United States Department of Labor
Employees' Compensation Appeals Board

HAZEL G. JOHNSON, Appellant	)	
and	)	**Docket No. 06-174**
	)	**Issued: March 14, 2006**
U.S. POSTAL SERVICE, POST OFFICE, Greensboro, NC, Employer	)	

Appearances:
Hazel G. Johnson, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On October 31, 2005 appellant filed a timely appeal of the September 30, 2005 nonmerit decision of the Office of Workers' Compensation Programs denying her request for reconsideration and the June 6, 2005 merit decision denying her claim for a schedule award to her left lower extremity. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUES

The issues are: (1) whether appellant has established entitlement to a schedule award to her left lower extremity; and (2) whether the Office properly refused to reopen appellant's claim for further review of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On December 13, 2002 appellant, then a 45-year-old manual clerk, filed a claim for right shoulder conditions she alleged were due to repetitive overhead reaching of pushing a gate button within the performance of her federal duties on June 1, 2002. On April 2, 2003 the Office

accepted appellant's claim for a right shoulder impingement syndrome and right shoulder bicipital tendinitis. Appellant continued to work limited duty following her work-related injury. On April 28, 2003 appellant underwent an approved right shoulder surgery, acromial joint arthroplasty and stopped working. Appellant was eventually placed on the periodic rolls. The record further reflects that appellant retired from federal employment.

By decision dated May 18, 2004, the Office awarded appellant a 13 percent permanent impairment schedule award to her right arm for the period April 18, 2004 to January 26, 2005. On June 1, 2004 the Office accepted the condition of a temporary aggravation of lymphedema left leg.

On October 1, 2004 appellant filed a claim for a schedule award for her left leg alleging that there was a change to her baseline lymphedema condition after she underwent right shoulder surgery. Submitted with her request was an undated report from Dr. Wanda Panosh, a Board-certified internist, which the Office first received on December 9, 2003. She stated that appellant had severe primary (congenital) left leg lymphedema and that it was medically necessary for her to wear and use compression aids everyday and every night. Dr. Panosh opined that the right shoulder surgery of April 28, 2003 resulted in permanent increased damage to the internal tissue of appellant's lower extremity as appellant was not able to use her right arm to apply daily compression. This resulted in increased edema and increased fibrosis and appellant was no longer able to fit into her compression garments. Dr. Panosh stated that appellant was out of compression for the period April 28 to June 30, 2003 and attached copies of volumetric measurements of appellant's legs from August 2002 and June 30, 2003, to demonstrate increased edema.

In a letters dated October 26, 2004, the Office requested further information, from appellant and Dr. Panosh, including a recent examination and a finding of whether maximum medical improvement has been reached. The Office additionally informed them of the requirements for establishing a lower extremity impairment under the fifth edition of the American Medical Associations, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). No further information was received.

In a June 1, 2005 report, an Office medical adviser indicated that the date of maximum medical improvement was unknown. The Office medical adviser noted that Dr. Panosh represented appellant's condition as of August 2002 and had indicated a temporary aggravation of preexisting chronic lymphedema of both lower extremities. The Office medical adviser concluded that a one-time examination of the lower extremities for chronic edema in 2002, was not sufficient to establish a permanent aggravation of the lymphedema.

By decision dated June 6, 2005, the Office denied appellant's claim for a schedule award for her left leg, finding opinion that the medical evidence did not demonstrate any permanent, impairment.

In a June 9, 2005 letter, appellant requested reconsideration and advised that she was seen at Lymflo Therapies for a total of 23 sessions, for intensive therapy to try to regain her baseline volume. She stated that the reports from Dr. Carol Kirchenbaum, who treated her in connection with physical therapy had not been considered and that additional information was forthcoming.

Appellant submitted a copy of the June 1, 2003 Office's medical adviser's report. The Office did not receive any additional reports.

By decision dated September 30, 2005, the Office denied reconsideration, finding that the evidence submitted was cumulative, repetitious or immaterial/irrelevant in nature.[1]

LEGAL PRECEDENT -- ISSUE 1

An employee seeking compensation under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence.[3]

Under section 8107 of the Act[4] and section 10.404 of the implementing federal regulation,[5] schedule awards are payable for permanent impairment of specified body members, functions or organs. The Act, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides*[6] has been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[7]

A schedule award is not payable until maximum improvement of appellant's condition has been reached.[8] Maximum improvement means that the physical condition of the injured member of the body has stabilized and will not improve further.[9] Generally, maximum improvement has not been reached until medical treatment has been discontinued.[10] The

[1] Subsequent to the issuance of the Office's September 30, 2005 decision, the Office received additional evidence. As this evidence was not previously submitted to the Office for consideration prior to its decision of September 30, 2005, it represents new evidence which can not be considered by the Board in the current appeal. The Board's jurisdiction is limited to reviewing the evidence that was before the Office at the time of its final decision. 20 C.F.R. § 501.2(c). Appellant may resubmit this evidence to the Office, along with a formal request for reconsideration pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606(b).

