U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL A. WELSH and DEPARTMENT OF THE NAVY, NAVAL AIR WARFARE CENTER WEAPONS DIVISION, China Lake, CA

Docket No. 01-1211; Submitted on the Record;
Issued February 6, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant has more than a 15 percent impairment of the left lower extremity, for which he received a schedule award; and (2) whether the Office of Workers' Compensation Programs abused its discretion in denying appellant's request for reconsideration.

On July 28, 1998 appellant, then a 42-year-old facility inspection specialist, filed a claim for traumatic injury alleging that on July 16, 1998 he sustained an injury to his left knee while in the performance of duty.

In a report dated August 12, 1998, Dr. Marshall P. Fisher, Board-certified in radiology, read a left knee magnetic resonance imaging (MRI) scan taken that day as revealing an oblique tear of the posterior horn in the medial meniscus and a small joint effusion.

On September 16, 1998 the Office accepted left knee strain and subsequently authorized several surgical procedures including left knee arthroscopy, chondroplasty, shaving of the medial femoral condyle and repair of the femoral notch. On May 13, 1999 the Office authorized a series of injectable medications designed to relive symptoms of appellant's pain.[1]

In a medical report dated October 24, 1998, Dr. Smith stated that he had performed left knee arthroscopy, chondroplasty, shaving of the femoral condyle and repair of the femoral notch.

Appellant returned to work on November 16, 1998 after undergoing surgery on October 24, 1998.

[1] Dr. Thomas L. Smith, appellant's treating orthopedic surgeon, stated in an April 14, 1999 report that appellant will need total knee arthroplasty "due to the degenerative breakdown of his articular cartilage." He then added that there was a new injectable medication available "in relieving symptoms of this progressive process."

On July 21, 1999 appellant filed a claim for a schedule award. On July 29, 1999 the Office requested Dr. Smith to provide an impairment rating for appellant using the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993).

On August 11, 1999 Dr. Smith submitted a report with range of motion findings. He stated that appellant could not crawl, squat or kneel, that he was in pain when he climbed and that his condition "impairs usual job duties." Dr. Smith noted 2 centimeters of atrophy of the left quadriceps muscle over the right, and weakness which caused some problems climbing. He noted appellant's subjective complaints of pain at 7 to 8 all the time, 10 at worst, aches at night and while sitting, diffuse not local, no sensory loss and full range of motion, bilaterally. Flexion and extension were normal with no ankylosis noted. Regarding post-traumatic irregularity, Dr. Smith stated that appellant had "significant articular cartilage breakdown of medical femoral condyle and intercondylar notch. Not to bone on condyle. Full thickness in notch." Loss of function due to additional factors were noted as "pain/weakness." He stated that the date of maximum medical improvement was August 11, 1999.

The Office referred appellant's medical records and a September 10, 1999 statement of accepted facts to Dr. Arthur S. Harris, an Office medical consultant Board-certified in orthopedic surgery, for a determination of appellant's left lower extremity impairment.

In a report dated September 22, 1999, Dr. Harris stated that he had reviewed appellant's medical records and determined that he had residual mild to moderate degenerative joint disease of the knee. Relying on the A.M.A., *Guides*, he used the arthritis impairment table to arrive at a 15 percent impairment of the left lower extremity as a result of post-traumatic arthritis in the left knee, pain, crepitation, thigh atrophy and weakness."[2]

On November 23, 1999 the Office granted a schedule award for 15 percent impairment of his left leg. The award for appellant's left leg covered a period of 43.20 weeks, beginning on August 11, 1999 and continuing through June 8, 2000.

By undated letter received on March 20, 2000, appellant requested reconsideration. In support of his request, he submitted a November 30, 1999 report from Dr. Smith who stated that appellant had a greater than 15 percent left leg impairment and referred to his July 1999 report regarding appellant's pain and current disabilities.[3]

In a medical report dated December 28, 1999 and received by the Office on March 20, 2000, Dr. Smith stated that "[X]-rays taken today show no narrowing of the joint space at this time but I suspect he will have more x-ray evidence of arthritis in a year or two."

