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BEFORE THE INDUSTRIAL ACCIDENT BOARD
OF THE STATE OF DELAWARE

DANIEL GOFFREDO,	)	
	)	
Employee,	)	
	)	
v.	)	Hearing No. 1382302
	)	
	)	
THE GALMAN GROUP,	)	
	)	
Employer.	)	

DECISION ON PETITION TO DETERMINE ADDITIONAL COMPENSATION DUE and PETITION TO DETERMINE DIFIGUREMENT

Pursuant to due notice of time and place of hearing served on all parties in interest, the above-stated cause came before the Industrial Accident Board on July 28, 2015, in the Hearing Room of the Board, New Castle County, Delaware. Pursuant to Del. Code Ann. tit. 19, § 2348(k), the Board required an extension of time to complete the written decision.

PRESENT:

MARILYN DOTO

ROBERT MITCHELL

Joan Schneikart, Workers' Compensation Hearing Officer, for the Board

APPEARANCES:

Donald E. Marston, Attorney for the Employee

Nathan V. Gin, Attorney for the Employer

NATURE AND STAGE OF THE PROCEEDINGS

On March 15, 2012, Daniel Goffredo ("Claimant") sustained compensable injuries to the low back, right knee and left lower extremity while working as a laborer for The Galman Group ("Galman"). By prior agreements as to compensation, he has received total disability benefits at the compensation rate of $365.54 per week, based on his weekly salary of $548.31 at the time of the work accident; partial disability benefits; permanency benefits for a 13.5% loss of use to the lumbar spine and a 7.5% loss of use to the right lower extremity; and disfigurement benefits related to the low back (3 weeks) and right lower extremity (5 weeks).

On October 30, 2014, Claimant filed a Petition to Determine Additional Compensation Due seeking permanent impairment benefits for a 37% loss of use to the left lower extremity. The employer contends that Claimant sustained no permanent impairment for the left lower extremity distinct from the 13.5% lumbar spine permanency agreement.[1]

Claimant also filed a Petition for Disfigurement on October 30, 2014, seeking disfigurement benefits for an altered gait or limp to the left lower extremity. The two petitions were consolidated for the present hearing on the merits.

The parties submitted a joint Stipulation of Facts, pursuant to *Rules of the Industrial Accident Board of the State of Delaware* ("I.A.B. Rules") Rule 14(A).

SUMMARY OF THE EVIDENCE

Stephen J. Rodgers, M.D., a preventative and occupational medicine specialist, testified on behalf of Claimant. The doctor examined him on May 2 and October 14, 2014, and has

[1] The parties stipulate entering into a prior agreement for permanency benefits for a 13.5% loss of use to the low back in September 2014. However, no formal documentation, an "Agreement as to Compensation," has been filed to date with the Office of Workers' Compensation.

reviewed his medical records. Dr. Rodgers opines that Claimant sustained a 37% permanent impairment of the left lower extremity related to the work accident.

In reviewing the medical records, Dr. Rodgers noted that an EMG from March 5, 2013, was interpreted as abnormal by Dr. Beneck, but he could not completely rule out an L5 and S1 radiculopathy of the left lower extremity and recommended clinical correlation. However, Dr. Rodgers opined the positive findings were objective and indicated the various lower extremity muscles were dead or dying. Another EMG from September 2013 was interpreted as showing mild bilateral radiculopathy without ongoing evidence of denervation. An MRI of the lumbar spine from March 6, 2013, showed "enhancing scar tissue" which did not encase the bilateral L5 nerve roots in the lateral recess. Dr. Rodgers opined that finding is significant as it can be a source of problems with nerves having their origin at L5.

Claimant described the mechanism of injury to the doctor. He was carrying sixteen lengthy pieces of wood on his shoulder and had a misstep causing him to spin. His knee gave out and the force of the wood caused imbalance and twisted him around. He continues with symptoms of the back with activity. While surgery improved his right knee, it is sometimes still painful, especially if he kneels on it. The knee also "pops" at times. He has numbness in the left leg from the calf down and loss of proprioception, or the body's ability for sensory awareness, which restricts his walking distances and makes his leg feel heavy. When he tries to work out, he can press 55 pounds on the right side but only 20 pounds on the left. He saw Dr. Crain recently for his left knee and had an MRI done. He wears a brace on his left leg.

Upon physical examination, Dr. Rodgers could not obtain deep tendon reflexes at the patella and the Achilles, bilaterally. The left kneecap was once centimeter less in girth than the right, and the left calf had significant atrophy. He wore a brace to the examination, which was

removed for testing. Strength assessment on the left from flexion/extension at the knee, ankle and great toe was markedly decreased on the left compared to the right side.

