United States Department of Labor
Employees' Compensation Appeals Board

W.D., Appellant	)	
and	)	**Docket No. 17-0404**
	)	**Issued: July 11, 2018**
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT, OFFICE OF THE INSPECTOR GENERAL, Washington, DC, 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 December 14, 2016 appellant, through counsel, filed a timely appeal from an October 28, 2016 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 the claim.

[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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than one percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On April 2, 2012 appellant, then a 50-year-old criminal investigator, filed a traumatic injury claim (Form CA-1) alleging that, on March 30, 2012, he sustained a gunshot wound to his lower right leg in the course of agency-authorized firearms training while in the performance of duty. He stopped work on April 2, 2012.

On May 11, 2012 OWCP accepted the claim for right lower leg gunshot wound. Appellant received wage-loss compensation and medical benefits.

In a November 2, 2012 report, Dr. Phong Nguyen, a Board-certified internist, opined that appellant reached maximum medical improvement (MMI) from the gunshot injury of March 30, 2012.

In a January 30, 2014 report, Dr. Spencer T. Tseng, a treating physician Board-certified in physical medicine, rehabilitation, and pain management, opined that appellant reached MMI from the gunshot injury of March 30, 2012.

On March 4, 2014 appellant filed a claim for a schedule award (Form CA-7).

In a letter dated June 26, 2014, OWCP advised appellant that additional information was needed to process his claim for a schedule award as there was no narrative report outlining his current condition and whether he had any permanent impairment as a result of his work-related condition. It advised him to submit medical evidence from his physician in support of his claim for a schedule award based upon the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[3] OWCP afforded appellant 30 days to submit such evidence.

On July 3, 2014 OWCP received an April 30, 2014 impairment rating from Dr. Stuart J. Goodman, a Board-certified neurologist. Dr. Goodman noted appellant's history of injury and treatment and provided examination findings. He indicated that appellant had an abnormal gait and complaints of discomfort and weakness involving the right lower extremity, which was aggravated by movement, exercise, and sitting for prolonged periods of time. Dr. Goodman noted that x-rays revealed no fracture, with metallic bodies in soft tissue of the right calf. Regarding a motor examination, he determined that appellant had an antalgic gait with mild plantar flexor weakness on the right side. Dr. Goodman noted that the scars from the wound were visualized. He advised that reflexes were 1+14 and plantar responses were flexor. He found that appellant's sensory examination revealed decreased sensation along the gastrocnemius muscle area. Dr. Goodman referred to the A.M.A., *Guides* and opined that appellant reached MMI on

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

January 30, 2014, per his treating physician. He referenced the A.M.A., *Guides* and explained that adjustment grids and grade modifiers were utilized. Dr. Goodman referenced Table 16-5,[4] (Adjustment Grid: Summary) and found that appellant warranted a grade modifier 1. He referenced Table 16-6,[5] (Functional History Adjustment - Lower Extremities) and determined that appellant qualified for a grade modifier 1. Dr. Goodman referred to Table 16-7,[6] (Physical Examination Adjustment - Lower Extremities), and found appellant was entitled to a grade modifier 1. He reviewed Table 16-8[7] (Clinical Studies Adjustment - Lower extremities) and found that appellant was entitled to a grade modifier 1. Dr. Goodman explained that this led to the utilization of Table 16-9,[8] pathology for determining the grade and impairment rating, class 1. He opined that appellant had 30 percent permanent impairment of the right lower extremity.

In letters dated September 3, October 8, November 19, and December 10, 2014, and February 19, March 24, May 21, and July 24, 2015, counsel for appellant indicated that appellant filed his request for a schedule award and requested an update with regard to the status of the schedule award.

In an August 7, 2015 report, OWCP's medical adviser determined that he had reviewed the medical evidence and the report from Dr. Goodman. He explained that he was unable to make an impairment determination as Dr. Goodman did not give range of motion of the knee or ankle to gauge any impairment based on the alternative range of motion method. The medical adviser recommended that appellant be referred for a second opinion examination.

On September 17, 2015 OWCP referred appellant for a second opinion examination to determine the extent of appellant's work-related residuals and whether appellant sustained a permanent impairment, along with a statement of accepted facts, a set of questions and the medical record to Dr. Chester DiLallo, a Board-certified orthopedic surgeon.

