United States Department of Labor
Employees' Compensation Appeals Board

G.W., Appellant	)	
and	)	**Docket No. 16-0525**
	)	**Issued: August 2, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Boston, MA, Employer	)	

Appearances:
Daniel B. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 27, 2016 appellant, through counsel, filed a timely appeal from a December 8, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[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.*

[3] Appellant, through counsel, filed a timely request for oral argument, pursuant to 20 C.F.R. § 501.5(b). After exercising its discretion, the Board, by an August 10, 2016 order, denied appellant's request for an oral argument, noting that counsel's arguments on appeal could be adequately addressed in a Board decision based on a review of the case record as submitted. *Order Denying Request for Oral Argument*, Docket No. 16-0525 (issued August 10, 2016).

ISSUE

The issue is whether appellant met his burden of proof to establish more than 23 percent permanent impairment of his left lower extremity and more than 8 percent permanent impairment of his right lower extremity, for which he previously received schedule awards.

FACTUAL HISTORY

On April 23, 2013 appellant, then a 64-year-old retired letter carrier, filed an occupational disease claim (Form CA-2) for bilateral hip and knee conditions, which allegedly arose in the performance of duty on or about January 31, 2010.[4] In August 2013, OWCP accepted his claim for aggravation of preexisting bilateral hip and knee osteoarthritis.[5]

On September 13, 2013 appellant filed a claim for a schedule award (Form CA-7).

In a January 31, 2013 report, Dr. David C. Morley, Jr., a Board-certified orthopedic surgeon, discussed appellant's factual and medical history and reported the findings of his physical examination on that date. He noted that the findings of June 1, 2012 left knee x-ray testing revealed no evidence of significant arthritic changes with four millimeters of medial compartment joint space.[6] The findings of June 1, 2012 right knee x-ray testing showed early marginal osteophytes in the medial femoral condyle, but no evidence of osteophyte formation in the lateral and patellofemoral joint spaces. Dr. Morley posited that appellant's bilateral knee and hip conditions had been aggravated by his work as a letter carrier.

In another January 31, 2013 report, Dr. Morley discussed his calculation of the permanent impairment of appellant's lower extremities under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009) (A.M.A., *Guides*). He determined that appellant had 37 percent permanent impairment of his left lower extremity due to his left hip condition, 7 percent permanent impairment of his left lower extremity due to his left knee condition, 18 percent permanent impairment of his right lower extremity due to his right hip condition, and 20 percent permanent impairment of his right lower extremity due to his right knee condition. Under Table 16-4 (Hip Regional Grid) beginning on page 512, Dr. Morley applied the diagnosis-based impairment (DBI) method of rating appellant's lower extremity permanent impairment due to his hip conditions and found a class 3 condition of his left hip (due to total hip replacement) and a class 2 condition of his right hip (due to arthritis). Under Table 16-3 (Knee Regional Grid) beginning on page 509, he used the DBI rating method for appellant's lower extremity permanent impairment to find a class 1 condition of his left knee (due to primary knee joint arthritis) and a class 2 condition of his right knee (due to primary knee joint arthritis).

[4] Appellant retired effective December 31, 2010.

[5] Appellant also has a previously accepted traumatic injury claim for right medial meniscus tear, which occurred on May 28, 2003 (OWCP File No. xxxxxx835). On November 25, 2003 he had undergone a right knee partial lateral meniscectomy and medial femoral condyle chondroplasty. On January 26, 2006 appellant had undergone a left total hip arthroplasty.

[6] The record includes a report of the June 1, 2012 left knee x-ray testing which contains an impression of apparent mild degenerative changes with no acute abnormality identified.

In a September 3, 2013 report, Dr. Morley determined that appellant had 37 percent permanent impairment of his left lower extremity due to his left hip condition, 10 percent permanent impairment of his left lower extremity due to his left knee condition, 20 percent permanent impairment of his right lower extremity due to his right hip condition, and 18 percent permanent impairment of his right lower extremity due to his right knee condition. He again applied the DBI impairment rating method under Table 16-3 and Table 16-4 to evaluate appellant's left and right hip conditions and his right knee condition. Dr. Morley used the range of motion (ROM) impairment rating method under Table 16-23 on page 549 to evaluate his left knee condition. He used the Combined Values Chart beginning on page 604 to combine the various impairment ratings and to find a total permanent impairment of 43 percent for the left lower extremity and a total permanent impairment of 34 percent for the right lower extremity.