At the May 2014 visit, Dr. Rodgers assessed a 17% impairment to the lumbar spine and a 10% impairment to the right lower extremity, relying on the *AMA Guides to the Evaluation of Permanent Impairment, 5th Edition* ("AMA Guides 5th"). He used the on the DRE method to assess the low back, placing Claimant into a DRE Lumbar Category III, and Section 17-3, utilizing a diagnosis-based approach, for the right lower extremity.

At the second visit in October 2014, Dr. Rodgers focused on the left lower extremity. The intervening medical records show further visits with Dr. Rudin and Dr. Crain for low back pain and left leg pain. Claimant continued with left foot numbness and heaviness, despite taking Lyrica to modulate nerve pain, and left posterior calf pain. He continued with left foot drop and had not received authorization for a molded ankle foot orthotic. When Claimant saw Dr. Rudin on July 30, 2014, he was there to review a left lower extremity EMG, and had experienced several episodes of acute left leg pain the week before.

In reviewing the medical records, Dr. Rodgers noted the MRI of the lumbar spine by Dr. Silverstein from September 2013 showed changes in the areas to which the nerves exit the spinal canal and go down the legs that would lead to multiple abnormalities and an operative procedure..

Claimant told Dr. Rodgers that he was working 40 hours a week doing maintenance, which involved mostly roofing. He was having a very difficult time with certain aspects of his work, such as being on ladders or slopes. He is unable to take steps serially and uses a "death grip" holding onto ladders for fear of falling. His family physician was prescribing Cymbalta, which is mood stabilizer sometimes used for neuropathic pain. He continued with low back and right leg problems, as well as weakness in the left leg which falls asleep with pins and needles

sensation. The brace is uncomfortable and cumbersome. He was wearing high-laced paratrooper boots along with the brace.

Upon physical examination, the doctor found deep tendon reflexes to be 1+ at the left and right patellars. The right Achilles was sluggish and the left was unobtainable. The left thigh measured one centimeter less than the right, and the left calf was 1.6 centimeters less than the right. Claimant had a significant loss of muscle mass on the left leg. Strength of the left leg was significantly decreased, with dorsiflexion of the foot and dorsi and plantar flexion of the great toe.

Dr. Rodgers concluded that Claimant had developed a significant impairment to the left lower extremity for a 37% loss of use, relying on the protocol of Chapter 17 of the AMA Guides 5th. Section 17.3, at page 555, provides the procedure summary and examples that the doctor utilized including using the grouping that provides the greatest impairment percent. Under Section 17.2c, "Gait Derangement," Dr. Rodgers opined that Claimant's use of a molded ankle foot orthotic would be a mild` disturbance of gait which represents a 15% whole person value. He converted this value to a 37% regional permanency for the left leg. The doctor also evaluated other issues as described by Sections 17.2b through 17.n with respect to unilateral atrophy, manual muscle testing, and neural injuries in addition to gait disturbance.

Dr. Rodgers believes that Claimant needs the brace and the molded foot orthotic because the nerves that supply the muscles allowing him to raise the foot are the same muscles that deal with certain ways of turning the ankle in and out. The nerves that supply such activity usually come from the fourth and fifth lumbar and first sacral segments. Claimant now has a foot drop diagnosis and nerve damage. There is no treatment for it other than to stabilize the ankle and foot, and he has measured atrophy and muscle weakness on the left side only. Dr. Rodgers found

no evidence of symptom exaggeration or magnification by Claimant at either of his visits. He has ongoing complaints about symptoms down the left lower extremity that comport with the back injury that he suffered. The foot drop is the inability to raise the foot up, which causes other associated weaknesses. The work injury and surgery caused damage to the nerves from L4 to S1, which are the nerves that supply those lower extremity muscles. The doctor's clinical findings for the left lower extremity are consistent with damage to those nerves. The 37% loss of use to the left lower extremity is a result of the compensable work injury to the low back that he suffered.

From a functional point of view, Dr. Rodgers believes that Claimant lost about a third of the use of his left lower extremity, which is consistent with the calculations he arrived at based on the AMA Guides 5th. It is necessary for Claimant to wear the brace, the high boots and molded orthotic to address the foot drop. Activities such as standing, climbing and walking are all impacted by the condition of his left lower extremity.