In an October 16, 2015 report, Dr. DiLallo noted appellant's history of injury and treatment and examined appellant. His findings included that appellant experienced tingling and the sensation of relative numbness in the posterior aspect of his right leg, which increased without medication. Dr. DiLallo explained that, from an everyday functional standpoint, appellant had to decrease running because he did not run as effectively due to the injury to his right leg. He explained that, if appellant indeed ran, his symptoms increased. Dr. DiLallo also believed that, due to residuals of the gunshot wound to his right leg, his activities at home in terms of chores had decreased. Furthermore, he noted that appellant indicated that he formerly liked to hike, but now, he had a great deal of apprehension about hiking due to the persistent tingling was accompanied by what he described as a little numbness in the right leg below the knee, and principally posteriorly. Dr. DiLallo also advised that appellant related that he had a tendency to have irritation

[4] A.M.A., *Guides* 515.

[5] *Id*. at 516.

[6] *Id*. at 517.

[7] *Id*. at 519.

[8] *Id*. at 520.

of his Achilles tendon and occasional nighttime discomfort and cramps. He advised that at that time, appellant had an essentially normal gait, and he was able to heel and toe walk without apparent weakness. Dr. DiLallo also found essentially full range of motion of his foot and ankle with dorsiflexion, plantar flexion, inversion, and eversion. Regarding range of motion, the measurements were recorded as plantar flexion of 38 degrees on the left, uninjured side, and on the right, 45 degrees. Dr. DiLallo determined that dorsiflexion was to 5 degrees; inversion was to 40 degrees bilaterally, and eversion was to 10 degrees bilaterally. He found no measurable atrophy of the calf when measured at comparable levels. Dr. DiLallo also indicated that voluntary muscle testing of all groups of the lower extremities bilaterally below the knee were intact by motor nerve evaluation and by nerve root assessment. He explained that most notably, there was a depressed area at the posterolateral aspect of the knee which was described as the entry wound for the bullet that injured appellant. Furthermore, distally, approximately three inches above the ankle, and in the midline, he found an exit wound, which was well healed by tertiary intent. Dr. DiLallo determined that appellant had very distinct numbness to light touch and pinprick in a distribution best described as that of the sural nerve. He opined that appellant sustained an injury to the sural nerve, resulting in the symptoms that he continued to experience.

Dr. DiLallo determined that MMI occurred on November 2, 2012, the date of Dr. Nguyen's report. He diagnosed residuals of a gunshot wound to the right lower extremity, with no related surgeries. Dr. DiLallo referred to Table 16-5,[9] for functional modifiers. He explained that the physical examination was not relevant as it was part of the initial diagnosis. Dr. DiLallo also advised that Table 16-7[10] in reference to atrophy was not applicable as appellant had no measurable atrophy on clinical examination. He explained that regarding the peripheral nerve section 16-4c and Table 16-11,[11] the lateral sural nerve was the nerve providing innervation to the area of numbness and tingling, and the tables were utilized to determine the grade or class of the injury based on a peripheral nerve evaluation. Dr. DiLallo utilized the tables and that data, and the section for the permanent impairment worksheet of lower extremity, titled "Peripheral Nerve Impairment." He explained that the sural nerve was given a severe grade of three based on loss of pinprick sensation, and light touch, which was equivalent to a class 1 injury. Dr. DiLallo provided an adjustment of 1 for a functional history, including the Pain Disability Questionnaire executed by appellant on October 16, 2015, which was graded as mild, and a final grade of C for this impairment, which he opined was three percent permanent impairment of the lower extremity.

In a report dated December 2, 2015, OWCP's medical adviser noted appellant's history of injury and treatment, and the reports from Dr. Goodman and Dr. DiLallo He utilized the A.M.A., *Guides* and determined that appellant reached MMI on November 2, 2012, the date of Dr. Nguyen's evaluation. The medical adviser explained that Dr. Goodman found decreased sensation along the gastrocnemius area, but he did not conclude that the finding demonstrated injury to a specific nerve. He explained that the x-ray revealed "metallic foreign bodies in the soft tissue adjacent to the lateral tibial plateau." The medical adviser concluded that this located the injury to the soft issue adjacent to the lateral right knee. He explained that the most relevant

[9] *Id*. at 515.

