# United States Department of Labor
# Employees' Compensation Appeals Board

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| **D.C., Appellant** | ) | |
| **and** | ) | **Docket No. 21-0954** |
| | ) | **Issued: October 11, 2022** |
| **U.S. POSTAL SERVICE, POST OFFICE, Cincinnati, OH, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
JAMES D. McGINLEY, Alternate Judge

### *JURISDICTION*

On June 8, 2021 appellant, through counsel, filed a timely appeal from a May 7, 2021 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.

[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 her burden of proof to establish greater than 7 percent permanent impairment of the right lower extremity and 16 percent permanent impairment of the left lower extremity for which she previously received schedule award compensation.

## ***FACTUAL HISTORY***

On May 8, 2012 appellant, then a 50-year-old window clerk, filed an occupational disease claim (Form CA-2) alleging that she developed neuropathy and blisters on her feet from years of standing on concrete floors for 98 to 100 percent of her workday. She noted that she first became aware of her condition on October 1, 2006 and realized that its relation to her federal employment on April 18, 2012. On the reverse side of the claim form the employing establishment noted that appellant stopped work on February 9, 2012. OWCP accepted the claim for bilateral hallux valgus and subsequently expanded the acceptance of the claim to include open wound of right lesser toe, complete traumatic amputation of one right toe, closed fracture of left foot metatarsal bone, left foot stress fracture, other complications due to other internal orthopedic device, implant and graft, left, chronic osteomyelitis of the left ankle and foot, and open wound of the left foot unspecified toe(s). Appellant returned to modified work on December 1, 2014.

On February 11, 2012 appellant underwent a left foot ulcer debridement. On February 17, 2012 she underwent a left foot bunionectomy. On October 31, 2012 appellant underwent a removal of hardware, left foot, and excision of nonunion with revisional surgery with repair of the first metatarsal fracture with internal fixation. On January 18, 2013 she underwent an excision retained deep orthotic hardware and an excision of osteomyelitis, and application of tissue expander and skin tensioning device. On July 17, 2013 appellant had a fusion of the first metatarsophalangeal joint of the left foot, a bone graft with repair of metatarsal nonunion of the left foot, excision of a bone spur of the left foot, and external fixation of the left foot. On September 18, 2013 she underwent excision of open wound with advancement tissue skin flap left foot, incision and drainage of the bone of the left foot, and debridement with pulse lavage. On June 10, 2014 appellant underwent an exostectomy second toe middle phalanx and distal phalanx of the left foot and removal of internal hardware of the left foot.

On December 15, 2014 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On September 22, 2015 counsel for appellant submitted a permanent impairment rating from Dr. Martin Fritzhand, a Board-certified urologist.

In report dated September 10, 2015, Dr. Fritzhand noted appellant's history of injury and medical treatment. He related her physical examination findings and provided a permanent impairment rating. Dr. Fritzhand noted that, for the diagnoses of left hallux valgus and arthrodesis of the left second toe, he used Table 16-2, Foot and Ankle Regional Grid, on page 502 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[3] and found that appellant had 18 percent permanent impairment of the left lower

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

extremity. Regarding her left ankle, he chose the diagnosis of tendon strain and determined that she had seven percent permanent impairment of the left lower extremity. For the diagnosis of right hallux valgus, Dr. Fritzhand determined that appellant had two percent permanent partial impairment of the right lower extremity.

On November 6, 2015 appellant underwent an amputation from the second long toe on the right foot.[4]

On May 27, 2016 OWCP forwarded Dr. Fritzhand's report, the medical record, and a statement of accepted facts to Dr. David Krohn, a Board-certified internist serving as an OWCP district medical adviser (DMA).

On June 21, 2016 Dr. Krohn, the DMA, reviewed Dr. Fritzhand's report and concluded that appellant had 25 percent permanent impairment of the left lower extremity and 2 percent impairment of the right lower extremity.

By decision dated October 4, 2016, OWCP granted appellant a schedule award for 25 percent permanent impairment of the left lower extremity.[5]

On June 13, 2018 appellant filed a claim for compensation (Form CA-7) for an increased schedule award.

