loss of motion, ankle, Table 16-22, page 549, flexion 70 degrees equaled zero percent impairment, extension 12 degrees equaled zero percent impairment for a total impairment zero percent. For loss of motion, great toe, Table 16-19, page 549, flexion 40 degrees equaled zero percent impairment, and 30 degrees extension, equaled two percent impairment. The medical adviser totaled the impairments for the hindfoot, ankle, and great toe and found total impairment for the left lower extremity was four percent.

By decision dated July 28, 2016, OWCP awarded appellant four percent permanent impairment of the left lower extremity and four percent permanent impairment of the right lower

extremity. The period of the award was from January 21 to June 30, 2016 for a total of 23.04 weeks of compensation.

On August 5, 2016 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative, which was held on February 17, 2017. No new relevant medical evidence was received.[7]

By decision dated March 20, 2017, OWCP's hearing representative affirmed the July 28, 2016 OWCP decision. He found that the weight of the medical evidence rested with the medical adviser's impairment calculations as he had explained why his impairment calculations were lower than those of Dr. Adarmes.

LEGAL PRECEDENT

Section 8107 of FECA 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.[8] Neither FECA nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[10]

The sixth edition of the A.M.A., *Guides* provides that ROM method may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using ROM may not be combined with a diagnosis-based impairment (DBI) and stands alone as a rating.[11]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that DBI is the primary method of calculation for the lower limb. The ROM method is 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.[12]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the medical adviser for an opinion concerning the nature and percentage in

[7] Duplicative evidence, previously of record, was received.

[8] 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).

[9] *K.H.*, Docket No. 09-0341 (issued December 30, 2011).

[10] *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 (March 2017).

[11] A.M.A., *Guides* 497; *K.H.*, Docket No. 13-0501 (issued January 28, 2014).

[12] *Id.*

accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted appellant's occupational disease claim for the conditions of bilateral plantar fibromatosis, other valgus deformities of the bilateral feet, bilateral hallux valgus (acquired), and aggravation of acquired equinus deformity of the bilateral feet and authorized a September 11, 2013 right foot surgery. By decision dated July 28, 2016, it granted appellant an award for four percent permanent impairment of the left lower extremity and four percent permanent impairment of the right lower extremity. The weight of the medical evidence was accorded to the opinion of its OWCP medical adviser, who concurred with appellant's physician that the stand alone ROM impairments were appropriate to use as the foot and ankle grid did not adequately address the issue of the great toe in a nonankylosed state.[14]

Section 16.7b, page 544, of the A.M.A., *Guides* provides that ROM should be measured after a warm up, that the maximum ROM should be measured at least three times, and that the maximum measurement is used to determine ROM measurement.[15] OWCP's medical adviser properly noted that the lower extremity chapter of the A.M.A., *Guides* does not provide for rounding of measurements to the nearest number as provided in rating upper extremity impairments based on ROM.[16] Thus, the medical adviser properly interpreted the A.M.A., *Guides* in finding that rounding of measurements to the nearest whole number was not applied to lower extremity impairment calculations based on ROM, which Dr. Adarmes apparently had done.

OWCP's medical adviser properly rated appellant's permanent impairment of the lower extremities under Table 16-19, Table 16-20, and Table 16-22 utilizing Dr. Adarmes' findings. He explained that application of the A.M.A., *Guides* to Dr. Adarmes' measurements for loss of ROM resulted in four percent right lower extremity permanent impairment and four percent left lower extremity permanent impairment. In his January 21, 2016 report, Dr. Adarmes provided three active ROM for the great toe, ankle and hindfoot for both the left and right lower extremities. For loss of motion, great toe, rounded, Table 16-19, his measurements for the right toe are: 30 degrees MTP extension which results in two percent impairment and 19 degrees IP flexion which results in two percent impairment. Dr. Adarmes' measurements for the left toe are: 30 degrees for MTP extension which results in two percent impairment and 40 degrees IP flexion which results in zero percent impairment.

[13] *Supra* note 10 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (March 2017).

[14] The ROM method is used to determine actual impairment values of the lower extremities only when it is not possible to otherwise define impairment. *E.M.*, Docket No. 14-0311 (issued July 8, 2014).

[15] A.M.A., *Guides* 544.

[16] *Id*. at 464.

For loss of motion, ankle, rounded, Table 16-22, Dr. Adarmes' measurements of the right ankle are: plantar flexion 70 degrees which results in zero percent impairment; and dorsiflexion 12 degrees which results in zero percent impairment. His measurements of the left ankle are: plantar flexion 70 degrees which results in zero percent impairment; and dorsiflexion 12 degrees which results in zero percent impairment.

For loss of motion, hindfoot, rounded, Table 16-20, Dr. Adarmes' measurements of the right hindfoot are: inversion 30 degrees which results in zero percent impairment; eversion 11 degrees which results in zero percent impairment. His measurements of the left hindfoot are: inversion 10 degrees which results in two percent impairment; eversion 12 degrees which results in zero percent impairment. Under the A.M.A., *Guides*, the proper impairment calculation for the right lower extremity would be four percent impairment for the great toe plus zero percent impairment for the ankle plus zero percent impairment for the hindfoot, for a total right lower extremity impairment of four percent. The proper impairment calculation for the left lower extremity would be two percent impairment for the great toe plus zero percent impairment for the ankle plus two percent impairment for the hindfoot, for a total left lower extremity impairment of four percent.

The Board finds, however, that Dr. Adarmes rated appellant's permanent impairment of the hindfoot based on loss of ROM due to hindfoot deformity, under Table 16-21. OWCP's medical adviser did not rate appellant's permanent impairment of either lower extremity under this Table and he did not explain why such a rating was inappropriate. OWCP's procedures provide that if the medical evidence neglects to provide rationale for the percentage of impairment specified, the claims examiner should request a clarification or a supplemental report from the medical adviser.[17] OWCP should therefore request that its medical adviser clarify whether appellant is entitled to an additional schedule award pursuant to Table 16-21. After such further development as deemed necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

[17] *Supra* note 13.

ORDER

IT IS HEREBY ORDERED THAT the March 20, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision.

Issued: July 12, 2018
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board