United States Department of Labor
Employees' Compensation Appeals Board

L.I., Appellant	)	
and	)	**Docket No. 12-417**
	)	**Issued: August 3, 2012**
DEPARTMENT OF THE ARMY, INSTALLATION MANAGEMENT COMMAND, Fort Bragg, NC, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 21, 2011 appellant, through his attorney, filed a timely appeal from an August 30, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) regarding his schedule award claim and an October 5, 2011 nonmerit decision denying his request for reconsideration. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim and the nonmerit issue.

ISSUES

The issues are: (1) whether appellant has more than a three percent permanent impairment of the left lower extremity, for which he received a schedule award; and (2) whether OWCP properly denied his request for reconsideration under 5 U.S.C. § 8128.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On January 13, 2003 appellant, then a 50-year-old welder, injured his left knee at work while stepping on the bumper of a truck. OWCP accepted the claim for chondromalacia of the left patella and osteoarthritis of the left knee. On July 11, 2003 appellant underwent an authorized left knee arthroscopy with debridement of the medial meniscus tear and chondroplasty. On October 27, 2003 he returned to modified-duty work. In a June 13, 2005 decision, OWCP determined that appellant's modified position of human resources assistant, fairly and reasonably represented his wage-earning capacity with no loss of wage-earning capacity.

On November 22, 2004 appellant requested a schedule award. In August 24 and November 4, 2004 reports, Dr. James P. Flanagan, a Board-certified orthopedic surgeon, provided examination findings and opined that appellant had impairment. Under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*), he opined that appellant had 35 percent impairment of the left leg based on strength, osteoarthritis and range of motion. In an April 28, 2005 report, an OWCP medical adviser opined that appellant had two percent permanent impairment for a partial medial meniscectomy. He stated no impairment could be based on range of motion and noted that impairment for arthritis could only be calculated under Table 14-31, page 544. On March 9, 2006 Dr. Flanagan opined that appellant had 40 percent impairment of the left leg. He noted that appellant would need a total knee replacement in the near future. On April 10, 2006 an OWCP medical adviser opined that appellant had 20 percent impairment of the left leg based on loss of range of motion. He explained that loss of strength could not be combined with the other impairments. In response to OWCP's request for clarification, the medical adviser, in a November 17, 2006 report, indicated that appellant had 20 percent impairment for loss of range of motion plus 2 percent impairment for his partial medial meniscectomy, for a total of 22 percent impairment of the left lower extremity.

OWCP asked Dr. Flanagan to review the medical adviser's report and provide a more comprehensive impairment rating. In a December 19, 2006 report, Dr. Flanagan indicated that appellant's impairment rating was not going to change. He noted the only thing that would change would be appellant's pain level which would increase until he was ready to proceed with a total knee replacement.

After appellant inquired about his schedule award claim, OWCP on June 4, 2009 asked that Dr. Flanagan provide an impairment rating under the sixth edition of the A.M.A., *Guides*. In an October 6, 2009 report, Dr. Flanagan stated that, under Table 16.3 of the sixth edition of the A.M.A., *Guides,* appellant had a class 3 severe problem for the left knee that totaled 49 percent left leg impairment. He recommended a total knee replacement. On November 24, 2009 OWCP stated that it would not consider the schedule award claim as it did not appear appellant was at maximum medical improvement since Dr. Flanagan recommended additional treatment.

In an April 7, 2010 letter, appellant stated that he declined the recommended total knee arthroplasty and wished to be assigned a permanent impairment rating. In a May 27, 2010 report, Dr. Flanagan noted examination findings and opined that appellant reached maximum

medical improvement. He stated that, while a total knee replacement might be needed at some point, it did not look like it would be needed in the near future.

In an August 17, 2010 report, an OWCP medical adviser recommended that appellant be seen for a second opinion examination.