In a July 25, 2018 report, Dr. Fritzhand applied Table 16-2, page 502, of the A.M.A., *Guides*, Foot and Ankle Regional Grid, to the diagnoses of arthrodesis of the great toes and minor toes of the left foot. He related that appellant's class of diagnosis (CDX) was a class 2. After applying the grade modifiers, Dr. Fritzhand determined that she sustained 18 percent permanent impairment of the left lower extremity. For the left ankle, he used Table 16-22, page 549, Ankle Motion Impairments, and found that appellant's loss of range of motion (ROM) plantar flexion and dorsiflexion of mild severity, resulted in 14 percent left lower extremity permanent impairment. Dr. Fritzhand rated appellant's ROM of the left hind foot and found that her mild inversion and eversion resulted in a four percent left lower extremity permanent impairment. Using the Combined Values Chart, page 602, and Tables 16-7 and 16-25, pages 517 and 550, he determined that she had a final rating of 34 percent permanent impairment of the left lower extremity.

For the right lower extremity, Dr. Fritzhand used Table 16-16, page 542, for amputation of the lesser toes, finding a CDX 1 impairment of eight percent. He also applied Table 16-19, page 549, greater toe impairments, finding five percent impairment due to hallux valgus and moderate impairment secondary to loss of metacarpophalangeal extension and a second percent lower

[4] Appellant has a prior claim under OWCP File No. xxxxxx324 alleging that on August 21, 2012 that she fell on both knees while in the performance of duty. She also has an occupational disease claim under OWCP File No. xxxxxx105 alleging arthritis from prolonged standing and walking. These claims have been combined with the present claim, with OWCP File No. xxxxxx621 serving as the master file.

[5] Regarding the right lower extremity, OWCP explained that appellant had an amputation of the second long toe of the right foot on November 6, 2015; therefore, it was unknown if she had reached maximum medical improvement (MMI). OWCP advised her that a development letter had been sent on September 7, 2016.

extremity impairment due to loss of flexion. Using the Combined Values Chart, Dr. Fritzhand determined that appellant had a final rating of 14 percent permanent impairment of the right lower extremity.

On September 4, 2018 OWCP referred Dr. Fritzhand's report to Dr. Ari Kaz, a Board-certified orthopedic surgeon serving as a DMA, for review of the permanent impairment calculations.

By report dated September 30, 2018, Dr. Kaz, using the diagnosis-based impairment (DBI) method, determined that a diagnosis of fusion of left great toe yielded 17 percent left lower extremity impairment. He also found that using the ROM methodology yielded 31 percent left lower extremity impairment. Dr. Kaz noted that ROM was not to be combined with a DBI. He explained that the current rating superseded the prior 25 percent left lower extremity rating, because in that rating the ROM and DBI methods were inappropriately combined. Dr. Kaz indicated that MMI was reached on July 25, 2018.

By letter dated October 31, 2018, OWCP provided Dr. Fritzhand with the DMA's report and requested a supplemental report addressing the deficiencies.

In a November 29, 2018 report, Dr. Fritzhand disagreed with Dr. Kaz and explained that he had addressed grade modifiers for physical examination and clinical studies and that he disagreed that the ROM and DBI ratings could not be combined. He advised that each value was ''stand-alone'' and that they were always combined using the Combined Values Chart.

On December 13, 2018 Dr. Fritzhand's report was sent to the DMA, Dr. Kaz, for review.

In a December 19, 2018 report, the DMA noted that Dr. Fritzhand's report reiterated that appellant had multiple accepted conditions and that this was the rationale for combining the impairment ratings. As Dr. Fritzhand was a urologist, the DMA recommended an impairment rating by a Board-certified orthopedic surgeon with fellowship training in foot and ankle.

On January 22, 2019 OWCP referred appellant to Dr. Ralph Rohner, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation. In a February 12, 2019 report, Dr. Rohner related appellant's physical examination findings. Regarding the right lower extremity, he provided an impairment rating based on a hallux valgus deformity status postamputation of the second and third digits. Dr. Rohner utilized Tables 16-2, page 508, Table 16-1, page 516, and Table 16-8, page 519, of the A.M.A., *Guides* and, after applying the grade modifiers, determined that appellant had two percent permanent impairment for each right foot second and third toe. He concluded that she had four percent permanent partial impairment of the right lower extremity. For the left lower extremity, Dr. Rohner determined that the diagnoses of left hallux valgus deformity, fracture metatarsal bone left foot, nonunion of fracture left foot, other complications due to other internal orthopedic device, implant and graft, left foot, and chronic osteomyelitis, left ankle/foot, were rated for fusion of the great and minor toes using Table 16-2, page 508, Foot and Ankle Regional Grid, and applying grade modifiers, resulted in a final left lower extremity permanent impairment of 17 percent.

In an April 14, 2019 report, Dr. Kaz, the DMA, concurred with Dr. Rohner's impairment rating. The DMA also explained that, as there was a clear diagnosis of left first and lesser toe

fusion and clear amputation of the right second and third toes, this case had a clearly defined diagnosis impairment.