In reviewing Dr. Gelman's defense medical examination report form April 2015, Dr. Rodgers disagrees that the prior lumbar spine rating would include the radiculopathy as it affects the left lower extremity. Radiculopathy is one of the findings that can be used to support the severity of a lumbar spine permanency but does not include compensation for the left lower extremity. Dr. Rodgers does not find that a 15% permanency to the lumbar spine presents an accurate reflection of the additional problems with the left lower extremity as it does not address the loss of function and the effect it has on Claimant's activities of daily living involving the lower extremity. In Claimant's case, it is appropriate to have a separate rating for the left lower extremity in addition to the lumbar spine.

On cross examination, Dr. Rodgers agreed that the main source of Claimant's complaints when evaluating his permanency was due to the foot drop, which was caused by a peroneal nerve distribution problem. Following the work accident, Claimant underwent a compensable left-sided laminectomy at L5 in November 2012, and he has not had any surgery to the left lower extremity. The doctor agreed that a May 2013 MRI of the left lower extremity showed no appreciable abnormality along the course of the left peroneal nerve and a March 2013 MRI of the lumbar spine noted"perfect decompression of the left L5 and S1" levels. Furthermore, the findings on a September 2013 MRI of the lumbar spine were not sufficient for a recommendation for surgery. Dr. Rodgers agreed that the medical records of Dr. Rudin before May 2013 support that he was concerned about a potential peroneal nerve injury, even though an EMG was normal. Dr. Rudin noted he was unclear about the etiology of Claimant's foot weakness but suspected it was due to the lumbar spine pathology that was treated earlier. Dr. Rudin ordered a foot drop splint for him. When Dr. Rudin saw Claimant for follow-up in July 2013, he recommended that Claimant see Dr. Silversteen, a neurologist, even though Claimant did not appear to have a peroneal neuropathy based on the recent MRI or EMG studies. Dr. Silversteen's notes from September 2013 included that Claimant's symptoms were most consistent with a chronic lumbar radiculopathy with chronic L5-S1 nerve root injury, with no evidence of any neurologic etiology, and he recommended repeat testing.

Dr. Rodgers agreed that he previously assessed Claimant with a 17% permanency to the low back based on his placement into a DRE Lumbar Category III, which can include significant radiculopathy, such as dermatomal pain, sensory loss, or loss of relevant reflexes, muscle strength, or measured unilateral atrophy.

Dr. Rodgers did not observe Claimant walking without his orthotic or foot brace at the most recent visit in October 2014. At that time, he was working 40 hours a week primarily doing maintenance and roofing activities.

The primary source of Dr. Rodger's permanency opinion is based on the fact that Claimant is using an ankle foot orthosis. His report did not note whether Claimant had a mild, moderate or severe limp.

Claimant, age fifty-one, testified he continues to have problems with his left leg. It is weak, feels heavy, and falls asleep constantly with a pins and needles sensation. The foot drop causes him to trip and roll his ankle constantly. He has difficulty using ladders like he did before the work accident. He must climb one rung at a time, before advancing to the next rung, and use a railing. He used to climb laterally, using both legs on alternate rungs. He can no longer ride a bicycle, motorcycle, kayak, and jog or box like he used to do because his balance is off with the left leg. He now has difficulty stepping down from a van or walking on uneven ground. He has fallen 50 to 60 times because of this.

When he saw Dr. Gelman in April 2015 he was not wearing his brace because the back of his leg gets rubbed raw with its use. He must wear paratrooper or combat boots constantly, and must throw up his left leg to clear the foot and ankle when walking. The brace causes him to walk with a slight altered gait. The brace goes up to his knee and down under his ankle and the bottom of the foot. He must cut out the side tongue of his boots to make room for the brace and wears a sock between the brace and his boot. The Velcro attachments and plastic is very hot. He regularly wears the brace, prescribed by Dr. Rudin for support, to work. He can no longer wear sandals and mostly sits at home. His altered gait is more apparent when he is no longer wearing his boot or brace, as he must walk on the side of his foot. When standing, his foot extends

sideways and his toes curl up. He also has atrophy of the lower left calf, compare to the right side. He develops pain down his left calf and foot when his leg falls asleep.

On cross examination, Claimant explained that he currently works full-time for another employer doing commercial maintenance, including exterior roofing, HVAC, plumbing and electrical work. The roofing portion is about 20% of his job duties. Maintenance is the only type of work he knows. Following the work accident, he underwent compensable low back surgery by Dr. Rudin in November 2012 and right knee surgery by Dr. Crain in April 2013. However, Dr. Rudin is his primary surgeon, who provided him with a foot brace a year ago. He wears the brace daily while working, but takes it off at home as it is uncomfortable.

