U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SHERYL S. MITCHELL and U.S. POSTAL SERVICE,
POST OFFICE, Kansas City, MO

Docket No. 98-1972; Submitted on the Record;
Issued October 5, 1999

DECISION and ORDER

Before MICHAEL E. GROOM, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issues are: (1) whether appellant has established that she sustained greater than a five percent impairment of the left lower extremity, for which she received a schedule award; and (2) whether the Office of Workers' Compensation Programs abused its discretion by refusing to reopen appellant's case for a merit review.

The Office accepted that on December 21, 1992 appellant, then a 38-year-old clerk, sustained a left knee sprain, left medial meniscus tear later requiring arthroscopic repair and a left ankle sprain, when she tripped and fell over a tray.[1] Appellant was intermittently absent from work from the date of injury through August 1996 and received benefits on the daily compensation rolls. She claimed a schedule award on January 2, 1996.[2]

Appellant was treated initially by Dr. Gary L. Porubsky, an orthopedic surgeon, for left knee and ankle sprains. In an October 6, 1993 report, Dr. Don Miskew, a consultant to the employing establishment, recommended limited duty. In reports from September 2, 1993 through June 22, 1994, Dr. Robert T. Littlejohn, an attending orthopedic surgeon, recommended restricted, sedentary duty. In an August 12, 1994 report, Dr. George H. Woy, an attending

[1] The Office noted concurrent, nonoccupational conditions of morbid obesity, hypertension, right knee surgery, gallbladder surgery in 1993, degenerative disc disease and degenerative disease of the right knee.

[2] Appellant initially claimed a schedule award on April 5, 1995. The Office advised appellant that, as she was contemplating recommended arthroscopic surgery and had not reached maximum medical improvement, her schedule award claim was premature.

Board-certified orthopedic surgeon, recommended left knee arthroscopy to repair a torn left medial meniscus,[3] and prescribed continued limited duty.[4]

Beginning on April 27, 1995 appellant was treated by Dr. Ronald Zipper, an attending osteopath and Board-certified orthopedic surgeon. Dr. Zipper performed diagnostic arthroscopy of the left knee with medial meniscoplasty on July 18, 1996. He diagnosed "[d]egenerative arthritis with torn medial meniscus … with pathologic medial plica synovialis." Dr. Zipper submitted periodic progress notes strongly recommending a weight loss program. In an August 22, 1996 report, he noted that on August 21, 1996 while at work, appellant's chair collapsed due to loose screws, causing her to fall, "striking the left knee and the left shin." Dr. Zipper stated an impression of "[c]ontusion left knee and lower extremity," held her off work through August 29, 1996 and prescribed medication and physical therapy. In a November 14, 1996 report, he noted appellant's complaints of pain with occasional swelling "particularly with prolonged weight bearing." Dr. Zipper opined that appellant had reached maximum medical improvement.

In a July 23, 1997 report, Dr. George Varghese, a Board-certified physiatrist of professorial rank, reviewed the medical record and provided findings on his July 18, 1997 examination. Dr. Varghese related appellant's complaints of pain with occasional swelling when standing or walking for prolonged periods, that climbing stairs was difficult and that she took ibuprofen to relieve her symptoms. He noted that appellant was working full-time modified duty. Dr. Varghese observed that appellant was morbidly obese and had been so prior to the injury. He found "tenderness along the medial side of the knee and also in the patella tendon," crepitus without ligament instability, normal menisci, no inflammatory changes, a range of motion from 0 to 115 degrees, normal strength reflexes and no sensory deficit. Referring to the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter, the A.M.A., *Guides*), Dr. Varghese found no limitation of range of motion according to Table 41, page 78,[5] normal strength and a 70 percent rating for pain according to Table 20, page 151.[6] "Since it is in the femoral nerve distribution, as per Table 68 [page 89], this amounts to a 5 percent rating for the lower extremity."[7] He also noted a 2 percent impairment for internal

[3] An August 1, 1994 magnetic resonance imaging (MRI) scan of the left knee showed "a tear of the posterior horn of the medial meniscus."

[4] On January 31, 1995 the employing establishment offered appellant a position as a modified general clerk, with sedentary duties within her medical restrictions. Appellant accepted the position on February 6, 1995.

[5] Table 41, page 78, entitled "Knee Impairment," specifies that a range of knee motion from 4 to 110 degrees would be considered as unimpaired. Appellant's range of motion exceeds this parameter.

[6] Table 21, page 151, entitled "Classification and Procedure for Determining Impairment Due to Pain or Sensory Deficit Resulting from Peripheral Nerve Disorders," describes a Class 4 sensory impairment of 61 to 80 percent as "[d]ecreased sensation with or without pain or minor causalgia that may prevent activity."

[7] Table 68, page 89, entitled "Impairment from Nerve Deficits," provides that dysesthesia of the lateral femoral cutaneous nerve equals a 7 percent impairment of the lower extremity.

derangement due to partial medial meniscectomy according to Table 64, page 85,[8] with a 4 millimeter (mm) joint space on x-ray which was not ratable according to Table 62, page 83.[9] Dr. Varghese noted that as the Office's procedures did not permit utilizing both Table 64 and Table 20 in determining the percentage of impairment, he would rely on Table 20 as it provided the greater percentage of impairment. He concluded, therefore, that appellant had a five percent permanent impairment of the left lower extremity.

In an August 25, 1997 report, Dr. Daniel D. Zimmerman, an Office medical adviser, noted reviewing Dr. Varghese's report and the medical record and stated a date of maximum medical improvement of July 18, 1997. Referring to the fourth edition of the A.M.A., *Guides*, Dr. Zimmerman also calculated a 5 percent permanent impairment of the left lower extremity, based on a "grade of 70 percent for pain in the distribution of the femoral nerve, from Table 68, p. 89. The maximum percent impairment due to dysesthesia, which is pain, for the lower extremity is 7 percent. Using the calculation parameter set forth in Table 20 … 70 percent times 7 percent equals 4.9 percent," which was then rounded up to 5 percent.