On May 14, 2109 OWCP requested that Dr. Rohner provide further clarification regarding the calculations for the right lower extremity and the date of appellant's MMI.

In an August 5, 2019 addendum, Dr. Rohner noted that his assessment was based on the DBI method and the amputation diagnosis. He explained that the ROM method was used as a physical examination adjustment factor and was only used to determine actual impairment values when it was otherwise not possible to define impairments. Dr. Rohner explained that, in this case, there was a clearly defined diagnosis of amputation of right second and third toes. He opined that "[t]herefore, ROM method is not a preferred method."

In a September 27, 2019 report, DMA Dr. Kaz, concurred with Dr. Rohner's impairment rating. He also related that appellant had reached MMI on July 25, 2018, the date of Dr. Fritzhand's evaluation.

By decision dated October 11, 2019, OWCP denied appellant's claim for an additional left lower extremity schedule award. It found that the final impairment rating for the left lower extremity was 17 percent permanent impairment and for the right was 4 percent permanent impairment. OWCP explained that, as 25 percent permanent impairment previously had been awarded for the left lower extremity, no additional impairment award was due.

By decision dated October 17, 2019, OWCP granted appellant a schedule award for four percent permanent impairment of the right lower extremity.

On October 23, 2019 appellant, through counsel, requested a hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated November 27, 2019, OWCP set aside the October 11, 2019 decision and remanded the case for further development. It requested that the DMA review FECA Bulletin No. 17-06 and determine whether the ROM methodology could be used as an alternative rating method.

On December 9, 2019 OWCP referred appellant to Dr. Rohner for a second opinion examination.

In a memorandum dated January 8, 2020, OWCP noted that counsel had related when appellant appeared for her appointment on January 7, 2020 Dr. Rohner informed her that he had not been provided with any information, took some measurements, and sent her home. In a January 7, 2020 report, Dr. Rohner related that her date of MMI was February 12, 2019 and he indicated that, based on his examination, his impairment rating remained the same at 17 percent permanent impairment of the left lower extremity and 4 percent permeant impairment of the right lower extremity.

On January 11, 2020 Dr. Michael Katz, a Board-certified orthopedic surgeon, serving as the DMA, reviewed Dr. Rohner's February 12, 2019 report. He explained that appellant had a seven percent permanent impairment of her right lower extremity. Dr. Katz related that his impairment rating was higher for the right lower extremity, as it was his opinion that the

appropriate rating for the second and third toes was based on Table 16-16, page 542, Amputation, rather than Table 16-2, page 501, Foot and Ankle Regional Grid, as employed by Dr. Rohner. He concluded that appellant had four percent permanent impairment due to amputation of the minor toe at the second joint, and three percent permanent impairment due to amputation of the minor toe at the third joint. Dr. Katz further explained that, for the left lower extremity, his determination was lower at 16 percent because Dr. Rohner determined the net adjustment incorrectly, as he subtracted "1" for CDX of impairment from each modifier instead of "2" as this was a class 2 impairment. He noted that, since the present impairment of 16 percent for the left lower extremity did not exceed the prior award of 25 percent, there was no additional award due for the left lower extremity. Dr. Katz advised that the permanent impairment of the right lower extremity impairment was seven percent and that the net additional award due was three percent, determined by subtracting the overlapping, prior award of four percent from the present impairment of seven percent.

By decision dated January 29, 2020, OWCP granted three percent additional permanent impairment for the right lower extremity. It denied an additional schedule award for permanent impairment of the left lower extremity. OWCP thereafter received a report dated January 7, 2020, wherein Dr. Rohner reiterated his determination that appellant had 4 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity. For the right lower extremity, Dr. Rohner used the diagnosis of right hallus valgus deformity status postamputation of the second and third toes. He utilized Table 16-2, page 508, Foot and Ankle Regional Grid, CDX 1 for the right foot second toe, and found a grade modifier for functional history (GMFH) of 2, a grade modifier for physical examination (GMPE) of 2, and a grade modifier for clinical studies (GMCS) of 0. After applying the grade modifiers, Dr. Rohner determined that appellant had two percent impairment for the second toe and two percent impairment of the third total for a final permanent impairment of the right lower extremity of four percent. For the left lower extremity, he noted the diagnoses of left hallus valgus deformity, fracture metatarsal bone, left foot, nonunion of fracture left foot, other complications due to other internal orthopedic device, implant and graft, left foot, and chronic osteomyelitis, left ankle/foot. Dr. Rohner utilized the diagnosis of fusion of great and minor toes and applied Table 16-2, page 508. He placed appellant's impairment in a CDX of 2 and related that she had a GMFH of 2, a GMPE of 2, and a GMCS of 0, after applying the grade modifiers and subtracting a CDX of 1, determined that she had 17 percent permanent impairment of the left lower extremity.