In a report dated March 24, 2000, Dr. Leonard Simpson, an Office medical adviser and a Board-certified orthopedic surgeon, reviewed the medical evidence and found appellant as having no more than a 15 percent impairment of the left lower extremity. Dr. Simpson stated

[2] A.M.A., *Guides*, 83, Table 62, arthritis impairments.

[3] Dr. Smith's July 14, 1999 report had been received by the Office on August 3, 1999, prior to the November 23, 1999 schedule award.

that there was no x-ray evidence of a significant joint-line narrowing that would indicate any impairment greater than the 15 percent recommended by Dr. Harris in the September 1999 report.

By decision dated April 4, 2000, the Office denied modification of the November 23, 1999 schedule award.

On April 25, 2000 appellant requested reconsideration and submitted an April 11, 2000 report from Dr. Smith, who stated that appellant has "severe, progressive degenerative arthritis" of the left knee, that his pain is a constant 7 to 8 based on a 1 to 10 scale, and that his activity level is decreasing steadily due to pain. He noted "articular cartilage breakdown in the intercondylar notch and medial compartment of [the left] knee as seen on arthroscopy in October 1998. There is no doubt that these changes have progressed and are causing [appellant] a significant amount of pain and loss of use." Dr. Smith updated his August 11, 1999 impairment evaluation on that day by adding that appellant now had 3 and one-half centimeters of atrophy of left versus right quadriceps, that his active left knee range of motion was decreased on left to about 80 degrees flexion, with full bilateral range of motion when passive and that loss of function due to additional factors was changed to include "active range of motion, quads atrophy 2 degrees, disuse."

In a report dated May 8, 2000, Dr. Harris again reviewed appellant's records and determined that he had no more than a 15 percent impairment to the left lower extremity and that his date of maximum medical improvement was April 11, 2000. He noted that x-ray reports as late as December 1999 "do not demonstrate any joint space narrowing," and that the prior 15 percent impairment rating took into account "pain which interferes with function," and appellant's limitation of motion and quadriceps atrophy.

By decision dated May 18, 2000, the Office denied modification of its prior decisions.

On June 15, 2000 the Office referred appellant to Dr. William Boeck, Jr., a Board-certified orthopedic surgeon, for a second opinion evaluation regarding whether appellant sustained a right knee injury as a consequence of his work-related injury and, if so, whether surgical intervention was warranted.

In a report dated August 1, 2000, Dr. Boeck stated that the diagnosis of chondromalacia in the right knee was established by the presence of patellofemoral crepitus and symptoms of right knee pain, aggravated by prolonged standing and walking, the use of stairs and similar activities. He recommended against right knee surgery "until there has been demonstrated failure of all manner of conservative treatment of the knee problem."

On August 29, 2000 the Office expanded appellant's accepted claims to include right knee, chondromalacia.

On September 7, 2000 the Office authorized Dr. John J. Kayvanfar as his treating physician, but declined authorization for right knee surgery.

By letters dated September 14 and 18, 2000, appellant requested reconsideration and submitted an October 13, 2000 report from Dr. Kayvanfar who stated that he treated appellant on

February 15, 2000 for ongoing left knee pain based on a right knee injury which has been giving him trouble, with no relief in spite of arthroscopic surgery, and this has caused him to favor the left knee, which has not helped either. Upon examination, he noted that appellant's right knee demonstrated tenderness over the patellofemoral joint line, medially as well as laterally. The left knee demonstrated minimal muscle atrophy, with normal range of motion, no instability was noted. Dr. Kayvanfar diagnosed right and left knee lateral patella compression syndrome and plica syndrome. He noted that appellant had been treated by Dr. Smith for both knees who performed right knee surgery. Dr. Kayvanfar noted that Dr. Smith reviewed x-rays and a magnetic resonance imaging (MRI) scan and determined that appellant had left knee torn cartilage, and, in spite of conservative treatment, "has not improved much." He recommended left knee surgery.