By decision dated September 16, 1997, the Office granted appellant a schedule award for a 5 percent permanent impairment of the left lower extremity, equivalent to 14.40 weeks of compensation at the 75 percent rate, to be paid from July 11 to October 19, 1997.

In a March 3, 1998 letter, appellant requested reconsideration of the Office's September 16, 1997 decision, and requested that Dr. Zipper be authorized to perform a schedule award rating.[10]

By decision dated March 5, 1998, the Office denied appellant's request for reconsideration on the grounds that her March 2, 1998 letter, the only evidence submitted in support thereof, did not raise "substantive legal questions" or include "new and relevant evidence."

Regarding the first issue, the Board finds that appellant has not established that she sustained greater than a five percent impairment of the left lower extremity, for which she received a schedule award.

Section 8107 of the Federal Employees' Compensation Act[11] and section 10.304 of the implementing regulations[12] provide that schedule awards are payable for permanent impairment of specified body members, functions or organs, but do not specify how to determine the

[8] Table 64, page 85, entitled "Impairment Estimates for Certain Lower Extremity Impairments," provides that a partial medial meniscectomy is equivalent to a 2 percent impairment of the lower extremity.

[9] Table 62, page 83, entitled "Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals," provides that a 4 mm interval for the knee is considered normal and not indicative of an impairment.

[10] In a February 20, 1998 telephone memorandum, an Office claims examiner noted that appellant's visit to Dr. Zipper for a schedule award evaluation would not be covered as appellant was already given a schedule award. In a March 2, 1998 telephone memorandum, an Office claims examiner noted instructing appellant "to send in a letter explaining why she wanted to have another [schedule award] evaluation" and that perhaps such evaluation would be covered by the Office.

[11] 5 U.S.C. § 8107.

[12] 20 C.F.R. § 10.304.

percentage of impairment. Therefore, the Office has adopted the A.M.A., *Guides*, as a standard for determining the percentage of impairment and the Board has concurred in such adoptions.[13] The A.M.A., *Guides* lists specific procedures for determining impairment of affected body parts. A physician must first determine the effect of the medical condition on life activities and determine the date of maximum medical improvement.[14] Using the appropriate tables and grading schemes of the A.M.A., *Guides*, the physician then determines the percentage of any impairment due to pain, loss of sensation, motor deficits and other functional losses. Proper use of the A.M.A., *Guides*, ensures consistent results and equal justice for all claimants.

In this case, in a July 23, 1997 report, Dr. Varghese, a Board-certified physiatrist of professorial rank, reviewed the medical record and provided detailed findings on examination. Dr. Varghese then correlated these findings to the appropriate tables and grading schemes of the fourth edition of the A.M.A., *Guides*, and determined that appellant had a five percent permanent impairment of the left lower extremity due to pain in the femoral nerve distribution. Dr. Zimmerman, an Office medical adviser, agreed with Dr. Varghese's calculations in an August 25, 1997 report.

The Board notes that Dr. Ronald Zipper, an attending osteopath and Board-certified orthopedic surgeon, did not provide medical evidence directly contradicting Dr. Varghese's calculations, or indicate that appellant had a ratable impairment other than pain.[15] Appellant's other physicians also did not provide such evidence.

Regarding the second issue, the Board finds that the Office did not abuse its discretion by refusing to reopen appellant's case for a merit review.

[13] *Leisa D. Vassar*, 40 ECAB 1287, 1290 (1989); *Francis John Kilcoyne*, 38 ECAB 168, 170 (1986).

[14] A.M.A., *Guides*, 4, 5.

[15] The Board notes that on appeal, appellant submitted new medical evidence, a May 7, 1998 report from Dr. Zipper. However, the Board may not consider evidence for the first time on appeal that was not before the Office at the time the final decision was issued, in this case March 5, 1998. Therefore, the Board will not consider Dr. Zipper's May 7, 1998 report. 20 C.F.R. § 501.(2)(c).

To require the Office to open a case for reconsideration, section 10.138(b)(1) of Title 20 of the Code of Federal Regulations provides in relevant part that a claimant may obtain review of the merits of the claim by written request to the Office identifying the decision and the specific issue(s) within the decision, which the claimant wishes the Office to reconsider and the reasons why the decision should be changed and by:

"(i) Showing that the Office erroneously applied or interpreted a point of law, or

"(ii) Advancing a point of law or fact not previously considered by the Office, or

"(iii) Submitting relevant and pertinent evidence not previously considered by the Office."[16]

Section 10.328(b)(2) provides that any application for review of the merits of the claim, which does not meet at least one of the requirements listed in paragraphs (b)(1)(i) through (iii) of this section will be denied by the Office without review of the merits of the claim.[17]

Appellant's March 3, 1998 letter, the only evidence she submitted in support of her March 3, 1998 request for reconsideration, merely requested that the Office authorize Dr. Zipper to perform a schedule award rating. Appellant did not allege or submit new evidence demonstrating that the Office committed legal error, or that the schedule award calculations performed by Drs. Varghese and Zimmerman were incorrect or otherwise deficient. Thus, the Office was correct in finding, in its March 5, 1998 decision, that the March 3, 1998 letter was insufficient to warrant reopening appellant's case for a merit review.

The decisions of the Office of Workers' Compensation Programs dated March 5, 1998 and September 16, 1997 are hereby affirmed.

Dated, Washington, D.C.
October 5, 1999

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member

[16] 20 C.F.R. § 10.138(b)(1).

[17] 20 C.F.R. § 10.138(b)(2).