On February 4, 2020 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review hearing representative, which was held on June 5, 2020.

On March 4, 2020 OWCP forwarded Dr. Rohner's January 7, 2020 impairment report to the DMA, Dr. Katz, for review.

In a March 11, 2020 report, Dr. Katz again explained that the impairment rating for the left lower extremity should be 16 percent not 17 percent, as Dr. Rohner incorrectly subtracted CDX 1 instead of 2 when applying the net adjustment formulas.

On August 7, 2020 OWCP set aside and remanded the January 29, 2020 decision to obtain an explanation from Dr. Rohner of any disagreement he had with Dr. Katz' assessment and an

opinion as to whether the A.M.A., *Guides* would allow rating appellant's conditions using the ROM method.

In a November 3, 2020 addendum, Dr. Rohner agreed with Dr. Katz' report and noted that the net additional award was three percent for the right lower extremity, after subtracting the prior award of four percent from the current impairment rating of seven percent. He explained that there was no additional impairment for the left lower extremity and the final permanent impairment of the left lower extremity was 16 percent which was below the 25 percent previously awarded.

In a November 24, 2020 report, Dr. Katz noted that Dr. Rohner agreed with his determinations and no further actions or modifications of his recommendations were necessary. He explained that ROM was used primarily as a factor in the adjustment grid and was used as a stand-alone rating when other grids referred to this section or no other diagnosis based section was applicable for rating of a condition in the regional grids, but had a significant functional loss. Dr. Katz concluded that this criteria did not justify the use of ROM rating for appellant's left lower extremity.

By decision dated December 1, 2020, OWCP denied appellant's claim for an additional schedule award for the left lower extremity. It explained that both, the second opinion physician, Dr. Rohner and the DMA, Dr. Katz, concurred as to the final rating of 16 percent permanent impairment of the left lower extremity.

On December 11, 2020 appellant, through counsel, requested a telephonic hearing, which was held on March 10, 2021.

By decision dated December 31, 2020, OWCP granted appellant an additional three percent permanent impairment of the right lower extremity, for a final impairment rating of seven percent, as four percent had been previously paid. It also noted that she had already received 25 percent permanent impairment award for the left lower extremity and no further award was warranted.

On January 25, 2021 appellant, through counsel, requested a telephonic hearing, which was held on March 10, 2021. Counsel argued that a schedule award should be rescinded, if it was later determined that it was incorrect, to afford appellant due process.

By decision dated May 7, 2021, an OWCP hearing representative affirmed the December 1 and 31, 2020 decisions.

## ***LEGAL PRECEDENT***

The schedule award provisions of FECA[6] and its implementing federal regulations[7] 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,

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants and the Board has concurred in such adoption.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

Chapter 16 of the sixth edition of the A.M.A., *Guides*, pertaining to the lower extremities, provides that diagnosis-based impairment is the primary method of calculation for the lower limb and that most impairments are based on the diagnosis-based impairment where impairment class is determined by the diagnosis and specific criteria as adjusted by the grade modifiers for GMFH, GMPE, and GMCS. It further provides that alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and ROM. ROM is primarily used as a physical examination adjustment factor.[10] The A.M.A., *Guides*, however, also explain that some of the diagnosis-based grids refer to the ROM section when that is the most appropriate mechanism for grading the impairment. This section is to be used as a stand-alone rating when other grids refer to this section or no other diagnosis-based sections of the chapter are applicable for impairment rating of a condition.[11]

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. After the CDX is determined from the applicable table in the A.M.A., *Guides* (including identification of a default grade value), the net adjustment formula is applied using the 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]

## ***ANALYSIS***

The Board finds that appellant has not met her burden of proof to establish greater than 7 percent permanent impairment of her right lower extremity and 16 percent permanent impairment of her left lower extremity for which she previously received schedule award compensation.

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[8] *Id.*; *see S.M.*, Docket No. 20-1667 (issued June 24, 2021); *V.J.*, Docket No. 19-1789 (issued April 8, 2020); *Jacqueline S. Harris*, 54 ECAB 139 (2002).

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

[10] A.M.A., *Guides* (6th ed. 2009) 497, section 16.2.