[2] 5 U.S.C. §§ 8101-8193.

[3] *Gary J. Watling*, 52 ECAB 278 (2001).

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] A.M.A., *Guides* (5th ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[7] *See Joseph Lawrence, Jr., supra* note 6; *James J. Hjort*, 45 ECAB 595 (1994); *Leisa D. Vassar*, 40 ECAB 1287 (1989).

[8] *Orlando Vivens*, 43 ECAB 303, 308 (1991); *Robert L. Mitchell*, 35 ECAB 8, 13 (1982).

[9] *Id.*

[10] *Id.*

determination of the date of maximum medical improvement is factual in nature and depends primarily on the medical evidence.[11]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for a right shoulder impingement syndrome, right shoulder bicipital tendinitis and a temporary aggravation of lymphedema left leg. Appellant subsequently filed a claim for a schedule award to her left leg and submitted an undated report from her physician, Dr. Panosh.

The Office referred the case to an Office medical adviser for an opinion on the percentage of permanent impairment. The Office's procedures indicate that referral to an Office medical adviser is appropriate when a detailed description of the impairment from the attending physician is obtained.[12] In the instant case, the Office medical adviser noted that the date of maximum medical improvement was unknown and that Dr. Panosh's one-time examination was not sufficient to establish any permanent impairment to appellant's left leg. In a letter dated October 26, 2004, the Office advised appellant of the deficiencies in the medical evidence and provided her an opportunity to submit additional evidence. There is no other medical evidence of record which demonstrates a permanent impairment of appellant's left leg in conformance with the A.M.A., *Guides*. Therefore, appellant is not entitled to a schedule award.

LEGAL PRECEDENT -- ISSUE 2

Section 10.606(b)(2) of Title 20 of the Code of Federal Regulations provides that a claimant may obtain review of the merits of the claim by either: (1) showing that the Office erroneously applied or interpreted a specific point of law; (2) advancing a relevant legal argument not previously considered by the Office; or (3) constituting relevant and pertinent new evidence not previously considered by the Office.[13] Section 10.608(b) provides that, when an application for reconsideration does not meet at least one of the three requirements enumerated under section 10.606(b)(2), the Office will deny the application for reconsideration without reopening the case for a review on the merits.[14]

ANALYSIS -- ISSUE 2

Appellant's June 9, 2005 request for reconsideration neither alleged, nor demonstrated that the Office erroneously applied or interpreted a specific point of law. Additionally, she did not advance a relevant legal argument not previously considered by the Office. Consequently,

[11] *Jerre R. Rinehart*, 45 ECAB 518, 520 n.3 (1994).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

[13] 20 C.F.R. § 10.606(b)(2).

[14] 20 C.F.R. § 10.608(b).

appellant is not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(2).[15]

With respect to the third requirement, submitting relevant and pertinent new evidence not previously considered by the Office, appellant forward a copy of the Office medical adviser's June 1, 2005 report, which was of record. The Board has held that the submission of evidence which repeats or duplicates evidence already in the case record does not constitute a basis for reopening the case.[16] Appellant mentioned that reports of her physician at Lymflo Therapies and stated that additional information would be received; however, no new evidence was submitted prior to the Office's September 30, 2005 decision. As appellant did not submit any relevant and pertinent new evidence, she is not entitled to a review of the merits of her claim based on the third requirement under section 10.606(b)(2).[17]

Consequently, the Office properly declined to reopen appellant's claim for a merit review regarding permanent impairment of the left leg.

CONCLUSION

The Board finds that the Office properly denied appellant's claim for a schedule award for her accepted left leg condition as she failed to submit the necessary medical evidence to establish entitlement to a schedule award. The Board further finds that the Office properly denied appellant's request for reconsideration.

[15] 20 C.F.R. § 10.608(b)(2)(i) and (ii).

[16] *Denis M. Dupor*, 51 ECAB 482 (2000).

[17] 20 C.F.R. § 10.608(b)(2)(iii).

ORDER

IT IS HEREBY ORDERED THAT the September 30 and June 6, 2005 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: March 14, 2006
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board