United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
	)	**Docket No. 20-0253**
and	)	**Issued: June 17, 2020**
	)	
U.S. POSTAL SERVICE, JACKSON DELTA STATION, Jackson, MS, 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:
ALEC J. KOROMILAS, Chief Judge
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On November 11, 2019 appellant, through counsel, filed a timely appeal from a September 18, 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 permanent impairment of his left lower extremity, warranting a schedule award.

FACTUAL HISTORY

On March 7, 2017 appellant, then a 39-year-old city carrier, filed a traumatic injury claim (Form CA-1) alleging that on March 3, 2017 he sustained a severe left ankle sprain with swelling in his ankle and foot when his left foot turned inward as he was walking down steps while in the performance of duty. On the reverse side of the claim form, the employing establishment noted that appellant stopped work on March 4, 2017.

OWCP accepted appellant's claim for sprain of the other ligament and tibiofibular ligament of the left ankle and subluxation of the left ankle joint.[3] On October 3, 2017 appellant underwent an authorized left ankle arthroscopy with lateral ankle ligament repair, which was performed by Dr. Jamey Burrow, an attending Board-certified orthopedic surgeon.[4] OWCP paid appellant wage-loss compensation on the supplemental rolls commencing May 4, 2017.

On August 25, 2018 appellant returned to full-duty work at the employing establishment.

In an August 9, 2018 medical report, Dr. Burrow discussed his findings on physical examination and diagnosed sprain of other ligament of the left ankle, subsequent encounter. He advised that appellant had reached maximum medical improvement (MMI) with zero percent permanent impairment. Dr. Burrow released him to return to work with restrictions based on the results of a functional capacity evaluation.

On November 5, 2018 appellant filed a claim for a schedule award (Form CA-7).

OWCP, in a November 6, 2018 development letter, requested that appellant submit an impairment evaluation from his attending physician addressing whether he had reached MMI and evaluating the extent of permanent impairment, if any, in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] It afforded him 30 days to submit the necessary evidence. Appellant did not submit additional evidence.

[3] By decision dated September 12, 2018, OWCP denied appellant's request to expand the acceptance of his claim to include the conditions of depression, hypertension, stress/emotional condition, and diabetes as causally related to his accepted March 3, 2017 employment injury.

[4] In his October 3, 2017 operation report, Dr. Burrow found extensive anterior, medial, and lateral gutter synovitis with no chondral abnormality. He further found stable syndesmosis. Dr. Burrow reported that after debridement of the ankle, there was some laxity in the tibiotalar joint with talar tilt testing approximately 15 to 20 degrees with stress.

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

By decision dated December 10, 2018, OWCP denied appellant's claim for a schedule award. It noted that he had not responded to its November 6, 2018 request for medical documentation including an impairment evaluation.

In an October 31, 2018 report Dr. Lisa Marie Sheppard, a Board-certified radiologist and neurologist, noted her review of appellant's September 28, 2018 left knee and ankle x-rays. She reported that the left knee demonstrated overall normal mineralization and mild osteophyte formation of the lateral joint space. The superior to inferior measurement of the medial joint space was 3.7 millimeters (mm). The superior to inferior measurement of the lateral joint space was 3.4 mm. The patellofemoral joint space demonstrated an "AP" measurement of 3.2 mm. No joint effusion was noted and no lyric or blastic lesions were observed. Utilizing the lateral projection of the left ankle, the superior to inferior measurement of the tibiotalar joint space was 2 mm. The superior to inferior measurement of the talocalcaneal joint space was 2.3 mm. The measurement of the talonavicular joint was 1.2 mm.

