United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
	)	**Docket No. 20-0769**
and	)	**Issued: January 12, 2021**
	)	
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHAL SERVICE, College Park, GA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 24, 2020 appellant, through counsel, filed a timely appeal from a November 26, 2019 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 to consider the merits of this case.

[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 21 percent permanent impairment of the left lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On February 13, 2013 appellant, then a 33-year-old federal air marshal, filed a traumatic injury claim (Form CA-1) alleging that on February 10, 2013 he experienced extreme pain in his left knee while running on a treadmill in a hotel gym while in the performance of duty. OWCP accepted the claim for tear of the medial meniscus of the left knee, current. It authorized left knee arthroscopy with partial medial meniscectomy, which was performed on January 16, 2014 and repeat left knee arthroscopy with partial medial meniscectomy, which was performed on April 10, 2014, and paid wage-loss compensation. The surgeries were performed by Dr. Champ L. Baker, III, an attending Board-certified orthopedic surgeon. On May 19, 2014 appellant returned to full-time modified-duty work with restrictions

OWCP received a June 3, 2014 visit status report in which Dr. Baker noted examination findings and provided assessments of a current tear of the medial cartilage and/or meniscus tear of the left knee and status post left knee arthroscopy and partial medial meniscectomy. Dr. Baker opined that appellant had two percent permanent impairment of the left knee due to his partial medial meniscectomy. He determined that he reached maximum medical improvement (MMI) and advised that he could return to full-duty work with no restrictions.[3]

On June 10, 2014 OWCP routed Dr. Baker's June 3, 2014 report, a statement of accepted facts (SOAF), and the case file to Dr. Howard P. Hogshead, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for an opinion on permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

Dr. Hogshead, in a June 11, 2014 medical report, agreed with Dr. Baker's two percent left lower extremity permanent impairment rating, noting that it was consistent with the sixth edition of the A.M.A., *Guides*. He also agreed that the date of MMI was June 3, 2014, the date of Dr. Baker's impairment evaluation.

By decision dated July 29, 2014, OWCP granted appellant a schedule award for two percent permanent impairment of the left lower extremity. The period of the award ran for 5.76 weeks from June 3 through July 13, 2014 and was based on the June 3 and 11, 2014 impairment ratings of Dr. Baker and the DMA, respectively.

On February 3, 2019 appellant filed a claim for an additional schedule award (Form CA-7).

[3] The record indicates that appellant returned to full-duty work with no restrictions on June 4, 2014.

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

In a March 18, 2019 report, Dr. Sonny Dosanjh, a Board-certified physiatrist, noted that appellant presented for an impairment evaluation of the left lower extremity (left knee). He also noted a history of the accepted February 10, 2013 employment injury, a February 5, 2005 motorcycle accident, and appellant's treatment history, and reviewed medical records. Dr. Dosanjh noted that appellant had pain over his left knee and left foot/ankle. He also had a normal gait and station. On physical examination of the left knee, Dr. Dosanjh reported, among other things, no tenderness, warmth, erythema or objective synovitis and crepitus, reduced range of motion (ROM), and pain on palpation. On examination of the left ankle, he also found no warmth or erythema, decreased inversion, eversion, dorsiflexion, and plantar flexion, and swelling, tenderness, reduced ROM, and pain on palpation, severe palpatory findings, including crepitus and joint line tenderness medial and lateral joint line, positive Talar Tilt, positive laxity, and mild edema of the left lower extremity. Dr. Dosanjh noted that a September 11, 2013 magnetic resonance imaging (MRI) scan of the left knee x-ray revealed a medial meniscus tear. A December 28, 2018 left knee x-ray showed medial joint space narrowing that measured 3.4 millimeters (mm) and lateral joint space that measured 3.6 mm. Dr. Dosanjh provided assessments of posterior horn medial meniscal tear, status post January 16, 2014 left knee arthroscopy and partial medial meniscectomy, status post April 10, 2014 repeat left knee arthroscopy and medial meniscectomy, primary knee joint osteoarthritis of the left knee, and status post February 15, 2005 open reduction internal fixation of the left cuboid fracture and open reduction internal fixation of the left Lisfranc fracture/dislocation after the motorcycle accident. He also provided assessment that the left foot demonstrated postsurgical changes with fusion of the mid foot. There was complete fusion with two screws and k-wire of the cuboid with the lateral cuneiform and the navicular bones. These bones were completely fused. There was extensive arthritis of the medial cuneiform and the first metatarsal bones and joint space. No joint space was identified which could be measured. There were extensive bony productive changes. The osteophytes were riding bone-on-bone. The measurement for the medial cuneiform for the first metatarsal was 0.1 mm and the first metatarsophalangeal joint was 0.5 mm. There was narrowing and sclerosis with hooking identified. There were bony productive changes of the talonavicular and talocalcaneal joint as well. The talonavicular joint space measured at 1.4 mm, the talocalcaneal joint space measured at 2.2 mm, and the tibiotalar joint space measured at 2.9 mm.