[10] *Id*. at 517.

[11] *Id*. at 533.

diagnosis-based impairment was based upon Table 16-3, Knee Regional Grid for "other soft tissue lesion."[12] The medical adviser opined that the diagnosis correlated with a class 1 default grade C impairment rating (in the absence of consistent motion deficits) equating to one percent impairment of the right lower extremity. He utilized the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13] The medical adviser found that a Functional History (GMFH) -- Class of Diagnosis (CDX) condition, (no ataxic gait or abnormality of stance) was equivalent to -1. He found that Physical Examination (GMPE) - CDX = 0 (GM = 1 for minimal palpatory findings). The medical adviser found that Clinical Studies (GMCS) – CDX = 0 (He determined that clinical studies confirmed the diagnosis). The medical adviser explained that this moved the grade one position to the left, which resulted in a grade B or one percent impairment of the right lower extremity. He explained that his impairment rating differed from that of Dr. DiLallo, because Dr. DiLallo utilized a sural nerve lesion. However, the only findings supporting a possible neurologic injury (numbness, tingling, and diminished sensation) were subjective findings. The medical adviser explained that none of the physicians who treated appellant opined that there was a discreet nerve injury. He reiterated that appellant reached MMI on November 2, 2012. The medical adviser explained that this was confirmed by follow-up examination on January 30, 3014 and treatment in the interim.

Accordingly, by decision dated December 8, 2015, OWCP granted appellant a schedule award for one percent permanent impairment of the right lower extremity. The award covered a period of 2.88 weeks from November 2 to 22, 2012.

On December 16, 2015 counsel requested a telephonic hearing, which was held before an OWCP hearing representative on August 15, 2016.

By decision dated October 28, 2016, OWCP's hearing representative affirmed the December 7, 2015 decision. It found that the medical evidence submitted was insufficient to establish permanent impairment of appellant's right lower extremity greater than the one percent previously awarded.

LEGAL PRECEDENT

The schedule award provisions of FECA,[14] and its implementing federal regulations,[15] 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.[16] For decisions after

[12] *Id*. at 509.

[13] *Id*. at 521.

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

[16] *Id*. at § 10.404(a).

February 1, 2001, the fifth edition of the A.M.A., *Guides* is used to calculate schedule awards.[17] For decisions issued after May 1, 2009, the sixth edition will be used.[18]

In addressing lower extremity impairments, the sixth edition requires identifying the impairment class for the diagnosed condition, which is then adjusted by grade modifiers based on functional history, physical examination and clinical studies.[19] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[20]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than one percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

OWCP accepted appellant's traumatic injury claim for a gunshot wound to the right lower leg. Thereafter, on March 4, 2014, appellant filed a claim for a schedule award and furnished an April 30, 2014 report of Dr. Goodman, who opined that appellant had 30 percent permanent impairment of the right lower extremity. However, Dr. Goodman found that x-rays revealed no fracture, again with metallic bodies in soft tissue of the right calf. He found decreased sensation along the gastrocnemius area, but did not conclude that the finding demonstrated injury to a specific nerve. As he did not adequately explain how he used the A.M.A., *Guides* to rate impairment or rate impairment of a scheduled member pursuant to the A.M.A., *Guides*, Dr. Goodman's opinion is of diminished probative value.[21] Board precedent is well settled that when an attending physician's report gives an estimate of impairment, but does not address how the estimate is based upon the A.M.A., *Guides*, OWCP is correct to follow the advice of its medical adviser or consultant where he or she has properly applied the A.M.A., *Guides*.[22]

The Board notes that the second opinion physician, Dr. DiLallo, provided an October 16, 2015 report. Dr. DiLallo examined appellant and provided findings, which included essentially full range of motion of his foot and ankle with dorsiflexion, plantar flexion, inversion, and eversion. He determined that voluntary muscle testing of all groups of the lower extremities bilaterally below the knee were intact by motor nerve evaluation and by nerve root assessment. Dr. DiLallo found most notably, a depressed area at the posterolateral aspect of the knee which was described as the entry wound for the bullet that injured appellant. Furthermore, distally,

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

[18] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.*, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[19] A.M.A., *Guides* 494-531; *see J.B.*, Docket No. 09-2191 (issued May 14, 2010).