[11] *Id.* at 543; *see also M.D.*, Docket No. 16-0207 (issued June 3, 2016); *D.F.*, Docket No. 15-0664 (issued January 8, 2016).

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

[13] *Id.* at 23-28.

The A.M.A., *Guides* explain that, while the ROM method is an alternative approach for calculating permanent impairment of the lower extremities, it is to be used primarily as a physical examination factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment.[14]

In a July 25, 2018 report, the treating physician, Dr. Fritzhand, opined that appellant had a final rating of 14 percent permanent impairment of the right lower extremity and 34 percent permanent impairment of the left lower extremity. However, in a December 19, 2018 report, the DMA, Dr. Kaz, reviewed Dr. Fritzhand's report and determined that it incorrectly combined ROM and DBI ratings. As noted, the ROM method is to be used as a stand-alone rating when other grids refer to that method and or no other diagnosis-based sections are applicable for impairment rating of a condition.[15] Dr. Fritzhand failed to explain why the DBI method was not applicable and why he combined DBI and ROM ratings. The Board also notes that the A.M.A., *Guides* explain that in most cases only one diagnosis in each region (*i.e.*, hip, knee, ankle/foot) is to be rated. The examiner is to use the diagnosis with the highest impairment rating in that region that is causally related for the impairment calculation.[16] As Dr. Fritzhand's reports did not comport with OWCP's procedures, they lack probative value.[17]

Both the second opinion physician, Dr. Rohner, a Board-certified orthopedist, and the DMA, Dr. Katz, a Board-certified orthopedic surgeon, concurred in their opinions and explained that the A.M.A., *Guides* do not allow an impairment rating due to loss of ROM for the applicable diagnoses. In an August 5, 2019 addendum to his February 12, 2019 report, Dr. Rohner explained that the ROM method is used as a physical examination adjustment factor and is only used to determine actual impairment values when it was otherwise not possible to define impairments. He explained that, in this case, there was a clearly-defined diagnosis of amputation of right second and third toes. Dr. Rohner opined: "[t]herefore, ROM method is not a preferred method." In a September 27, 2019 report, the DMA, Dr. Katz, concurred with Dr. Rohner's opinion.

In a report dated January 7, 2020, Dr. Rohner reiterated his determination that appellant had 4 percent permanent impairment of the right lower extremity and 17 percent permanent impairment of the left lower extremity. He utilized Table 16-2, page 508, Foot and Ankle Regional Grid, CDX 1 for the right foot second toe, and found a GMFH of 2, a GMPE of 2, and a GMCS of 0. After applying the grade modifiers, determined that appellant had two percent impairment for the second toe and two percent impairment of the third toe for a final permanent impairment of the right lower extremity of four percent. For the left lower extremity, Dr. Rohner utilized the diagnosis of fusion of great and minor toes and applied Table 16-2, page 508. He placed appellant's impairment in a CDX of 2 and related that appellant had a GMFH of 2, a GMPE of 2, a GMCS of 0. After applying the grade modifiers and subtracting a CDX of 1, Dr. Rohner

[14] A.M.A., *Guides* 497; *see also M.S.*, Docket No. 20-0036 (issued February 5, 2021); *N.M.*, Docket No. 19-1925 (issued June 3, 2020); *M.P.*, Docket No. 18-1298 (issued April 12 2019).

[15] *Id.*, at page 497, section 16.2; *see also M.D.*, *supra* note 12; *D.F.*, *supra* note 12.

[16] *Id.*, at page 497.

[17] *See D.K.*, Docket No. 21-0303 (issued July 8, 2021); *see D.L.*, Docket No. 20-0059 (issued July 8, 2020); *see M.M.*, Docket No. 17-0197 (issued May 1, 2018).

determined that appellant had 17 percent permanent impairment of the left lower extremity. In a March 11, 2020 report, Dr. Katz explained that the impairment rating for the left lower extremity should be 16 percent, not 17 percent as Dr. Rohner incorrectly subtracted 1 instead of the CDX value of 2 when applying the net adjustment formula. In a November 3, 2020 addendum, Dr. Rohner agreed with Dr. Katz' findings.

The Board finds that there is no medical evidence of record supporting greater impairment than the 16 percent award for the left lower extremity, for which she previously received a schedule award.

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 permanent impairment.

## ***CONCLUSION***

The Board finds that appellant has not met her burden of proof to establish greater than seven permanent impairment of the right lower extremity and 16 percent permanent impairment of the left lower extremity, for which she previously received schedule award compensation.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the May 7, 2021 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 11, 2022
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board