In April 2014 OWCP referred appellant for a second opinion examination with Dr. Frank A. Graf, a Board-certified orthopedic surgeon. It requested that Dr. Graf provide opinions regarding appellant's current diagnoses, causal relationship of his medical conditions to work factors, disability from work, and work-related permanent impairment of his lower extremities.

In a May 6, 2014 report, Dr. Graf reported physical examination findings of that date and indicated that appellant's current symptoms were in his right hip and both knees. He noted that appellant was able to slowly squat to 93 degrees of knee flexion in both knees, that there was tenderness to palpation along the medial compartment joint lines of both knees, and that there was no instability in either knee. Dr. Graf indicated that appellant had disability due to the residuals of the accepted work injuries, but he did not specify the level of disability. He noted that appellant had reached maximum medical improvement (MMI) in his left hip and both knees, but that appellant was considering total right hip replacement due to increasing pain and should not be considered at MMI for the right hip. Dr. Graf attached a worksheet in which he provided permanent impairment calculations under the standards of the sixth edition of the A.M.A., *Guides*. He determined that, under Table 16-4, appellant had 31 percent permanent impairment of his left lower extremity due to a class 3 left hip condition (total hip replacement) and that, under Table 16-3, he had 10 percent permanent impairment of his left lower extremity due to a class 1 left knee condition (arthritis). Dr. Graf also found that, under Table 16-4, appellant had 20 percent permanent impairment of his right lower extremity due to a class 2 right hip condition (arthritis) and that, under Table 16-3, he had 20 percent permanent impairment of his right lower extremity due to a class 2 right knee condition (arthritis).

OWCP requested that Dr. Graf produce a supplemental report regarding his rating of the permanent impairment of appellant's lower extremities, to include clarification regarding whether appellant's right hip condition had reached MMI. In a supplemental June 3, 2014 report and worksheet, Dr. Graf determined that appellant had 38 percent permanent impairment of his left lower extremity and 20 percent permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. He found that, under Table 16-4, appellant had 31 percent permanent impairment of his left lower extremity due to a class 3 left hip condition (total hip replacement) and that, under Table 16-3, he had 10 percent permanent impairment of his left lower extremity due to a class 1 left hip condition (arthritis). Dr. Graf indicated that the 20 percent permanent impairment of appellant's right lower extremity was due to a class 2 condition of his right knee (arthritis) as calculated under Table 16-3. He did not

provide a permanent impairment rating for appellant's right hip and noted that appellant should not be considered at MMI for the right hip.

In a June 20, 2014 letter, OWCP requested that Dr. Morley Slutsky, a Board-certified occupational medicine physician, evaluate appellant's permanent impairment in his capacity as an OWCP medical adviser. It advised Dr. Slutsky that he should only consider the permanent impairment rating provided by Dr. Morley and that he should provide permanent impairment ratings for appellant's lower extremities under the standards of the sixth edition of the A.M.A., *Guides*.[7] OWCP asked Dr. Slutsky to discuss any disagreement with Dr. Morley's impairment rating and requested that he determine the date of MMI based on the medical evidence of record.

In a June 20, 2014 report, Dr. Slutsky found that appellant had 32 percent permanent impairment of his left lower extremity and 11 percent permanent impairment of his right lower extremity under the standards of the sixth edition of the A.M.A., *Guides*. He noted that, under Table 16-4, appellant had 31 percent permanent impairment of his left lower extremity due to a class 3 left hip condition (total hip replacement) and that, under Table 16-3, he had 2 percent permanent impairment of his left lower extremity due to a class 1 left knee condition (soft tissue lesion with consistent motion deficits). Dr. Slutsky also found that, under Table 16-4, appellant had nine percent permanent impairment of his right lower extremity due to a class 1 right hip condition (arthritis) and that, under Table 16-3, he had two percent permanent impairment of his right lower extremity due to a class 1 right knee condition (partial lateral meniscectomy).[8] He used the Combined Values Chart to combine the various impairment ratings and to find total permanent impairment of 32 percent for the left lower extremity and total permanent impairment of 11 percent for the right lower extremity. Dr. Slutsky found that appellant had reached MMI for both knees and hips by January 31, 2013 because these conditions had stabilized by that date.