In a September 30, 2010 report, Dr. James A. Maultsby, a Board-certified orthopedic surgeon and OWCP referral physician, reviewed appellant's history and noted examination findings. He also had appellant undergo an electromyogram (EMG) and a functional capacity evaluation. Dr. Maultsby stated that the left knee and leg were larger and stronger than the right knee and there was no weakness. He noted that this was different from appellant's examining physician, who gave 3/5 weakness. Dr. Maultsby stated that appellant had 5/5 strength and that he could fully extend and flex both knees equally. X-rays revealed three millimeters' (mm) thickness of the articular cartilage of the left knee. Dr. Maultsby noted that there was four mm thickness on the right knee, which was one mm difference. He also noted very mild cartilage narrowing. Dr. Maultsby opined that, under Table 16-3 of the sixth edition of the A.M.A., *Guides*, appellant had class 1 primary knee arthritis. He stated that the modifier for functional history would be 1 or below; however, this would be disregarded because appellant's physical examination was contrary to the functional history as the physical examination revealed full range of motion, full extension and full flexion of both knees. The modifier for clinical studies was also zero. Under Table 16-3, appellant had primary joint arthritis with a mild problem. Because he had three mm cartilage interval, he was a class 1 or seven percent impairment of the left leg. Regarding objective findings, Dr. Maultsby indicated that there was no decrease in strength, no atrophy, no ankylosis and no sensory changes, except for some on top of the foot, which was not related to the knee condition. He opined that appellant was likely addicted to his pain medicine. Dr. Maultsby asserted that Dr. Flanagan's 49 percent impairment rating was not supported by objective findings.

OWCP determined that a conflict in medical opinion existed between Dr. Flanagan and Dr. Maultsby regarding appellant's permanent impairment and referred appellant to Dr. Robert W. Elkins, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a November 17, 2010 report, Dr. Elkins indicated his review of appellant's medical record and the statement of accepted facts. He reported appellant's complaints of left knee pain and swelling with popping and grinding. Appellant reported knee pain with almost any activity. On examination, he refused to toe walk or knee walk. Quad strength was diminished and appellant complained of severe left knee pain with a range of motion from 3 degrees of flexion to 104 degrees of flexion. There was a negative drawer sign and no atrophy, crepitus or instability. Appellant had tenderness to the slightest touch over the medial joint line. He diagnosed degenerative arthritis of the left knee, possible re-tear left medial meniscus, chronic pain syndrome and mild symptom magnification and pain accentuation. Appellant recommended a standing x-ray as well as a magnetic resonance imaging (MRI) scan of the left knee. In a February 10, 2011 report, Dr. Elkins noted that appellant's December 29, 2010 MRI scan and January 26, 2011 standing x-rays of the left knee revealed degenerative changes of the medial meniscus and early minimal osteoarthritis. He opined that appellant reached maximum medical improvement. Dr. Elkins also opined that appellant's subjective complaints outweighed his

objective findings. Under pages 509 through 511 of the sixth edition of the A.M.A., *Guides*, he stated that appellant's main symptom generator was patellofemoral arthritis and not the prior partial meniscectomy. Dr. Elkins noted that, although the percentages were similar, they were not exactly the same. He stated that appellant had a class 1 or three percent impairment. Dr. Elkins noted that appellant had a grade 1 modifier for physical examination, some of which was indicative of symptom magnification and a grade 1 modifier for functional history. After the net adjustment formula, he opined that appellant had three percent impairment of the left lower extremity due to his patellofemoral arthritis.

In a March 2, 2011 report, an OWCP medical adviser noted that the impartial medical examiner's reports of November 17, 2010 and February 10, 2011 were thorough and objective and that the A.M.A., *Guides* were correctly used. He found that three percent permanent impairment for the left leg for chondromalacia patella/patella femoral arthritis was correct.

In a March 14, 2011 decision, OWCP issued a schedule award for three percent permanent impairment of the left leg. Special weight was accorded to Dr. Elkin's impartial medical opinion.

Appellant requested an oral hearing, which was held telephonically on June 21, 2011. At the hearing, he indicated that he originally injured his left knee on October 7, 2002.[2] Appellant testified as to his current problems with his left knee and stated that he felt a rating of three percent permanent impairment was not justifiable. He disagreed with Dr. Elkins' report and stated that he could not fully extend his leg. Appellant stated that there were no other intervening injuries to his left knee. He stated that he retired on disability in September 2009.