Hi current employer is aware of his prior work injury and has accommodated him with ladder extenders and providing others to assist him. His doctors have recommended that he not perform maintenance work, but have provided no restrictions for him.

Andrew J. Gelman, D.O, an orthopedic surgeon, testified by deposition on behalf of Galman. He examined Claimant on four occasions: May 22, 2012; June 11, 2013; December 2, 2013; and April 6, 2015. Dr. Gelman opined that Claimant has sustained no permanent impairment to the left lower extremity, related to the March 2013 work accident, separate and apart from the permanency to the low back that the parties have already agreed upon. Dr. Gelman concluded that under either the AMA Guides 5th or the AMA Guides 6th, there should be no separate permanent impairment rating for the left lower extremity because the permanency evaluation of the low back subsumes or include the neurologic deficits affecting the lower extremity.

At the June 2013 defense medical examination, Claimant's complaints were for pins and needles sensation with numbness in both legs. When walking, he trips and rolls his ankle and

had sustained a number of falls as result. Upon physical examination, Dr. Gelman noted he favored the left leg when walking and standing. He presented wearing a brace, which he removed for the exam; however, he was not using a crutch or cane. He exhibited diminished sensation over the top and bottom of the left foot compare to the right, and mild atrophy of the left lower leg compared to the right side. Patellar reflexes were intact and the sciatic tension signs were negative. He had tenderness over the left trochanteric area.

Dr. Gelman assessed Claimant was post single level decompression addressing the L4-5 level, and that he had neurological residual pertaining to the left lower extremity. However, the doctor made no separate diagnosis to the left lower extremity related to the work accident. He did not believe Claimant needed further active care as he was exercising on his own and wearing a brace to support his neurological residual to the left foot and ankle.

At the December 2013 defense medical examination, Claimant reported similar symptoms to the prior visit. Claimant again presented with gait antalgia, favoring the left leg, and he was wearing a high top shoe but not the brace from the prior visit. He exhibited weakness in left ankle dorsiflexion and left foot inversion, eversion and plantar flexion. He had no great toe extension on the left and decreased sensation over the left lateral calf and the top and bottom of the left foot. Essentially, his exam findings were unchanged from the prior visit and indicated some neurological residual attributable to the lumbar spine L5 nerve root compromise.

At the April 2015 defense medical examination, his complaints focused on the left leg with symptoms into the buttock as well as into the foot and ankle. The clinical findings were similar to the prior defense medical examinations, except for a new decreased patellar reflex on the left. He presented without wearing a foot or ankle brace. Dr. Gelman's assessment was post

L4-5 surgery with L5 nerve root residual manifesting itself with sensory, motor and reflex findings.

At that visit, Dr. Gelman assessed a 15% loss of use to the lumbar spine related to the work accident relying on the AMA Guides 5th and the *AMA Guides to the Evaluation of Permanent Impairment, 6th Edition* ("AMA Guides 6th"). The doctor placed Claimant into a DRE Category III under the AMA Guides 5th methodology. Claimant was treated for a single level pathology form a single incident. Thus, the doctor utilized Section 15.4, AMA Guides 5th, at page 384, and Table 15-3, to reach his conclusion. He has significant signs of radiculopathy, including sensory, reflex and motor changes to specific dermatomes. The doctor assessed between a 10 and 13% whole person rating. Placing Claimant mid-range at 11.5%, he converted using a .75 conversion factor to reach a 15% permanency for the low back.

Dr. Gelman opined that Claimant did not have a separate left lower extremity permanency in addition to the lumbar permanency, as Dr. Rodgers suggests. Absent an independent bodily part diagnosis, the lumbar spine impairment encompasses the neurological residual affecting the left lower extremity. The method used by Dr. Rodgers for assessing a left lower extremity rating based on Claimant's use of an orthotic and his gait derangement represents a "fall-back" method, not typically utilized and not appropriate in Claimant's case. For a lower extremity, a gait derangement may be applicable, but there are other better methods to use. To provide a gait derangement for everyone using a cane puts them into a 37% whole person rating, which is not logical. The problems with the left leg in Claimant's case have already been accounted for in the low back rating. So by rating gait, there is duplication in what has already been addressed by the radiculopathy component of the lumbar spine. Plus, there is not a separate diagnosis referable to the left leg, such as an ACL tear or ankle fracture.

Claimant's lower extremity complaints are related to the low back and the L5 nerve that extends down the leg for function in the foot and ankle. There is not a separate diagnosis why the foot is weak or has decreased sensation.

