

dislocation, bilateral abnormality of gait and difficulty in walking. By decision dated November 16, 2005, it granted appellant a schedule award for nine percent impairment of the right lower leg. In a July 24, 2007 decision, OWCP accepted osteoarthritis. On July 31, 2007 it granted a schedule award for an additional nine percent impairment of appellant's right lower extremity due to this additional condition. By decision dated July 6, 2010, OWCP denied his claim for an additional schedule award beyond the 18 percent permanent impairment already granted.

Appellant requested authorization for an evaluation with Dr. Robert Abady, a podiatrist, which OWCP authorized. In a report dated January 10, 2011, Dr. Abady noted appellant's request for a schedule award evaluation under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. (A.M.A., *Guides*).² He stated that appellant reported pain and stiffness in his right ankle, which appellant attributed to walking in the performance of duty. Dr. Abady found a history of diabetes mellitus, arthritis and left ankle fusion. He found that appellant had edema of the bilateral ankles with grossly intact sensory evaluation in the feet bilaterally. Appellant exhibited decreased deep tendon reflexes and contracted digits. Dr. Abady found crepitus during dorsiflexion and plantar flexion of the right ankle and pain on range of motion. He reported pain on palpation of the right anterior talus area and mild pain on palpation of the ligaments. Dr. Abady found that appellant had decreased stride length and wide base of gait. He reviewed x-rays which demonstrated degenerative changes to the anterior ankle with possible impingement and osteophytes on the anterior ankle. Dr. Abady diagnosed ankle joint pain, ankle synovitis and ankle arthritis. He provided an impairment rating based on loss of range of motion reporting dorsiflexion of zero degrees, a seven percent impairment based on Table 17-11 of the A.M.A., *Guides*.³ Appellant demonstrated 20 degrees of plantar flexion for seven percent impairment according to Table 17-11. Dr. Abady further found that appellant had 5 degrees of eversion, two percent impairment and 20 degrees of inversion also two percent impairment in accordance with Table 17-12 of the A.M.A., *Guides*.

Dr. Abady completed a permanent impairment worksheet on January 25, 2011 and found that appellant had class 1 impairment due to ankle arthritis a three percent impairment of his lower extremity in accordance with Table 16-2 of the A.M.A., *Guides*. He further found that appellant had class 1 impairment due to arthritis of the talonavicular, eight percent impairment of the lower extremity based on Table 16-2 of the A.M.A., *Guides*. Dr. Abady combined these impairments to reach 11 percent impairment of the right lower extremity. He noted that appellant had seven percent impairment of the ankle due to loss of range of motion. Dr. Abady concluded that appellant had 18 percent impairment of the right lower extremity.

² For new decisions issued after May 1, 2009, OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6a (January 2010); *see also*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

³ Dr. Abady's citations to the A.M.A., *Guides* for range of motion do not comport with the tables of the sixth edition of the A.M.A., *Guides*, but appear to be citations to the fifth edition of the A.M.A., *Guides*. A.M.A., *Guides*, (5th ed. 2001), 537, Tables 17-11, 17-12.

Appellant requested a schedule award on January 29, 2011. He requested reconsideration on February 8, 2011. OWCP referred appellant's medical evidence to the district medical adviser on February 28, 2011. In a report dated February 28, 2011, the medical adviser found that Dr. Abady had incorrectly combined the diagnosis-based estimate with the range of motion method to reach his impairment rating. He stated that range of motion was a "stand alone" method of calculation and could not be combined with the diagnosis-based estimate under the sixth edition of the A.M.A., *Guides*. The district medical adviser further found in reaching the diagnosis-based estimates that Dr. Abady failed to support his arthritis findings with an x-ray measure of articular cartilage thickness. He also noted that the A.M.A., *Guides* recommends the use of only one diagnosis per region. The district medical adviser concluded that there was no basis for an increased schedule award as Dr. Abady found that appellant had 18 percent impairment for which he had already received schedule awards.

By decision dated March 30, 2011, OWCP denied modification of its prior decisions finding that the medical evidence did not establish that appellant had more than 18 percent impairment of his right lower extremity for which he had received schedule awards.

LEGAL PRECEDENT

The schedule award provision of FECA⁴ and its implementing regulations⁵ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.⁶

The protocol and formula of the sixth edition of the A.M.A., *Guides* requires that the physician determine the class of diagnosis (CDX) and apply the appropriate grade modifiers for Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS) and apply the following formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) to reach the appropriate grade within the class of diagnosis.⁷ The A.M.A., *Guides* provide that, only if no other approach is available to rating, then the impairment should be calculated based on range of motion.⁸ Ratings based on range of motion cannot be combined with other approaches.⁹

⁴ 5 U.S.C. §§ 8101-8193, 8107.