Appellant submitted additional reports from Dr. Flanagan dated October 6, 2009[3] and July 8 and 15, 2011. In his July 8, 2011 report, Dr. Flanagan stated that appellant's left knee was progressively worsening. Appellant had very limited range of motion, poor quad strength and was barely able to do a straight leg raise. He also had difficulty rising out of the chair. Dr. Flanagan opined that appellant's best option was a knee replacement. He indicated that appellant's knee worsening would not change his rating. In his July 15, 2011 report, Dr. Flanagan noted that appellant had an injection.

By decision dated August 30, 2011, an OWCP hearing representative affirmed the March 14, 2011 decision.

On September 20, 2011 appellant requested reconsideration. He pointed out that Dr. Flanagan opined in his October 6, 2009 report that appellant had 49 percent impairment of the left lower extremity. Appellant submitted reports previously of record from Dr. Flanagan dated October 6, 2009 and July 8, 2011.[4]

[2] Claim number xxxxxx482 was assigned to the 2002 left knee injury and was administratively accepted without formal review for a limited medical expense.

[3] This report was previously of record.

[4] Although OWCP references a September 20, 2011 report from Dr. Flanagan, the record contains a report duplicative of Dr. Flanagan's July 8, 2011 report which it erroneously noted was dated September 20, 2011.

By decision dated October 5, 2011, OWCP denied appellant's reconsideration request on the grounds that evidence submitted was duplicative of evidence previously considered.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA and its implementing regulations[5] 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. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[6] For consistent results and to ensure equal justice under the law to 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* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

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).[9] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[11]

Section 8123(a) provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee the Secretary shall appoint a third physician who shall make an examination.[12] It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[13]

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[5] 20 C.F.R. § 10.404.

[6] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[7] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[9] A.M.A., *Guides* 3-6 (6th ed. 2008).

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

[11] *Id.* at 521.

[12] *Veronica Williams*, 56 ECAB 367, 370 (2005).

[13] *Regina T. Pellecchia*, 53 ECAB 155 (2001).

ANALYSIS -- ISSUE 1

The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments are to be classified by diagnosis. The classification is then adjusted by grade modifiers according to the formula noted above. Appellant's accepted diagnosed condition was chondromalacia of the left patella and osteoarthritis of the left knee, for which he underwent arthroscopic surgery on July 11, 2003. After he filed a claim for a schedule award, OWCP requested that Dr. Flanagan assess permanent impairment under the sixth edition of the A.M.A., *Guides* and, in an October 6, 2009 report, Dr. Flanagan opined that appellant had 49 percent left leg impairment under the A.M.A., *Guides*. Thereafter, Dr. Maultsby, OWCP's referral physician, examined appellant and opined that he had seven percent left leg impairment. OWCP properly found a conflict in the medical evidence and it referred appellant to Dr. Elkins, a Board-certified orthopedic surgeon, for an impartial medical examination and opinion on the matter.

The Board finds that OWCP properly determined that the weight of the medical opinion evidence regarding the extent of appellant's permanent impairment rests with the well-rationalized opinion of Dr. Elkins.

In his November 17, 2010 report, Dr. Elkins noted his review of the medical records, the statement of accepted facts and set forth his examination findings. He diagnosed degenerative arthritis of the left knee, possible re-tear left medial meniscus, chronic pain syndrome and mild symptom magnification and pain accentuation. Dr. Elkins recommended standing x-rays and an MRI scan of the left knee prior to providing an impairment determination. After reviewing the results of the December 29, 2010 MRI scan and January 26, 2011 standing x-rays of the left knee, he opined in a February 10, 2011 report that appellant had reached maximum medical improvement. Dr. Elkins also advised that appellant's subjective complaints outweighed his objective findings. He opined that, under Table 16-3, page 511 of the sixth edition of the A.M.A., *Guides*, appellant had three percent impairment of the left lower extremity due to patellofemoral arthritis. Dr. Elkins stated that appellant's main symptom generator was patellofemoral arthritis and not the prior partial meniscectomy. Under Table 16-3, page 511, he noted that appellant had a class 1 or three percent default impairment. Dr. Elkins assigned a grade one modifier for physical examination, some of which was indicative of symptom magnification and a grade one modifier for functional history. He utilized the net adjustment formula and found that there was no net adjustment. Thus, Dr. Elkins properly opined that appellant had three percent impairment of the left leg. OWCP's medical adviser concurred in Dr. Elkins' calculation.