Dr. Gelman noted Dr. Rudin's assessment at his April 15, 2015 examination for lumbar radiculopathy pertaining to the L4-5 intervertebral disc has been consistent over time and included the left leg symptoms were coming from the low back. Dr. Rodger's opinion that Claimant has lost about a third of use of his left leg "holistically" is not accurate in Dr. Gelman's opinion as Claimant has reasonably good function of the left lower extremity and was not even wearing a brace or using a cane at the last defense medical examination.

On cross examination, Dr. Gelman agreed that Dr. Rudin prescribed a left ankle brace for him for ankle dorsiflexion to address the L5 neurological feature in June 2013 following surgery. An EMG report from September 2013 concluded there was a mild chronic bilateral L5-S1 radiculopathy. Dr. Gelman agreed that on physical examination, Claimant demonstrated a swaying or throwing of the left lower extremity for the purposes of clearing the foot and ankle. The defense doctor agreed that his report noted Claimant's maintenance care may include a left foot and ankle orthosis and over the counter medication. He agreed that Claimant exhibited atrophy and sensory deficits, muscle weakness and motor weakness of the left lower extremity upon clinical examination. Dr. Gelman conceded molded foot orthotic would be an option with regard to the weakness, loss of motor strength, or foot drop of the left lower extremity.

However, Dr. Gelman concluded the etiology or the generator of the leg dysfunction is in the low back. In addition, work-ups ordered by Dr. Rudin, including an EMG and MRI, of the left lower extremity showed no appreciable abnormality for the left peroneal nerve as a peripheral nerve source for the symptoms.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Permanent Impairment

Pursuant to Del. Code Ann. tit. 19, § 2326, the Board is authorized to award compensation for certain permanent injuries to various areas of the body without regard to the earning power of the Claimant. On a petition for such a benefit, Claimant bears the burden of proof. The Board, or hearing officer, is free to accept the testimony of one or the other conflicting medical expert as long as the substantial evidence requirement is satisfied. *Reese v. Home Budget Center*, 619 A.2d 907, 910 (Del. 1992); *Scarberry v. Chrysler Corp.,* Del. Super, C.A. 96A-07-003, Herlihy, J. (Dec. 12, 1996). While it is important to have medical testimony, it is the function of the Board, and the not the physician, to determine the degree of a claimant's impairment. *See Turbitt v. Blue Hen Lines, Inc.,* 711 A. 2d 1214, 1215 (Del. 1998); *Poor Richard Inn v. Lister,* 420 A.2d 178, 180 (Del. 1980). With regard to this, the Board may use its experience and expertise as a tool for evaluating the evidence presented. *Turbitt,* at 1215.

As to an alleged 37% permanency to the left lower extremity, the Board accepts the opinion of Dr. Rodgers that Claimant demonstrated gait derangement, relying on the protocol of the AMA Guides 5th, at Section 17.3, to select the grouping that provides the greatest impairment percent for a lower extremity loss of use in this case. Claimant's reliance on a molded ankle and foot orthotic, as prescribed by Dr. Rudin, who performed compensable lumbar surgery on him in November 2012, results in a mild gait disturbance under Table 17-5, AMA Guides 5th, at page 529. Dr. Rodgers converted the 15% whole person impairment to a 37% regional impairment to the left lower extremity.

Dr. Rodgers explained that Claimant now requires the brace and molded orthotic because of impairment to the nerves which supply the foot and ankle with function. He has developed a "foot drop" diagnosis and nerve damage resulting from the work accident affecting the L4 to S1 nerves. Claimant has measured atrophy and muscle weakness on the left side only. There is no treatment to correct the problem other than to stabilize the ankle and foot. Claimant's subjective symptoms for weakness, numbness and loss of proprioception are consistent with the lumbar back radiculopathy residuals with which he has been diagnosed following the prior surgery. Dr. Rudin subsequently prescribed the orthotic for Claimant in June 2013, eight months after the surgery, and the employer previously accepted the modified foot/ankle brace as compensable. There is no dispute between the parties that Claimant's continuing left lower extremity symptoms and complaints are not consequences of his prior lumbar spine work injury and subsequent surgery.