Referring to Table 16-3 (Knee Regional Grid) on page 509 of the sixth edition of the A.M.A., *Guides*, Dr. Dosanjh utilized the diagnosis-based impairment (DBI) rating method and noted that appellant's left medial meniscus tear with a history of partial medial meniscectomy constituted a class of diagnosis (CDX) of 1, thereby warranting a default value of seven percent permanent impairment. He assigned a grade modifier for functional history (GMFH) of 1 under Table 16-6, a grade modifier for physical examination (GMPE) of 2 under Table 16-7, and a grade modifier for clinical studies (GMCS) of 2 under Table 16-8. Dr. Dosanjh concluded that appellant had three percent permanent impairment. He noted that appellant's left knee osteoarthritis with three millimeter interval at the medial joint space represented a CDX of 1 with a default value of seven percent under Table 16-3 (Foot and Ankle Regional Grid) on page 511. Dr. Dosanjh assigned a GMFH of 2 under Table 16-6, a GMPE of 2 under Table 16-7, and a GMCS of 2 under Table 16-8. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) = (2 - 2) + (2 - 2) + (2 – 2) = 0, which resulted in a grade C, seven percent permanent impairment of the left knee. Dr. Dosanjh noted that pages 497 and 529 of the A.M.A., *Guides* indicated that, if there were multiple diagnoses within a specific region, then the most impairing diagnosis would be rated. He advised that the most impairing problem in the knee was rated at

seven percent impairment based on arthritis. Dr. Dosanjh also utilized the DBI rating method to find that pan-talar arthritis of the left ankle represented a CDX of three under Table 16-2 on page 505 because it was a severe problem. He found a GMFH of 2 under Table 16-6 due to an antalgic gait, a GMPE of 3 under Table 16-7 due to loss of ROM and severe palpatory findings (including crepitus and joint line tenderness in the medial and lateral joint line, positive Talar tilt, and positive laxity), and a GMCS of 2 under Table 16-8 that confirmed the diagnosis of moderate pathology. Dr. Dosanjh utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) = (2 - 3) + (3 - 3) + (2 – 3) = -2, which resulted in a grade A, 26 percent permanent impairment. He referred to the Combined Values Chart on pages 609 through 606, and combined the 7 percent left knee impairment rating and the 26 percent left ankle impairment rating, which resulted in 31 percent total permanent impairment of the left lower extremity. In an addendum to his report, Dr. Dosanjh utilized the ROM rating method to determine impairment to the left ankle and tested three separate times with a goniometer. He reported that active ROM showed 30 degrees, 32 degrees, and 30 degrees of plantar flexion; 10 degrees, 12 degrees, and 12 degrees of dorsiflexion; 15 degrees, 13 degrees, and 15 degrees of inversion; and 12 degrees, 14 degrees, and 14 degrees of eversion. Dr. Dosanjh also tested loss of passive ROM three separate times with a goniometer which showed 33 degrees, 35 degrees, and 32 degrees of plantar flexion; 12 degrees, 12 degrees, and 13 degrees of dorsiflexion; 15 degrees, 14 degrees, and 15 degrees of foot inversion; and l3 degrees, 15 degrees, and 15 degrees of foot eversion. He concluded that, as the DBI left ankle impairment rating was greater than the ROM left ankle impairment rating, the greater impairment should be used according to the A.M.A., *Guides*.

