

accepted the claim for left ankle strain and paid all appropriate compensation. No time from work was lost due to the injury.

On April 1, 2013 appellant filed a claim for a schedule award. In a March 5, 2013 report, Dr. Gerald W. Torgesen, a podiatrist, advised that he has been treating appellant since June 2012. He noted that her original work-related injury of left ankle sprain resulted in altered gait and subsequent plantar fasciitis pain. While appellant had improved, there was still occasional left ankle and foot pain which could be limiting. There was also some instability in the left ankle as a result of the injury. Dr. Torgesen opined that appellant's injury had stabilized and she has reached a point of maximal medical improvement.

In an April 10, 2013 report, Dr. Michael S. Ravitch, a Board-certified orthopedic surgeon, noted the history of injury and that appellant had complained of pain and swelling in the left ankle. On examination there was swelling and tenderness about the lateral aspect of the left ankle as well as the plantar fascia of the left foot. Dr. Ravitch noted a March 31, 2011 magnetic resonance imaging scan was compatible with osteochondritis desiccans and possible strain of the posttibial ligament. He stated that appellant has undergone extensive physical therapy and had shown improvement but continued to have symptoms about the left ankle. Dr. Ravitch found that surgery was not indicated. He opined that appellant was stable and ratable and her claim could be closed.

OWCP referred appellant, together with a statement of accepted facts, the medical records and a list of questions, to Dr. Aubrey Swartz, a Board-certified orthopedic surgeon, for a second opinion evaluation to determine whether she sustained any permanent impairment due to her work injury. In a May 28, 2013 report, Dr. Swartz reviewed the history of injury, the medical records and noted appellant's complaints. He noted a weak left ankle with shooting pains in the left heel which traveled down the left medial foot and toes and an ache in the dorsum of her left foot and anterior ankle. Appellant was not able to walk long distances. She also utilized ice on a regular basis to the left ankle region. Clinical findings included full ankle range of motion, but decreased subtalar range of motion with inversion 10/15 and eversion 0/5 (left ankle compared to right ankle). There was some left calf girth atrophy of two centimeters, left being smaller than right. There was no left ankle tenderness, but slight dysesthesia was noted about the left lateral ankle with pinwheel testing. No clinical instability was noted. Dr. Swartz opined that appellant had a chronic strain of left ankle which was connected to the ligamentous strain and temporary aggravation of her preexisting degenerative condition, which resolved within the first 12 months, or by May 10, 2011. He opined that her current symptoms were related to the preexisting degenerative changes. Dr. Swartz found there were no current injury-related factors of disability including objective findings or subjective complaints and noted that there was no local tenderness found anywhere in the left ankle. Utilizing the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), he rated four percent left lower extremity impairment. Under Table 16-22, page 549, Dr. Swartz found extension or dorsiflexion of 20 degrees and plantar flexion of 50 degrees both equaled zero percent lower extremity impairment. Under Table 16-20, he found 10 degree inversion of left ankle equaled two percent lower extremity impairment and 0 degrees eversion equaled two percent lower extremity impairment. Dr. Swartz found that appellant had total four percent left lower extremity impairment, which was equivalent to class 1 under Table 16-25. He also stated

that a functional history adjustment would also result in class 1 impairment, which would equate to no change in the final award.

In a September 18, 2013 report, an OWCP medical adviser noted the history of injury and his review of the medical file, including Dr. Swartz's May 28, 2013 impairment evaluation. He agreed with Dr. Swartz's recommendation of an impairment based on a stand-alone method for loss of range of motion. The medical adviser also agreed with Dr. Swartz's impairment calculations under the A.M.A., *Guides* and that appellant had four percent impairment of the left lower extremity. He stated that maximum medial improvement was reached by May 10, 2011.

By decision dated October 2, 2013, OWCP issued a schedule award for four percent left lower extremity impairment. The award ran for 11.52 weeks from May 10 to July 29, 2011.

LEGAL PRECEDENT

The schedule award provision of FECA and its implementing regulations² set forth the number of weeks of compensation payable to employee sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.³ 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.⁴ As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.⁵

The sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).⁶ The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁷ The sixth edition of the A.M.A., *Guides* also provides that range of motion may be selected as an alternative approach in rating impairment under certain circumstances. A rating that is calculated using range of motion may not be combined with a diagnosis-based impairment and stands alone as a rating.⁸

² 20 C.F.R. § 10.404.

³ *Linda R. Sherman*, 56 ECAB 127 (2004); *Daniel C. Goings*, 37 ECAB 781 (1986).

⁴ *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁵ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *see also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

⁶ A.M.A., *Guides* 494-531.

⁷ *Id.* at 521.

⁸ *L.B.*, Docket No. 12-910 (issued October 5, 2012).

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the percentage of impairment using the A.M.A., *Guides*.⁹

ANALYSIS

The sixth edition of the A.M.A., *Guides* states that diagnosis-based impairment is the primary method of evaluation for the upper and lower limb and method of choice for calculating impairment.¹⁰ On the other hand, range of motion based impairment may be used as a stand-alone rating when other grids refer the evaluator to this method or when no other diagnosis-based sections are applicable for impairment rating of a condition.¹¹ A range of motion impairment stands alone and is not combined with diagnosis impairment.¹² In this case, both Dr. Swartz and OWCP's medical adviser utilized the range of motion based impairment rating.

The Board finds that OWCP properly relied on the opinions of Dr. Swartz and its medical adviser to find that appellant had four percent impairment of her left leg.

Dr. Swartz properly found under Table 16-22, page 549, that the full ankle range of motion of 20 degrees extension or dorsiflexion and 50 degrees plantar flexion both equaled zero percent lower extremity impairment. Under Table 16-20, he properly found that 10 degrees inversion of left ankle equaled two percent lower extremity impairment and 0 degrees eversion equaled two percent lower extremity impairment. Under Table 16-25, page 550, Dr. Swartz found appellant had total four percent left lower extremity impairment, which was equivalent to class 1 or mild impairment. He also stated that an adjustment for functional history would also result in class 1 impairment, which would not change in the final impairment of four percent.

The medical adviser reviewed the May 28, 2013 impairment evaluation of Dr. Swartz and agreed that the rating based on range of motion was appropriate. He applied the standards of the sixth edition of the A.M.A., *Guides* in the same manner as Dr. Swartz and concluded that appellant had four percent impairment of her left leg. The medical adviser additionally determined that maximum medical improvement was attained by May 10, 2011.

Appellant contends that she has not achieved maximum medical improvement as she continues to suffer pain, difficulty walking, and swelling and buckling of her left ankle. However, her physicians, Dr. Torgesen and Dr. Ravitch, both opined that maximum medical improvement had been reached despite the fact that she may continue to suffer symptoms. There is no additional evidence showing that appellant has greater impairment than four percent. For this reason, the Board finds that the weight of the medical evidence rests with Dr. Swartz and OWCP's medical adviser.

⁹ Federal (FECA) Procedure Manual, *supra* note 5 at Chapter 2.808.6(d) (August 2002).

¹⁰ A.M.A., *Guides*, 387, 461, 497, 543, 552.

¹¹ *Id.* at 552.

¹² *Id.* at 543.

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 did not sustain greater than four percent left lower extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the October 2, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 13, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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