In a January 20, 2015 letter, OWCP provided Dr. Morley 30 days to provide additional comments regarding appellant's permanent impairment. In a February 9, 2015 report, Dr. Morley indicated that he had reviewed Dr. Slutsky's June 20, 2014 report and discussed how his impairment rating differed from that of Dr. Slutsky. He noted that he believed that, with respect to appellant's left hip, the grade modifier for physical examination was "not applicable," whereas Dr. Slutsky had assigned the value of "zero" for this modifier. Dr. Morley indicated that, therefore, the "proper left impairment is 37 [percent]." With respect to appellant's left knee, he expressed his disagreement with Dr. Slutsky's use of the DBI rating method and indicated that appellant's impairment was best calculated under the ROM impairment rating method. Under Table 16-23 on page 549 of the sixth edition of the A.M.A., *Guides*, appellant had 10 percent permanent impairment of his left lower extremity due to mild limitation of left knee motion. Dr. Morley indicated that, with respect to appellant's right lower extremity, he disagreed with Dr. Slutsky's class designations for the right hip and knee conditions, and he

[7] OWCP indicated that it referred appellant for a second opinion medical examination with Dr. Graf and requested an opinion on permanent impairment, but noted that this was done in error as the case file was not in posture for a second opinion regarding permanent impairment at the time of the examination. It did not provide any further explanation of why it felt that the referral to Dr. Graf was in error.

[8] Dr. Slutsky calculated various grade modifiers for appellant's bilateral hip and knee conditions. For the left hip, he determined that appellant had a functional history grade modifier of 3 and a physical examination grade modifier of 0. Dr. Slutsky found that the grade modifier for clinical studies was not applicable because clinical studies were used to place appellant in the correct diagnostic class. *See* A.M.A., *Guides* 215-21.

reported that his assessment of the permanent impairment of the right lower extremity due to these conditions remained the same as noted in his earlier report.

OWCP determined that there was a conflict in the medical opinion evidence between Dr. Morley, the attending physician, and Dr. Slutsky, OWCP's medical adviser, and referred appellant to Dr. Robert R. Pennell, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on permanent impairment.

In a May 28, 2015 report, Dr. Pennell discussed appellant's factual and medical history and reported findings of his examination on May 28, 2015. He noted that, upon examination, appellant complained of very minor tenderness on palpation of his right hip but that he had no tenderness on palpation of his left hip. Appellant reported mild tenderness on palpation of his right knee lateral joint line, but no tenderness on palpation of his left knee. Dr. Pennell provided findings of ROM testing for both hips, knees, and ankles. He opined that appellant had 22 percent permanent impairment of his left lower extremity and 15 percent permanent impairment of his right lower extremity under the sixth edition of the A.M.A., *Guides*.[9] Dr. Pennell indicated that, under Table 16-4 beginning on page 512, appellant had class 2 impairment as a result of a left total hip joint replacement with a good result which resulted in 21 percent permanent impairment of his left lower extremity.[10] He noted that, under Table 16-3 beginning on page 509, appellant had one percent permanent impairment of his left lower extremity as the result of his left knee condition (other soft tissue lesion with significant palpatory and/or radiographic findings).[11] Dr. Pennell used the Combined Values Chart to combine these impairment ratings to conclude that appellant's total permanent impairment of the left lower extremity was 22 percent. He noted that, under Table 16-4, appellant had class 1 impairment as a result of his right hip arthritis which resulted in six percent permanent impairment of his right lower extremity.[12] Dr. Pennell indicated that, under Table 16-23 on page 549, appellant had 10 percent permanent impairment of his right lower extremity as a result of the loss of motion of the right knee joint. He used the Combined Values Chart to combine these impairment ratings and conclude that appellant's total permanent impairment of the right lower extremity was 15 percent.