In a July 22, 2019 development letter, OWCP advised appellant that the evidence submitted, including Dr. Dosanjh's March 18, 2019 report, was insufficient to establish his claim for an additional schedule award. It requested that he submit a report from his treating physician, which provided a permanent impairment rating pursuant to the sixth edition of the A.M.A., *Guides*. OWCP requested that the physician independently calculate the impairment using both the DBI and ROM methods, if allowed by the A.M.A., *Guides*, and identify the higher rating. It afforded appellant 30 days to submit the required medical evidence. No additional evidence was submitted.

On August 28, 2019 OWCP routed Dr. Dosanjh's report, a SOAF, and the case record to Dr. Jovito Estaris, a Board-certified occupational medicine physician, serving as a DMA, for review and a determination of permanent impairment of appellant's left lower extremity under the sixth edition of the A.M.A., *Guides*, and his date of MMI.

On September 13, 2019 Dr. Estaris utilized the findings in Dr. Dosanjh's March 18, 2019 report. He agreed with Dr. Dosanjh's finding that appellant had seven percent permanent impairment of the left lower extremity due to primary left knee medial meniscus tear with knee joint arthritis with three mm interval at the medial joint space. The DMA utilized the DBI rating method and determined that at Table 16-3 on page 511 of the sixth edition of the A.M.A., *Guides*, appellant's left knee diagnosis represented a CDX of 1 with a default value of seven percent. He noted that a GMFH was not used because Dr. Dosanjh's assignment of a GMFH of 1 for appellant's left knee medial meniscus tear and a GMFH of 2 for his left knee arthritis were inconsistent. The DMA further noted that a GMPE was also not applicable for the same reason as Dr. Dosanjh reported that the left knee had no tenderness and in the next sentence he reported that there was pain on palpation. He advised that tenderness was pain on palpation. The DMA indicated that a GMCS was not used because x-rays of the left knee showed 3.4 mm medial joint

space, which was used for proper placement in the DBI grid. He did not apply the net adjustment formula and determined that appellant had a class 1, grade C, seven percent permanent impairment of the left lower extremity. The DMA advised that the ROM rating method was not applicable because no ROM measurements were provided by Dr. Dosanjh. He further advised that Dr. Dosanjh's left foot/ankle impairment rating related to a 2005 motorcycle accident that was not a consequence of appellant's accepted left knee injury. The DMA related that appellant reached MMI on March 18, 2019, the date of Dr. Dosanjh's impairment evaluation. As appellant previously received a schedule award for two percent permanent impairment of the left lower extremity, he opined that appellant was entitled to an additional schedule award for five percent permanent impairment of the left lower extremity.

On October 15, 2019 OWCP requested that Dr. Estaris submit a supplemental report because he did not consider appellant's left foot/ankle condition in calculating his left lower extremity impairment rating because it resulted from appellant's 2005 motorcycle accident. It advised him that schedule awards not only include permanent impairment resulting from conditions accepted by OWCP as job related, but also any nonindustrial permanent impairment in the same scheduled member.