In a February 1, 2019 report, Dr. Sonny Dosanjh, a Board-certified physiatrist, noted that appellant presented for an initial evaluation of left ankle pain status post a March 3, 2017 work injury. He also noted a history of the accepted employment injury, the treatment history, and examination findings and diagnosed pan-talar arthritis. Dr. Dosanjh referenced Table 16-2, Foot and Ankle Regional Grid, on page 505 of the sixth edition of the A.M.A., *Guides* and found that pan-talar arthritis represented a class of diagnosis (CDX) of 3 representing a severe problem. Pursuant to Table 16-6, he assigned a grade modifier for functional history (GMFH) of 2 based on an antalgic gait. Pursuant to Table 16-7, Dr. Dosanjh assigned a grade modifier for physical examination (GMPE) of 3 due to loss of range of motion (ROM) and severe palpatory findings (including crepitus and joint line tenderness over the medial and lateral joint line, positive talar tilt, and positive laxity). Pursuant to Table 16-8, he assigned a grade modifier for clinical studies (GMCS) of 2 for studies used to confirm the diagnosis and moderate pathology. Using the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), Dr. Dosanjh calculated that appellant had a net adjustment of (2-3) + (3-3) + (2-3) = -2, which equaled a grade A default value that was moved up to a grade C or 26 percent permanent impairment of the left lower extremity.

On April 16, 2019 appellant, through counsel, requested reconsideration of the December 10, 2018 decision.

On April 29, 2019 OWCP routed Dr. Dosanjh's February 1, 2019 report, a statement of accepted facts (SOAF), and the case record to Dr. Ari Kaz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA) for review and determination regarding whether appellant sustained permanent impairment based on the sixth edition of the A.M.A., *Guides* and the date of MMI.

In a May 8, 2019 report, the DMA noted that he reviewed the SOAF, the case record, and Dr. Dosanjh's February 1, 2019 report. He indicated that it was unclear why Dr. Dosanjh elected to rate appellant based on a diagnosis of pan-talar arthritis. The DMA noted that page 506 of the A.M.A., *Guides* indicated that a subtalar joint space of more than two mm yielded zero percent permanent impairment and a talonavicular joint space of more than one mm yielded no impairment. He indicated that, while the ankle joint space of two mm yielded a class 2 problem per Table 16-2, he suggested that these were "radiographic findings only" and were not clinically

relevant and that a diagnosis of arthritis was not made on x-rays alone. The DMA noted that appellant was 42 years of age and it was extremely unusual for someone his age to develop significant arthritis (according to Dr. Dosanjh a severe class 3 problem) within 18 months of an ankle sprain. Furthermore, an April 18, 2017 magnetic resonance imaging (MRI) scan, which was much more sensitive than an x-ray, showed no marrow edema, cartilage abnormality, or evidence of arthritis. Additionally, the DMA explained that arthritis was not an accepted condition in the case and other than Dr. Dosanjh's opinion and the clinically unrelated x-ray finding, there was no evidence that appellant had ankle arthritis He maintained that this was strengthened by a lack of documentation by the radiologist stating that the ankle joint was arthritic. In addition, the greatest support was the operative findings of no cartilage injury noted by Dr. Dosanjh. The DMA noted that it was difficult to support the diagnosis of ankle arthritis when the operative surgeon looked at the cartilage and documented that it was normal. He determined that Dr. Dosanjh appeared to rely on radiographs to assign a diagnosis and an impairment rating. The DMA concluded, however, that the diagnosis of pan-talar arthritis had no other support in the medical records provided. He recommended another rating by an orthopedic surgeon with access to the complete medical records.

On May 13, 2019 OWCP referred appellant, together with a SOAF, the medical record, and a set of questions, to Dr. Byron T. Jeffcoat, a Board-certified orthopedic surgeon, for a second opinion examination regarding his current condition and the extent of his permanent impairment, if any, due to his accepted left ankle conditions.