OWCP referred the case to Dr. David I. Krohn, a Board-certified internist serving as an OWCP medical adviser, for an opinion on appellant's permanent impairment under the sixth edition of the A.M.A., *Guides*. In a report dated November 23, 2015, Dr. Krohn concluded that appellant had 23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity under the sixth edition of the A.M.A.,

[9] Dr. Pennell indicated that appellant was at MMI for his right hip and left knee on December 31, 2010 (his retirement date), for his right knee on November 25, 2004 (one year following the November 25, 2003 right knee operation), and for his left hip on January 26, 2007 (one year following the January 26, 2006 total left hip replacement).

[10] Dr. Pennell determined that, for his left hip, appellant had a functional history grade modifier of 0 and a physical examination grade modifier of 1. He found that the clinical studies grade modifier was not applicable. Dr. Pennell used the grade modifiers to calculate the net adjustment formula. *See* A.M.A., *Guides* 515-22.

[11] Dr. Pennell reported that, for his left knee, appellant had a functional history grade modifier of 1, a physical examination grade modifier of 1, and a clinical studies grade modifier of 1.

[12] Dr. Pennell determined that, for his right hip, appellant had a functional history grade modifier of 1 and a physical examination grade modifier of 0. He found that the clinical studies grade modifier was not applicable.

Guides. He derived his impairment ratings based on the examination findings of Dr. Pennell. With regard to the left lower extremity, Dr. Krohn found that appellant had 21 percent permanent impairment of the left lower extremity due to left hip arthritis (derived under Table 16-4). With respect to the left hip, he calculated the grade modifiers and applied the net adjustment formula in the same manner as Dr. Pennell to find 21 percent permanent impairment of the left lower extremity. With respect to appellant's left knee, Dr. Krohn determined that the correct diagnosis was other soft tissue lesion, *versus* Dr. Pennell's diagnosis of arthritis, because there was no evidence of left knee arthritis qualifying for a DBI impairment rating under Table 16-3 in the case file. He derived a two percent left lower extremity rating due to appellant's soft tissue lesion (under Table 16-3). Dr. Krohn used the Combined Values Chart to combine these values and to find that appellant had a total impairment rating of 23 percent for his left lower extremity. He found that appellant had six percent impairment of the right lower extremity due to right hip arthritis (derived under Table 16-4 (Hip Regional Grid) beginning on page 512). With respect to the right hip, Dr. Krohn calculated the grade modifiers and applied the net adjustment formula in the same manner as Dr. Pennell to find six percent permanent impairment of the right lower extremity. He opined that the most appropriate diagnosis for appellant's right knee was a class 1 lateral meniscal injury with a rating of two percent rating for the right lower extremity (derived under Table 16-3 (Knee Regional Grid) beginning on page 509). Dr. Krohn used the Combined Values Chart to combine these ratings and to find that appellant had a permanent impairment rating of eight percent for his right lower extremity.

In a December 8, 2015 decision, OWCP granted appellant schedule awards for 23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity. The awards ran for a total of 89.28 weeks and was based on Dr. Krohn's impairment rating which evaluated the examination findings obtained by Dr. Pennell.

LEGAL PRECEDENT

Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[13] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[14] Effective May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[15]

FECA provides that, if there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an

[13] 5 U.S.C. § 8107(c). For a total or 100 percent loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2).

[14] 20 C.F.R. § 10.404.