Dr. Estaris, in an October 24, 2019 letter, again utilized the findings in Dr. Dosanjh's March 18, 2019 report. He reiterated his prior finding that, based on the DBI method, appellant had seven percent left lower extremity permanent impairment due to left knee medial meniscus tear with joint arthritis. The DMA also reiterated why Dr. Dosanjh's left knee impairment rating was not acceptable under the A.M.A., *Guides*. Regarding impairment to the left ankle, he utilized the DBI rating method and found that, under Table 16-2 on page 506, left ankle arthritis with two-mm cartilage interval represented a CDX of 2 with a default value of 16 percent. The DMA advised that a GMFH was not used because it was not reliable (inconsistent). He assigned a GMPE of 3 for a tender left ankle with limited ROM and instability. The DMA indicated that a GMCS was not used because an x-ray of the left ankle showed two mm to three mm cartilage interval and it was used in the primary placement and class. He applied the net adjustment formula (GMPE – CDX) = (3 - 2) = 1, which moved the default value one space to the right resulting in a class 1, grade D, 17 percent permanent impairment of the left ankle. The DMA combined the 7 percent permanent impairment rating of the left knee with the 17 percent permanent impairment rating of the left ankle to find 23 percent permanent impairment of the left lower extremity. He also used the ROM rating method to determine impairment to the left ankle and noted that, under Table 16-22 and Table 16-20 on page 549, 30 degrees of plantar flexion, 12 degrees of dorsiflexion, and 14 degrees of eversion each yielded zero percent impairment, and 15 degrees of inversion yielded two percent impairment, resulting in two percent permanent impairment. Referring to Table 16-25 and Table 16-17 on pages 550 and 545, respectively, the DMA found that a ROM CDX of 1 represented two percent impairment and that a GMFH was not reliable, resulting in two percent permanent impairment of the left ankle. He concluded that the 17 percent DBI left ankle impairment rating was higher than the 2 percent ROM left ankle impairment rating and that it should be used. The DMA explained that the main discrepancy between his and Dr. Dosanjh's left ankle impairment rating was that Dr. Dosanjh used the DBI method for class 3 pan-talar arthritis based on page 505. He noted that the criteria for a diagnosis of arthritis under the DBI method was one mm to two mm cartilage interval for all three joints. The DMA indicated that Dr. Dosanjh's measurements for the talonavicular joint was 1.4 mm, the talocalcaneal joint was 2.2 mm, and the tibiotalar joint was 2.9 mm rounded up to 3 mm. He advised that the tibiotalar

joint measurement did not meet the criteria for pan-talar arthritis. As such, the DMA maintained that the CDX of pan-talar arthritis was not the appropriate diagnosis to use. He further maintained that arthritis with two mm cartilage interval (the average of all three joints, rounded up to two mm) was most appropriate and represented a CDX of 2 under Table 16-2. He reiterated his determination that appellant reached MMI on March 18, 2019.

OWCP, by decision dated November 26, 2019, granted appellant a schedule award for 21 percent permanent impairment of the left leg. The award ran for 60.48 weeks from March 18, 2019 through May 14, 2020 and was based on the October 24, 2019 impairment rating of the DMA, Dr. Estaris.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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 to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[9]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[10] In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the foot/ankle and knee, the relevant portions of the lower extremity for the present case, reference is made to Table 16-2 through Table 16-4 beginning on page 501.[11] After the CDX is determined from each of these tables (including identification of a default grade

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id. See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[9] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] A.M.A., *Guides*, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[11] *See* A.M.A., *Guides* 501-11 (6th ed. 2009).

value), the net adjustment formula is applied using GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)
>
> "If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the [claims examiner] CE.
>
> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating. However, the DMA should still render an impairment rating using the DMA method, if possible, given the available evidence."[14]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 21 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

In support of his schedule award claim, appellant submitted a March 18, 2019 report from Dr. Dosanjh, who found that appellant had reached MMI due to his accepted left knee tear of the

[12] *Id.* at 515-22.

[13] *Id.* at 23-8.

[14] FECA Bulletin No. 17-06 (May 8, 2017).