However, Dr. Rodgers concludes that Claimant has lost about a third of the use of his left lower extremity due to the foot drop and the necessity of wearing the orthotic and a high boot for support in order to walk, stand, and climb as he did before the 2012 work accident. Dr. Rodgers believes the lower extremity permanency rating assessed in relying on the AMA Guides 5th is consistent and reasonable with his loss of function analysis. While Dr. Rodgers believes that Claimant's left lower extremity problems originate from the low back work injury, the Board accepts his opinion that these issues constitute a separate loss of function attributable to the work accident beyond the prior agreement for a 13.5% permanency award for the lumbar spine which the parties stipulated to settling in September 2014.

The Board finds Claimant credible. He has described and demonstrated symptoms and complaints including foot drop, tingling numbness and weakness to the left lower extremity

causing problems with walking, standing and climbing, which impact his activities of daily living. He has an antalgic gait, which is more pronounced without use of the orthotic brace. But he must wear the orthotic daily to continue to work in his full-time maintenance job. Claimant takes the brace off when he is not working as it is uncomfortable and irritates the back of his leg. However, even when not wearing the orthotic, he must wear paratrooper or combat boots to provide support when walking or standing. He can no longer wear sandals or go barefoot.

The Board disagrees with Dr. Gelman's opinion that a further permanency rating for the left lower extremity is not appropriate and is "duplicative" because there is no separate diagnosis or pathological process as Claimant's complaints are the result of his lumbar spine injury via a radiating element for which he has been compensated with a previous 13.5% permanency award for low of use to the low back.

The Superior Court in *Cross v. State of Delaware*, Del. Super., C.A. No. 99A09005HOH, Herlihy, J., 2000 WL 33115722 at **5 (Oct. 17, 2000)(Memorandum Opinion) held that 19 *Del. C.* § 2326 allows for a separate rating for the legs. In reversing the Board's decision below denying additional impairment to the legs following a low back injury and permanency, the Superior Court explained:

> There is nothing in § 2326 or in case law to suggest that a claimant who has sustained an injury to one body part may not be compensated for other body parts which are adversely affected as a result of the same injury. In fact, the Board has acknowledged that an injury to one body part can cause a loss of use on one or more other body parts. *Smagala v. City of Wilmington*, Del. Super., C.A.No. 97A-09-006, Barron, J. (February 13, 1998).

Cross at **5.

While the symptoms of the lower extremities help to assess the impairment to the spine, they do not preclude a separate rating of the legs for permanent impairment. *Id.* Like the claimant in the *Cross* case, the Claimant here has previously received a prior causation acknowledgement for the

relationship of the left lower extremity injury to the work accident by its acceptance of medical expenses, i.e. the foot and ankle orthotic, for that body part. It is not necessary to have a separate diagnosis, referable to the left lower extremity, as Dr. Gelman suggests, to acknowledge an adverse effect to a body part other than the lumbar spine. However, in the alternative, the Board finds that Dr. Rodgers' diagnosis for a foot drop and an antalgic gait would satisfy such a separate requirement under the circumstances in this particular case.

Dr. Gelman's belief that Claimant's left lower extremity problems are subsumed in the lumbar spine permanency relying on Section 15.4 and Table 15-3, AMA Guides 5th, at page 384, is misplaced under the factual circumstances here. While the defense doctor's opinion takes into account the etiology of the left leg dysfunction, it does not provide adequate consideration as to the loss of function or use to the left lower extremity that Claimant has developed as a result of the 2012 work accident. The present case is not typical with respect to most lumbar radiculopathy cases as the Board finds Claimant's loss of use to the left lower extremity is significant and appreciable on its own merits as Dr. Rodgers suggests.

Moreover, there is no authority for the argument that the AMA Guides must be strictly followed. The Board and the testifying physicians, frequently use the AMA Guides as what it is: a *guide* to help determine the degree to which a person has lost the use of one or more body parts. *See Re: Smith v. Peninsula Oil & Propane,* Del. Super., C.A. No. S11A-11-004, Graves, J., 2012 WL 5462856 at **4 (Sept. 4, 2012)(Letter Opinion) *citing Hildebrandt v. DaimlerChrysler*, 2006 WL 3393588 at *4 (Del. Super.); *Bolden v. Kraft Foods*, 2205 WL 3526324, at *3 (Del.).

Thus, for the reasons set forth above, the Board concludes that Claimant has carried his burden to support an award of permanency benefits for a 37% loss of use to the left lower

extremity related to the 2012 work accident. Permanencies of the lower extremities are scheduled losses under Del. Code Ann. tit. 19, § 2326(a) in the amount of 250 weeks for a total loss. Therefore, Claimant is entitled to receive 92.5 weeks of compensation (37% of 250 weeks) for the permanency to the left lower extremity.