⁵ 20 C.F.R. § 10.404.

⁶ See *supra* note 2.

⁷ A.M.A., *Guides* 521.

⁸ *Id.* at 552.

⁹ *Id.* at 497.

ANALYSIS

OWCP accepted appellant's occupational disease claim for right foot metatarsophalangeal dislocation, bilateral abnormality of gait and difficulty in walking as well as osteoarthritis. It granted schedule awards totaling 18 percent impairment of his right lower extremity.

Appellant requested an additional schedule award and submitted a report from Dr. Abady dated January 10, 2011, rating 18 percent impairment of his right lower extremity. Dr. Abady found that appellant had two diagnoses, class 1 ankle arthritis, for a three percent impairment and class 1 talonavicular arthritis, for an eight percent impairment.¹⁰ The A.M.A., *Guides* require that the physician provide the cartilage interval to determine the class impairment. A mild class 1 ankle arthritis rating has a three millimeter (mm) cartilage interval.¹¹ Class 1 arthritis of the talonavicular joint has a one mm cartilage interval.¹² The A.M.A., *Guides* state that imaging studies are used to grade arthritis and that cartilage interval or joint space is the best indicator of disease stage and impairment for a person with arthritis of the lower extremity.¹³

As noted by the district medical adviser in a February 28, 2011 report, Dr. Abady did not provide the specific cartilage intervals found on x-ray instead noting only that x-rays demonstrated degenerative changes to the anterior ankle with possible impingement and osteophytes on the anterior ankle. This statement does not comport with the findings necessary for either a one mm cartilage interval in the talonavicular joint or "mild osteophytes with impingement, full-thickness articular cartilage defect, cystic changes on one side of joint, focal area of avascular necrosis or ununited osteochondral fracture" or a three mm cartilage interval required by the A.M.A., *Guides* for a class 1 impairment of the talonavicular joint or ankle.¹⁴

Dr. Abady also included two diagnoses for the involved limb, ankle and talonavicular joint arthritis, as noted by the district medical adviser. The A.M.A., *Guides* provide, "In most cases, only 1 diagnosis in a region (*i.e.*, [h]ip, knee and/or foot/ankle) will be appropriate."¹⁵ The A.M.A., *Guides* state that if appellant has two significant diagnoses the examiner should use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation. Dr. Abady should not have combined the two diagnosis-based estimates; rather, he should have selected the diagnosis which provided for the highest impairment rating. In this case, appellant could have received, if substantiated by x-rays, eight percent impairment for talonavicular joint arthritis only.

¹⁰ *Id.* at 506, Table 16-2.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* at 518.

¹⁴ *Id.* at 506, Table 16-2.

¹⁵ *Id.* at 497.

In the alternative, in accordance with the sixth edition of the A.M.A., *Guides*, Dr. Abady could have based his impairment rating solely on appellant's loss of range of motion. As noted previously, loss of range of motion impairment ratings are not to be combined with other impairment ratings. Dr. Abady provided the correct impairment ratings noting that appellant had 0 degrees of dorsiflexion and 20 degrees of plantar flexion, each resulting in a seven percent impairment.¹⁶ He properly noted that 5 degrees of eversion and 20 degrees of inversion were two percent impairment each.¹⁷ The A.M.A., *Guides* provide that range of motion should be added within one joint and that two or more joints should be combined.¹⁸ Appellant's range of motion impairments of 14 percent of the ankle and 4 percent of the hindfoot result in the total impairment rating of 18 percent.¹⁹

The district medical adviser reviewed Dr. Abady's report and listed the errors and deficiencies noted above. He stated that Dr. Abady did not provide the necessary findings on x-rays, that he improperly listed two diagnoses to a scheduled member and that he improperly combined range of motion with diagnosis-based estimate impairments. The medical adviser found that appellant had no more than 18 percent impairment of his right lower extremity for which he had already received schedule awards. It is well established that, when the attending physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his or her opinion is of diminished probative value in establishing the degree of permanent impairment and OWCP may rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings of the attending physician.²⁰ The Board finds that the findings and conclusions of the district medical adviser constitute the weight of the medical evidence through the proper application of the A.M.A., *Guides* and establish that appellant has no more than 18 percent impairment of his right lower extremity for which he has received schedule awards.

Appellant may request a schedule award or increased schedule award 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 no more than 18 percent impairment of his right lower extremity for which he has received schedule awards.

¹⁶ *Id.* at 549, Table 16-22.

¹⁷ *Id.* at 549, Table 16-20.

¹⁸ *Id.* at 548.

¹⁹ *Id.* at 604.

²⁰ *Linda Beale, 57 ECAB 429 (2006).*

ORDER

IT IS HEREBY ORDERED THAT the March 30, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 17, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board