In a report dated June 5, 2019, Dr. Jeffcoat noted appellant's history of injury and his review of the medical record. On physical examination, he reported that appellant could stand on his toes and heels and squat about 75 percent of normal and recover. Appellant could not touch his toes, lacking about two inches. There was full ROM of all extremities and no weakness or instability with left foot eversion or inversion. There was also no swelling, but demonstrated subjective tenderness over the distal fibula and medial malleolus. Appellant complained of subjective left talus pain. There was no atrophy by measurement of feet, ankles, or calves as compared to his normal right counterparts. There was a well-healed left foot/ankle puncture wound, the site of his 2017 arthroscopy, with no evidence of redness or erythema. Neurovasculature appeared intact and strength was normal with no joint effusion. In response to questions posed by OWCP, Dr. Jeffcoat related that clinically, he found no objective findings relative to appellant's March 3, 2017 work-related left ankle injury in his normal physical examination. The only findings he noted were subjective, which included pain over the medial tibiotalar and fibula talar ligaments. Dr. Jeffcoat advised that appellant's accepted left ankle sprain had resolved although appellant related that he developed left ankle pain when he walked on un-level ground for an extended period of time, a subjective complaint for which he wore an ankle orthosis. He noted that clinically, appellant had no left ankle instability. Again, Dr. Jeffcoat indicated that he found no objective findings pertinent to the original work-related left ankle injury in his evaluation. He maintained that there was no evidence of left ankle osteoarthritis as evidenced by left ankle x-ray findings (three views) in Dr. Burrow's December 26, 2017 notes, which showed diffuse osteopenia, otherwise no osteoarticular abnormalities. Dr. Jeffcoat further maintained that appellant had no other residuals of his accepted March 3, 2017 work injury. He determined that appellant reached MMI as of the date of his examination.

Regarding the extent of appellant's left lower extremity permanent impairment, Dr. Jeffcoat referred to Table 16-2 on page 501 of the sixth edition of the A.M.A., *Guides* for the diagnoses of sprain of the tibiofibular ligament and sprain of the other ligament of the left ankle, resulting in a CDX of 1 for the left ankle with a mid-range default value of one percent permanent impairment. He assigned a GMFH of 1 and GMPE and GMCS of zero. Dr. Jeffcoat applied the net adjustment formula of (1-1) + (0-1) + (0-1) to find a net adjustment of -2, which yielded zero percent permanent impairment of the left lower extremity.

On June 27, 2019 OWCP routed Dr. Jeffcoat's June 9, 2019 report, a SOAF, and the case record to the DMA for review as to whether appellant sustained permanent impairment as a result of his accepted conditions.

In a September 15, 2019 addendum to his May 8, 2019 DMA report, Dr. Kaz noted that he reviewed the SOAF, the medical record, and Dr. Jeffcoat's June 5, 2019 report. He noted that it was clear that appellant did not have ankle or pan-talar arthritis based on numerous x-rays as read by Dr. Burrow, the April 18, 2017 MRI scan, and most importantly Dr. Burrow's October 3, 2017 operative report in which he clearly documented normal cartilage. The DMA noted that Dr. Jeffcoat clearly documented the same opinion. He agreed with Dr. Jeffcoat that the appropriate diagnosis on which to base an impairment rating was ankle sprain, found in Table 16-2 on page 502 and previously used in his May 8, 2019 report. The DMA indicated that Dr. Jeffcoat clearly documented no ankle instability, as found by Dr. Burrow on numerous occasions. Dr. Jeffcoat also clearly delineated that there were no objective abnormal findings. The DMA maintained that this was the definition of a class 0 problem as found on page 502 which yielded zero percent permanent impairment. He noted that while Dr. Jeffcoat accurately found that the default class 1 rating was one percent, a class 1 rating required ankle instability. The DMA advised that without any documentation of ankle instability, the appropriate rating was class 0, which yielded zero percent permanent impairment of the left lower extremity. He concluded that the date of MMI was June 5, 2019.

By decision dated September 18, 2019, OWCP denied modification of its December 10, 2018 decision. It found that the weight of the medical evidence rested with the opinion of Dr. Burrow as supported by the opinions of Dr. Jeffcoat and its DMA.

LEGAL PRECEDENT

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[6]

[6] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

The schedule award provisions of FECA[7] and its implementing regulations[8] 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. OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants. As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[10] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[11] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with the medical adviser providing rationale for the percentage of impairment specified.[13]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish permanent impairment of his left lower extremity, warranting a schedule award.

In a February 1, 2019 report, Dr. Dosanjh, appellant's treating physician, diagnosed left ankle pan-talar arthritis and found that appellant had reached MMI and 26 percent permanent impairment of the left lower extremity under the sixth edition of the A.M.A., *Guides*. The Board notes, however, that OWCP has not accepted an arthritic condition as diagnosed by Dr. Dosanjh. For conditions not accepted by OWCP as being employment related, it is appellant's burden to submit rationalized medical evidence to establish causal relationship between the additional or consequential conditions and the accepted employment injury.[14] Dr. Dosanjh provided no

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *Supra* note 6 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[11] *Id*. at 494-531.