Disfigurement

The Board may award disfigurement benefits "provided that such disfigurement is visible and offensive when the body is clothed normally." Del. Code Ann. tit. 19, § 2326 (f). "Clothed normally" means such clothing as is normally worn by the claimant when involved in regular activities, including recreational, vocational and avocational activities. *Beam v. Chrysler Corp.*, 332 A.2d 143,145 (Del. 1975). Factors that the Board should consider in determining the number of weeks of benefits awarded are the size, location, shape and comparative severity of the disfigurement, as well as Claimant's testimony concerning the impact of the scar to determine the psychological and sociological impact, along with other relevant matters. *Colonial Chevrolet v. Conway*, Del. Super., C.A. No. 79A-FE-13, Longobardi, J. (Apr. 28, 1980); *see Murtha v. Continental Opticians, Inc.*, Del. Supr., No. 395, 1997, Walsh, J. (January 16, 1998)(Order)("We adopt the *Colonial Chevrolet* formulation as an accurate and appropriate interpretation of the statutory mandate."). In evaluating the subjective components of a disfigurement, which are not amenable to measured calculation, the Board may rely upon its accumulated experience. *Roberts v. Capano Homes, Inc.,* Del. Super., C.A. No. 99A-03-013, Del Pesco, J., slip. op. at 6-7 (November 8, 1999).

The Board may award "proper and equitable compensation for serious and permanent disfigurement to any part of the body up to 150 weeks." Del. Code Ann. tit. 19, § 2326(f).

The Board has recognized that an altered gait (i.e., a limp), while compensable as a permanent impairment, also affects a person's appearance and might, therefore, be considered a "disfigurement." *See, e.g., Bonkowski v. New Castle County*, Del. I.A.B., Hearing No. 958387, slip op. at 4-5 (December 22, 1998); *O'Brien v. U.S. Electric*, Del. I.A.B., Hearing No. 1057130, slip. op. at 9-10 (July 17, 1997). As the Board noted in *Bonkowski*, unlike more traditional disfigurements such as scars, a limp is difficult to quantify. *Bonkowski,* at 4-5. This renders some of the *Conway* factors, such as size and shape, inapplicable. Unlike other disfigurements, an altered gait is also within the subjective control of Claimant, requiring the Board to make a credibility judgment. Finally, the Superior Court has determined that when an altered gait constitutes a disfigurement, it is related to the lower extremities. *See Streets v. Tim O'Connell & Son, Inc.*, Del. Super., C.A. No. 00A-01-012, Cooch, J., slip. op. at 6 (July 21, 2000).

In this case, Claimant seeks a disfigurement award on the basis of an altered gait. As demonstrated at the hearing, while his altered gait is relatively mild in appearance, he must "throw" his left leg forward awkwardly when walking. The altered gait is more apparent when he is not wearing his orthotic and/or boot. When standing without the orthotic or boot, his left foot abnormally extends sideways and his toes curl up. He also has atrophy to the left lower calf.

The Board finds the altered gait and other associated findings to the left lower extremity to be compensable as they are plainly visible and causes Claimant social embarrassment.

Taking these factors into account, on a scale from 0 to 150 weeks, the Board awards ten (10) weeks of compensation for disfigurement related to the altered gait.

By this decision, Claimant shall receive an award for a 37% permanent impairment for loss of use to the left lower extremity. The Board's disfigurement award to the left lower extremity is ten (10) weeks. In cases such as this, where a body part has suffered a permanent

impairment as well as a disfigurement, the Board must (1) rate the number of weeks on the standard 0 to 150 scale; then (2) calculate the number of weeks on a scale between zero and the number of weeks awarded for permanent impairment plus 20%; and then (3) give a disfigurement award of the higher of the two calculations in weeks. 19 *Del. C.* § 2326(f); *see Bagley v. Phoenix Steel Corp.,* Del. Supr., 369 A.2d 1081, 1083-84. Under the adjusted scale of 111 weeks[2] for the left lower extremity, Claimant would receive 7.4 weeks of benefits for the altered gait. Since that result is less than the ten (10) weeks awarded on the standard scale, Claimant is awarded the higher calculation for the number of weeks as a disfigurement benefit.

Attorney's Fees and Medical Witness Fees

A claimant who receives an award is entitled to a reasonable attorney's fee in an amount not to exceed thirty percent of the award or ten times the average weekly wage in Delaware as announced by the Secretary of Labor at the time of the award, whichever is less. Del. Code Ann. tit. 19, § 2320. Such fees are not awarded, however, if thirty days prior to the hearing date the employer gives a written settlement offer to claimant or claimant's attorney which is "equal to or greater than the amount ultimately awarded by the Board." 19 *Del. C.* § 2320 (10)(b).