By decision dated February 16, 2001, the Office denied appellant's request for reconsideration on the grounds that the evidence submitted in support of the request was immaterial and insufficient to warrant review of the prior decision.

The Board finds that appellant has not established that he has more than a 15 percent permanent impairment of the left lower extremity, for which he received a schedule award;

Section 8107 of the Federal Employees' Compensation Act[4] 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. The Act, 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 Office has adopted the A.M.A., *Guides* (4th ed. 1993) as an appropriate standard for evaluating schedule losses and the Board has concurred in such adoption.[5]

Dr. Harris, in his September 22, 1999 and May 8, 2000 reports, properly relied on Dr. Smith's post-operative reports that appellant was symptomatic with pain in his left knee which interfered with function. He noted that Dr. Smith found limited active range of motion findings of 80 degree flexion due to pain and 3 and one half centimeters of atrophy of the left thigh. Dr. Harris also noted that the record did not include radiographic findings of degenerative arthritis in his knees. He determined that appellant had post-traumatic arthritis of the left knee which is consistent with mild to moderate degrees joint disease of the knee resulting in a 15 percent impairment of the left lower extremity based on the A.M.A., *Guides*.[6]

Accordingly, the Board finds that the Office medical consultant correctly applied the A.M.A., *Guides* in determining that appellant had no more than a 15 percent impairment of the left lower extremity, for which he had received a schedule award.

[4] 5 U.S.C. § 8107.

[5] *James J. Hjort*, 45 ECAB 595 (1994).

[6] A.M.A., *Guides* 83, Table 62.

Further, the Board finds that the Office did not abuse its discretion in refusing to reopen appellant's claim for merit review.

To require the Office to reopen a case for merit review under section 8128(a) of the Act,[7] the Office's regulations provide that a claimant must: (1) show that the Office erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by the Office; or (3) submit relevant and pertinent new evidence not previously considered by the Office.[8] When a claimant fails to meet one of the above standards, it is a matter of discretion on the part of the Office whether to reopen a case for further consideration under section 8128(a) of the Act.[9] To be entitled to merit review of an Office decision denying or terminating a benefit, a claimant must also file his or her application for review within one year of the date of that decision.[10]

In this case, appellant's medical evidence submitted in support of his request for reconsideration constituted the October 13, 2000 report from Dr. Kayvanfar, his treating physician. Dr. Kayvanfar, however, did not accurately recount appellant's history of injury or history of treatment. For example, he noted that appellant's initial work-related injury concerned his right knee, that Dr. Smith performed surgery on appellant's right knee instead of the left and that his right knee injury caused stress to his left knee. Dr. Kayvanfar's reports do not correctly identify that appellant's initial work-related injury involved the left knee, that his left knee was subject to surgery, that his left knee was the cause of his right knee condition. As his report did not provide an impairment rating in accordance with the A.M.A., *Guides*, it is irrelevant to appellant's claim. Therefore, appellant has not provided any evidence that would warrant reopening the record.

As appellant has not established that the Office erroneously applied or interpreted a point of law, advanced a point of law or fact not previously considered by the Office or submitted relevant and pertinent evidence not previously considered by the Office, he has not established that the Office abused its discretion in denying his request for review under section 8128 of the Act.

[7] Under section 8128 of the Act, "[t]he Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application." 5 U.S.C. § 8128(a).

[8] 20 C.F.R. § 10.606(b).

[9] *Joseph W. Baxter*, 36 ECAB 228, 231 (1984).

[10] 20 C.F.R. § 10.607.

The decisions of the Office of Workers' Compensation Programs dated February 16, 2001, May 18 and April 4, 2000 are hereby affirmed.[11]

Dated, Washington, DC
February 6, 2002

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[11] The Board notes that this case record contains evidence which was submitted to the Board subsequent to the Office's February 16, 2001 decision. The Board has no jurisdiction to review this evidence for the first time on appeal; *see* 20 C.F.R. § 501.2(c); *James C. Campbell*, 5 ECAB 35, 36 (1952).