[12] *Id*. at 411.

[13] *See supra* note 9 at Chapter 2.808.6(f) (March 2017).

[14] *R.R.*, Docket No. 15-0913 (issued March 25, 2016); *Alice J. Tysinger*, 51 ECAB 638 (2000).

explanation on how the diagnosed arthritic condition was causally related to the March 3, 2017 employment injury. The only support Dr. Dosanjh provided for his conclusion was that his opinion was based on his evaluation and history appellant provided. He did not explain how the additional condition of left ankle pan-talar arthritis was due to the accepted employment injury or a natural progression of the accepted sprain of the other ligament and tibiofibular ligament of the left ankle and subluxation of the left ankle joint. Dr. Dosanjh failed to provide sufficient medical rationale explaining the causal relationship between the diagnosis of pan-talar arthritis and the accepted March 3, 2017 employment injury, and thus, his report is insufficient to establish causal relationship or entitlement to a schedule award.[15]

In accordance with its procedures, OWCP properly routed the case record to its DMA who recommended, in a May 8, 2019 report, that appellant undergo further impairment evaluation by an orthopedic surgeon with access to his complete medical record. He further explained that it was unclear as to why Dr. Dosanjh rated appellant's left lower extremity permanent impairment based on the diagnosis of pan-talar arthritis, which was not supported by objective findings or accepted by OWCP as employment related.

Appellant was then referred to Dr. Jeffcoat for a second opinion. In a June 5, 2019 report, Dr. Jeffcoat found that appellant had zero percent permanent impairment of the left lower extremity under the sixth edition of the A.M.A., *Guides*. He reviewed his history, conducted a physical examination, and provided diagnoses. In calculating impairment for the left ankle, Dr. Jeffcoat selected the accepted diagnoses of sprain of the tibiofibular ligament and sprain of the other ligament of the left ankle, which represented a class 1 impairment with a default value of one percent impairment under Table 16-2 on page 501. He assigned modifiers and applied the net adjustment formula and found a net adjustment of -2 for a permanent impairment rating of zero percent for the left lower extremity.

In a September 15, 2019 addendum report, the DMA reviewed Dr. Jeffcoat's June 5, 2019 report and agreed with his finding that appellant had zero percent permanent impairment of the left lower extremity based on his accepted diagnoses of sprain of the tibiofibular ligament and sprain of the other ligament of the left ankle. He, however, disagreed with Dr. Jeffcoat's finding that the diagnoses warranted a CDX of 1 for a default value of one percent under Table 16-2 on page 502 of the A.M.A., *Guides*. The DMA related that a class 1 impairment required ankle instability and there was no documentation of ankle instability in the medical record. Thus, he advised that the appropriate rating was a class 0 default value, which yielded zero percent permanent impairment of the left lower extremity. Regardless, this disagreement over the appropriate diagnosis is immaterial to final impairment rating because it results in the same rating under both methodologies.

The Board finds that the DMA properly applied the A.M.A., *Guides* and determined that appellant had zero percent left lower extremity permanent impairment.

On appeal counsel contends that an unresolved conflict in medical opinion existed between Dr. Dosanjh and Dr. Jeffcoat with regards to appellant's continuing residuals of the accepted March 3, 2017 employment injury resulting in permanent impairment. As explained above,

[15] *R.R., id.*; *Deborah L. Beatty*, 54 ECAB 340 (2003).

Dr. Dosanjh did not attribute appellant's permanent impairment to his accepted employment-related left ankle injury. There is no evidence of record supporting a finding of permanent impairment due to appellant's accepted ankle condition. It is appellant's burden of proof to establish a permanent impairment of a scheduled member as a result of an employment injury.[16] He did not submit such evidence and thus, he failed to meet his burden of proof.[17]

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.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish permanent impairment of his left lower extremity, warranting a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the September 18, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 17, 2020
Washington, DC

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

Christopher J. Godfrey, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[16] *Supra* note 6.

[17] *T.H.*, *supra* note 6; *D.S.*, Docket No. 18-1140 (issued January 29, 2019).