Dr. Flanagan subsequently submitted a July 8, 2011 report, in which he noted findings of limited range of motion, poor quad strength was poor and difficulty doing straight leg raise as well as rising out of the chair and indicated that appellant needed a total knee replacement. He, however, specifically indicated that appellant's knee worsening would not change his

impairment rating. Thus, this report would not be sufficient to create a new conflict with Dr. Elkin's opinion regarding the extent of permanent impairment.[14]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

LEGAL PRECEDENT -- ISSUE 2

To require OWCP to reopen a case for merit review under section 8128(a), OWCP's regulations provide that the evidence or argument submitted by a claimant must: (1) show that OWCP erroneously applied or interpreted a specific point of law; (2) advance a relevant legal argument not previously considered by OWCP; or (3) constitute relevant and pertinent new evidence not previously considered by OWCP.[15] Section 10.608(b) of OWCP's regulations provide that when an application for reconsideration does not meet at least one of the three requirements enumerated under section 10.606(b)(2), OWCP will deny the application for reconsideration without reopening the case for a review on the merits.[16]

ANALYSIS -- ISSUE 2

On September 20, 2011 appellant requested reconsideration of OWCP's August 30, 2011 decision which found that he had no more than three percent impairment to his left leg. His request for reconsideration neither alleged nor demonstrated that OWCP erroneously applied or interpreted a specific point of law. Appellant did not advance a relevant legal argument not previously considered by OWCP. While he noted that Dr. Flanagan's October 6, 2009 report found 49 percent impairment of the left leg, this report was previously considered as it gave rise to the conflict that Dr. Elkins resolved.[17] Appellant is not entitled to a review of the merits of his claim based on the above-noted requirements under section 10.606(b)(2).

Appellant also did not submit relevant and pertinent new evidence not previously considered by OWCP. The medical reports from Dr. Flanagan dated October 6, 2009 and July 8, 2011 were previously considered by OWCP and repeat evidence already of record; thus, they are duplicative and do not constitute relevant and pertinent new evidence.[18]

The evidence submitted by appellant did not show that OWCP erroneously applied or interpreted a specific point of law; advance a relevant legal argument not previously considered

[14] Furthermore, submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is generally insufficient to overcome the weight accorded to the report of the impartial specialist or to create a new conflict. *S.J.*, Docket No. 09-1794 (issued September 20, 2010).

[15] 20 C.F.R. § 10.606(b)(2); *D.K.*, 59 ECAB 141 (2007).

[16] *Id.* at § 10.608(b); *K.H.*, 59 ECAB 495 (2008).

[17] *See J.P.*, 58 ECAB 289 (2007) (evidence or argument that repeats or duplicates evidence previously of record has no evidentiary value and does not constitute a basis for reopening a case).

[18] *See D.K.*, 59 ECAB 141 (2007).

or constitute relevant and pertinent new evidence not previously considered by OWCP. As appellant did not meet any of the necessary regulatory requirements, the Board finds that he is not entitled to further merit review.

On appeal, appellant's attorney argues that OWCP's decisions are contrary to fact and law. As noted, none of the medical evidence of record offered a rationalized medical opinion sufficient to create a new conflict with Dr. Elkins' impartial medical opinion.

CONCLUSION

The Board finds that appellant has no more than a three percent permanent impairment of the left lower extremity, for which he received a schedule award. The Board also finds that OWCP properly denied appellant's request for further review of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

ORDER

IT IS HEREBY ORDERED THAT the October 5 and August 30, 2011 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 3, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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