medial meniscus and authorized left knee arthroscopy with partial medial meniscectomy. Dr. Dosanjh utilized the DBI rating method found at Table 16-3[15] of the sixth edition of the A.M.A., *Guides* and determined that appellant's accepted diagnosis and authorized surgery represented a CDX of 1 with a default value of seven percent impairment. He assigned modifiers and applied the net adjustment formula and found three percent permanent impairment of the left knee. Dr. Dosanjh again utilized Table 16-3 and found that appellant's primary knee arthritis with three mm cartilage interval represented a CDX of 1 with a default grade C value of seven percent.[16] He assigned a GMFH of 2, GMPE of 2, and GMCS of 2.[17] Dr. Dosanjh applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS – CDX) = (2 - 2) + (2 - 2) + (2 – 2) = 0,[18] and found no adjustment in the default grade C permanent impairment of seven percent. He opined that, since appellant's primary knee arthritis yielded a higher impairment rating than the impairment rating for his medial meniscus tear and partial medial meniscectomy, he had seven percent permanent impairment of the left lower extremity based on pages 497 and 529. The Board notes, however, that, while Dr. Dosanjh reported a CDX of 1 for appellant's primary knee arthritis, he incorrectly used a CDX of 2 in the net adjustment formula to calculate seven percent left knee impairment. With respect to impairment to appellant's left ankle, he utilized the DBI rating method and found that his pan-talar arthritis represented a CDX of 3 under Table 16-2[19] because it was a severe problem. Dr. Dosanjh assigned a GMFH of 2 due to an antalgic gait,[20] a GMPE of 3[21] due to loss of ROM and severe palpatory findings (including crepitus and joint line tenderness in the medial and lateral joint line, positive Talar tilt, and positive laxity), and a GMCS of 2[22] to confirm the diagnosis of moderate pathology. He applied the net adjustment formula and found a -2 net adjustment, which yielded permanent impairment of 26 percent. Dr. Dosanjh then referred to the Combined Values Chart,[23] and combined the 7 percent left knee impairment rating and the 26 percent left ankle/foot impairment rating, which resulted in 31 percent total permanent impairment of the left lower extremity. He also utilized the ROM rating method to determine permanent impairment to the left lower extremity. Dr. Dosanjh provided three active and passive ROM measurements of appellant's left ankle/foot. He did not provide a specific impairment rating for permanent impairment due to loss of ROM, but concluded that appellant had 31 percent permanent impairment of the left lower extremity as the DBI impairment rating was greater than the ROM permanent impairment rating.

[15] A.M.A., *Guides* at 509, Table 16-3.

[16] *Id.* at 511, Table 16-3.

[17] *Id.* at 516, Table 16-6; *Id.* at 517, Table 16-7; *Id.* at 519, Table 16-8.

[18] *Id.* at *supra* note 14.

[19] *Id.* at 505, Table 16-2.

[20] *Id.* at 516, Table 16-6.

[21] *Id.* at 517, Table 16-7.

[22] *Id.* at 518, Table 16-8.

[23] *Id.* at pages 604 through 606.

In accordance with its procedures, OWCP properly referred the medical record to Dr. Estaris, a DMA,[24] who reviewed the clinical findings of Dr. Dosanjh on September 13, 2019 and concurred with Dr. Dosanjh's finding that appellant had seven percent permanent impairment of the left lower extremity due to primary left knee medial meniscus tear with knee joint arthritis with three mm interval at the medial joint space based on Dr. Dosanjh's report and the A.M.A., *Guides*. However, he disagreed with Dr. Dosanjh's assessment of the GMFH, GMPE, and GMCS adjustments. Utilizing the DBI method, the DMA referred to Table 16-3[25] and determined that appellant's left knee diagnosis represented a CDX of 1 with a default value of seven percent. He explained that, he did not assign a GMFH because Dr. Dosanjh's assignment of a GMFH of 1 for appellant's left knee medial meniscus tear and a GMFH of 2 for his left knee arthritis were inconsistent. Additionally, the DMA explained that a GMPE was not applicable for the same reason as Dr. Dosanjh reported that the left knee had no tenderness, but also reported pain on palpation. He maintained that tenderness was pain on palpation. The DMA indicated that a GMCS was not used because the left knee x-rays were used to establish the diagnosis in the DBI grid. He did not apply the net adjustment formula and opined that appellant had a class 1, grade C, seven percent permanent impairment of the left lower extremity. The DMA explained that the ROM rating method was not applicable to rate impairment of appellant's left ankle as he mistakenly noted that Dr. Dosanjh did not provide ROM measurements. He further explained that appellant's ankle injury resulted from a 2005 nonwork-related motorcycle accident. As appellant was previously awarded two percent permanent impairment of his left lower extremity, the DMA concluded that he was entitled to an additional impairment award of five percent, for a total of seven percent left lower extremity permanent impairment.