[15] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

examination.[16] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[17] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well-reasoned and based upon a proper factual background, must be given special weight.[18]

The Board has long held that an OWCP medical adviser may create a conflict in medical opinion with an examining physician.[19] OWCP's procedures provide that cases returned from a referee medical examiner should not routinely be sent to an OWCP DMA for review unless a schedule award is at issue.[20] Where a referee examination was arranged to resolve a conflict created by a DMA with respect to a schedule award issue, the same DMA should not review the referee specialist's report.[21] Instead, another DMA or OWCP medical consultant should review the file.[22]

When a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the DMA to review the calculations to ensure the referee physician appropriately used the A.M.A., *Guides*.[23]

ANALYSIS

OWCP accepted appellant's claim for aggravation of preexisting osteoarthritis of both hips and aggravation of preexisting osteoarthritis of both knees.[24] On September 13, 2013 appellant filed a Form CA-7 claiming a schedule award due to his accepted work injuries. By decision dated December 8, 2015, OWCP granted appellant schedule awards for 23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity. The awards were based on the impairment rating of Dr. Krohn, an OWCP medical adviser, who had evaluated the findings of Dr. Pennell, the impartial medical specialist.

[16] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321; *Shirley L. Steib*, 46 ECAB 309, 317 (1994). The district medical adviser (DMA), acting on behalf of OWCP, may create a conflict in medical opinion. 20 C.F.R. § 10.321(b).

[17] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[18] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[19] *See Harold Travis*, 30 ECAB 1071 (1979); *see* 20 C.F.R. § 10.321(b).

[20] *Supra* note 15 at Chapter 2.810.11f (September 2010).

[21] *Id.*

[22] *Id.*

[23] *Id.* at Chapter 2.810.8k (September 2010). Although the DMA may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. *Id.* The DMA cannot resolve a conflict in medical opinion. *Id.*

[24] On November 25, 2003 appellant had undergone a right knee partial lateral meniscectomy and medial femoral condyle chondroplasty. On January 26, 2006 he had undergone a left total hip arthroplasty.

The Board finds that appellant did not meet his burden of proof to establish more than 23 percent permanent impairment of his left lower extremity and more than 8 percent permanent impairment of his right lower extremity, for which he received schedule awards.

The Board notes that OWCP properly found that there was a conflict in the medical opinion evidence regarding the extent of appellant's permanent impairment between Dr. Morley, an attending physician, and Dr. Slutsky, OWCP's DMA, and referred appellant to Dr. Pennell for an impartial medical examination and opinion on permanent impairment.[25]

On appeal, counsel argues that OWCP improperly found a conflict in the medical opinion evidence between Dr. Morley and Dr. Slutsky because Dr. Morley examined appellant, but Dr. Slutsky did not examine him. OWCP regulations, Board precedent, and OWCP's procedures each recognize that an OWCP medical adviser, without having conducted a physical examination, can create a conflict in medical opinion evidence.[26]

In a May 28, 2015 report, Dr. Pennell opined that appellant had 22 percent permanent impairment of his left lower extremity and 15 percent permanent impairment of his right lower extremity under the sixth edition of the A.M.A., *Guides*. He indicated that, under Table 16-4 beginning on page 512, appellant had a class 2 impairment as a result of a left total hip joint replacement with a good result which represented 21 percent impairment of his left lower extremity. Dr. Pennell noted that, under Table 16-3 beginning on page 509, appellant had one percent permanent impairment of his left lower extremity as the result of his left knee condition (other soft tissue lesion with significant palpatory and/or radiographic findings). He used the Combined Values Chart to combine these impairment ratings and conclude that appellant's total permanent impairment of his left lower extremity was 22 percent. Dr. Pennell noted that, under Table 16-4, appellant had a class 1 impairment as a result of his right hip arthritis which resulted in six percent permanent impairment of his right lower extremity.[27] He indicated that, under Table 16-23 on page 549, appellant had 10 percent permanent impairment of his right lower extremity as a result of the loss of motion of the right knee joint. Dr. Pennell used the Combined Values Chart to combine these impairment ratings and conclude that appellant's total permanent impairment of his right lower extremity was 15 percent.