[20] *Id*. at 521.

[21] *See J.G.*, Docket No. 09-1128 (issued December 7, 2009) (an attending physician's report is of little probative value where the A.M.A., *Guides* are not properly followed).

[22] *J.Q.*, 59 ECAB 366 (2008); *Laura Heyen*, 57 ECAB 435 (2006).

approximately three inches above the ankle, and in the midline, he found an exit wound, which was well healed by tertiary intent. Dr. DiLallo determined that appellant had very distinct numbness to light touch and pinprick in a distribution best described as that of the sural nerve, which resulted in the symptoms that he continued to experience. He determined that MMI was reached on November 2, 2012, the date of Dr. Nguyen's report.

Dr. DiLallo explained that regarding the peripheral nerve section 16-4c and Table 16-11,[23] the lateral sural nerve was the nerve providing innervation to the area of numbness and tingling, and the tables were utilized to determine the grade or class of the injury based on a peripheral nerve evaluation. Dr. DiLallo utilized the tables and that data, and the section for the permanent impairment worksheet of lower extremity, titled "Peripheral Nerve Impairment." He explained that the sural nerve was given a severe grade of three based on loss of pinprick sensation, and light touch, which was equivalent to a class 1 injury. Dr. DiLallo provided an adjustment of 1 for a functional history, including the Pain Disability Questionnaire executed by appellant on October 16, 2015, which was graded as mild, and a final grade of C for this impairment, which he opined was a three percent impairment of the lower extremity. The Board notes that, while he offered a rating based upon the sural nerve, OWCP's medical adviser explained why that would not be applicable. OWCP's medical adviser explained that the only findings supporting a possible neurologic injury (numbness, tingling, and diminished sensation) were subjective findings. He also found that none of the physicians who treated appellant opined that there was a discreet nerve injury. Therefore, the Board finds that a rating based upon the sural nerve would not be warranted.

OWCP properly referred the case to its medical adviser whose opinion differed from that of the treating physician and the second opinion physician based upon the above-noted explanations.[24]

In a report dated December 2, 2015, OWCP's medical adviser noted appellant's history of injury and treatment, and the reports from Dr. Goodman and Dr. DiLallo. He utilized the A.M.A., *Guides* and determined that appellant reached MMI on November 2, 2012, the date of Dr. Nguyen's evaluation. The medical adviser explained why Dr. Goodman and Dr. DiLallo's reports were not sufficient to justify their ratings as indicated above. He explained that the x-ray revealed "metallic foreign bodies in the soft tissue adjacent to the lateral tibial plateau." The medical adviser concluded that the relevant injury was the soft issue adjacent to the lateral right knee. He explained that the most relevant diagnosis-based impairment was based upon Table 16-3, Knee Regional Grid for "other soft tissue lesion."[25] The medical adviser explained that this correlated with a class 1 default grade C impairment rating (in the absence of consistent motion deficits) equating to a one percent impairment of the right lower extremity. He utilized the net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[26] The medical adviser found that a functional history -- diagnosed condition, (no ataxic gait or abnormality of stance) was equivalent to -1. He found that (GMPE) - CDX = 0 (GM = 1 for minimal palpatory findings).

[23] A.M.A., *Guides* 533.

[24] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982).

[25] *Id*. at 509.

[26] *Id*. at 521.

The medical adviser found that (GMCS) – CDX = 0. He determined that clinical studies confirmed the diagnosis. The medical adviser explained that this moved the grade one position to the left, which resulted in a grade B or one percent impairment of the right lower extremity.

Therefore, the Board finds that the OWCP medical adviser correctly utilized the A.M.A., *Guides* and determined that appellant had one percent permanent impairment of the right lower extremity. Appellant has not submitted any other medical evidence conforming with the A.M.A., *Guides* establishing that appellant has greater permanent impairment.

Appellant may request a schedule award or 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 has not met his burden of proof to establish more than one percent permanent impairment of his right lower extremity, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the October 28, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 11, 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