On October 15, 2019 OWCP requested that the DMA provide a supplemental report rating appellant's left lower extremity impairment because he did not consider appellant's nonindustrial left foot/ankle injury sustained as a result of his 2005 motorcycle accident. In response, the DMA submitted an October 24, 2019 report reiterating his prior finding that, based on the DBI method, appellant had seven percent permanent impairment of the left lower extremity due to left knee medial meniscus tear with joint arthritis with three mm interval at the medial joint space and his rationale explaining why Dr. Dosanjh's assessments for GMFH, GMPE, and GMCS adjustments were not proper under the A.M.A., *Guides*. He utilized Dr. Dosanjh's March 18, 2019 findings to calculate impairment to the left ankle based on the DBI method. The DMA noted that appellant had a default value of 16 percent for a CDX of arthritis with two-mm cartilage interval arthritis under Table 16-2.[26] He explained that a GMFH was not applicable because Dr. Dosanjh's findings were unreliable and inconsistent. The DMA assigned a GMPE of 3 for a tender left ankle with limited ROM and instability**.** He explained that a GMCS was not used as a left ankle x-ray was used to establish the placement and class of the diagnosis. After applying the net adjustment formula,[27] the DMA concluded, that the net adjustment value of 1 moved the default value one space to the right resulting in 17 percent permanent impairment of the left ankle. He combined

[24] *Supra* note 10 at Chapter 2.808.6(f) (March 2017).

[25] *Supra* note 8.

[26] *Supra* note 20.

[27] *Id.* at 506, Table 16-2.

the 7 percent left knee impairment rating with the 17 percent left ankle impairment rating, which yielded 23 percent total permanent impairment of the left lower extremity. The DMA also utilized the ROM rating method to determine permanent impairment to the left ankle and found that, under Table 16-22 and Table 16-20,[28] 30 degrees of plantar flexion, 12 degrees of dorsiflexion, and 14 degrees of eversion each yielded zero percent impairment, and 15 degrees of inversion yielded two percent impairment, resulting in two percent permanent impairment of the left lower extremity. Referring to Table 16-25 and Table 16-17,[29] he found that appellant's loss of ROM represented a CDX of 1 with a default of two percent and that a GMFH was not reliable, resulting in two percent permanent impairment of the left ankle. The DMA concluded that the 17 percent DBI left ankle impairment rating should stand as it was greater than the 2 percent ROM left ankle impairment rating. He explained the discrepancy between his and Dr. Dosanjh's impairment rating, noting that Dr. Dosanjh's measurement of 2.9 mm or 3 mm for tibiotalar joint did not meet the criteria for impairment due to class 3 pan-talar arthritis under Table 16-2.[30] The DMA noted that the criteria under Table 16-2 included one mm to two mm cartilage interval for all three joints. He maintained that the most appropriate diagnosis was arthritis with two mm cartilage interval and the average of the measurements of all three joints of 1.4 mm for the talonavicular joint, 2.2. mm for the talocalcaneal joint, and 2.9 mm rounded up to three mm for the tibiotalar joint, yielded a class 2 impairment under Table 16-2. The Board finds that the 23 percent left lower extremity permanent impairment rating from the DMA represents the weight of the medical evidence in this case as he properly applied the appropriate provisions of the A.M.A., *Guides* to the clinical findings of record.[31] There was no evidence establishing greater impairment.

On appeal counsel contends that appellant has 31 percent permanent impairment of the left lower extremity based on the opinion of Dr. Dosanjh. As previously explained, however, Dr. Dosanjh's opinion is of diminished probative value as he failed to properly utilize the sixth edition of the A.M.A., *Guides* to support an award greater than the 21 percent.[32] There is no current medical evidence, in conformance with the A.M.A., *Guides*, which supports any greater 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.

[28] *Id.* at 549, Table 16-22 and Table 16-20.

[29] *Id.* at 550, Table 16-25; *Id.* at 545, Table 16-17.

[30] *Id*. 506, Table 16-2.

[31] *K.M.*, Docket No. 19-1526 (issued January 22, 2020); *G.S.*, Docket No. 19-0277 (issued August 22, 2019); *J.H.*, Docket No. 18-1207 (issued June 20, 2019).

[32] *K.P.*, Docket No. 18-0777 (issued November 13, 2018); *M.P.*, Docket No. 13-1225 (issued October 23, 2013); *Linda Beale*, 57 ECAB 429, 434 (2006). *See also James Kennedy, Jr.*, 40 ECAB 620, 627 (1989).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 21 percent permanent impairment of the left lower extremity for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the November 26, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 12, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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