Galman submitted to the Board, in a sealed envelope, a settlement offer it extended to Claimant on May 4, 2015. The Board did not open this envelope until after reaching a decision on the merits. The settlement offer for a 1.5% permanent impairment increase to the lumbar spine at the stipulated compensation rate with no permanency award for the left lower extremity was not "equal to or greater" than the 37% awarded to the left lower extremity by the Board. Therefore, attorney's fees shall be awarded on the issue of permanency.

[2] Calculation: [250 weeks (maximum for the lower extremity) x 37% (impairment)] + 20% = 144 weeks for the left lower extremity disfigurement.

However, the settlement offer of ten (10) weeks of disfigurement benefits for the altered gait was "equal to or greater" than the ten (10) weeks awarded by the Board. Therefore, no attorney's fees shall be awarded on the issue of disfigurement.

In determining an award of attorney's fees, the Board must consider ten factors.[3] *See General Motors Corp. v. Cox*, 304 A.2d 55, 57 (Del. 1973)(applied to I.A.B. hearings by *Jennings v. Hitchens,* 493 A. 2d 307, 310 (Del. Super. 1984)); *Thomason v. Temp Control*, Del. Super., C.A. No. 01A-07-009, Witham, J., *slip op.* at 5 - 6 (May 30, 2002). It is an abuse of the Board's discretion to fail to give consideration to these factors. *Thomason* at 7. When claimants seek an award of attorney's fees, they bear the burden of establishing entitlement to such an award. *Downes v. Phoenix Steel Corp.*, Del. Super., C.A. No. 99A-03-006, 1999 WL 458797 at **4, Goldstein, J. (June 21, 1999)(the burden of proof in a workers' compensation case is on the moving party). Since the Board must consider the *Cox* factors when reviewing a request for fees, it follows that claimants must address these factors in their applications. The failure to do so deprives the Board of the facts it needs to properly assess a claimant's entitlement to fees.

Counsel for Claimant seeks a fee up to the statutory maximum. Counsel submitted an affidavit attesting that he spent 25 hours preparing for the evidentiary hearing held on July 28, 2015, which lasted approximately two hours. His association with Claimant began in March 2012. September 2009. Counsel has a one-third contingency fee arrangement with Claimant. He was admitted to the practice of law in Delaware in 1981, and has considerable experience handling workers' compensation matters. Counsel did not attest that while working on this case,

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[3] The factors to be considered are: (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill needed to perform the services properly; (2) the likelihood (if apparent to the client) that acceptance of the employment would preclude other employment by the attorney; (3) the fees customarily charged in the locality for such services; (4) the amount involved and the results obtained; (5) time limitations imposed by the client or the circumstances; (6) the nature and length of the professional relationship with the client; (7) the experience, reputation and ability of the attorney; (8) whether the fee is fixed or contingent; (9) the employer's ability to pay; and (10) whether fees and expenses have been or will be received from any other source.

he was precluded from working on other cases, or that the case was unique or complex. Counsel stated that he did not expect to receive compensation from any other source. The employer did not object to the attorney's fee affidavit.

Taking into consideration the *Cox* factors set forth above, the Board concludes that an attorney's fee award of $8,100.00 is statutorily appropriate in this case.

Having received an award, the Claimant is entitled to have his medical witness fees taxed as costs against the employer, pursuant to Del. Code Ann., tit.19, §2322(e).

STATEMENT OF THE DETERMINATION

Based on the foregoing, the Board hereby GRANTS Claimant's Petition to Determine Additional Compensation Due for permanency benefits for a 37% loss of use of the left lower extremity related to the 2012 work accident in the amount of 92.5 weeks (37% of 250 weeks) to be paid at the stipulated compensation rate, and for ten (10) weeks of disfigurement benefits for an altered gait.

Claimant is also awarded his medical witness fees and one attorney's fee for the permanency award.

IT IS SO ORDERED this 22nd day of September 2014.

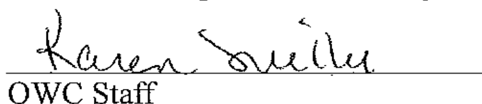
/s/ ROBERT MITCHELL

/s/ MARILYN DOTO

I hereby certify that the foregoing is a true and correct decision of the Industrial Accident Board.

Joan Schneikart
Workers' Compensation Hearing Officer

Mailed Date: 9-24-15



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