In a report dated November 23, 2015, Dr. Krohn, OWCP's medical adviser, derived an impairment rating under the sixth edition of the A.M.A., *Guides*, based on the examination findings of Dr. Pennell. It was proper for OWCP to refer the case to Dr. Krohn in his capacity as an OWCP medical adviser because OWCP procedures provide for such referrals in schedule award cases.[28] The Board finds that Dr. Krohn properly provided an opinion that appellant has

[25] In his most recent September 3, 2013 impairment rating, Dr. Morley found a combined 43 percent left lower extremity permanent impairment and 34 percent right lower extremity permanent impairment. Dr. Slutsky, the initial DMA, reviewed the record, including Dr. Morley's findings, and in a report dated June 20, 2014 found 32 percent left lower extremity permanent impairment and 11 percent permanent impairment of the right lower extremity. OWCP afforded Dr. Morley an opportunity to review Dr. Slutsky's impairment rating, and in a report dated February 9, 2015, appellant's physician disagreed with the DMA's impairment rating.

[26] *See supra* notes 16, 19, and 20.

[27] Dr. Pennell determined that, for his right hip, appellant had a functional history grade modifier of 1 and a physical examination grade modifier of 0. He found that the clinical studies grade modifier was not applicable.

[28] *See supra* notes 20 and 23.

23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity. His report constitutes the weight of the medical evidence with respect to appellant's permanent impairment because he corrected errors in Dr. Pennell's application of the standards of the A.M.A., *Guides*.[29]

Dr. Krohn properly concluded that appellant had 23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity under the sixth edition of the A.M.A., *Guides*. In his rating report, he found that Dr. Pennell had not properly applied the standards of the sixth edition of the A.M.A., *Guides*. For example, Dr. Krohn properly opined that the most appropriate method to rate appellant's right knee condition was to apply the DBI rating method under Table 16-3 for his right partial lateral meniscectomy. He correctly calculated that appellant had a two percent permanent impairment of his right lower extremity due to this condition. The Board notes that Dr. Pennell applied the ROM method under Table 16-3 to rate appellant's right lower extremity impairment due to his right knee condition, but that Table 16-3 does not provide for use of this method to rate appellant's right knee condition and Dr. Pennell did not otherwise adequately explain why it was appropriate to use the ROM method.[30] With respect to appellant's left knee, Dr. Krohn determined that the correct diagnosis was other soft tissue lesion, rather than arthritis, because there was no evidence in the case file of left knee arthritis which qualified appellant for an impairment rating under Table 16-3.[31] He then properly derived a two percent left lower extremity rating due to appellant's soft tissue lesion under Table 16-3.[32] The Board notes that Dr. Krohn properly derived the same permanent impairment ratings for appellant's left and right hips as Dr. Pennell. He then properly used the Combined Values Chart beginning on page 604 to combine the relevant impairment ratings and concluded that appellant had 23 percent permanent impairment of his left lower extremity and 8 percent permanent impairment of his right lower extremity. The Board has carefully reviewed Dr. Krohn's rating report and finds that he has adequately explained how it comports with the standards of the sixth edition of the A.M.A., *Guides*.

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.

[29] *See supra* note 23.

[30] *See* A.M.A., *Guides* 509-11. The A.M.A., *Guides* provides that the DBI method is the primary method of evaluating lower extremity permanent impairment. The ROM method is used to determine actual impairment values of the lower extremities only when it is not possible to otherwise define impairment. *Id.* at 497. *See also E.M.*, Docket No. 14-0311 (issued July 8, 2014).

[31] The Board notes that the record contains the findings of June 1, 2012 left knee x-ray testing which reveal no evidence of significant arthritis changes with four millimeters of medial compartment joint space. A claimant must have three millimeters of cartilage interval or full-thickness articular cartilage defect to qualify for a DBI rating under Table 16-3 and there is no evidence that appellant has either of these conditions. *See* A.M.A., *Guides* 511.

[32] The Board notes that Dr. Krohn's left lower extremity impairment rating due to appellant's left knee condition was actually higher than the one percent impairment rating provided by Dr. Pennell.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish more than 23 percent permanent impairment of his left lower extremity and more than 8 percent permanent impairment of his right lower extremity, for which he previously received schedule awards.

ORDER

IT IS HEREBY ORDERED THAT the December 8, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 2, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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