United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, North Chicago, IL, Employer**	)	**Docket No. 11-595** **Issued: January 23, 2012**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 10, 2011 appellant filed a timely appeal from a September 9, 2010 schedule award decision of the Office of Workers' Compensation Programs (OWCP). The Board also has jurisdiction over a December 14, 2010 decision which denied her 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 schedule award decision.

ISSUES

The issues are: (1) whether appellant has greater than 22 percent permanent impairment of her left lower extremity; and (2) whether OWCP properly denied her request for reconsideration.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On September 7, 2006 appellant, then a 41-year-old food service worker, injured her left knee when she slipped on ice in the employing establishment parking lot. OWCP accepted a tear of the medial meniscus of the left knee.

Appellant was treated by Dr. Edward J. Logue, a Board-certified orthopedic surgeon, from September 1, 2006 to May 25, 2007, for a tear of the left lateral meniscus sustained when she fell at work.

On July 20, 2007 appellant filed a claim for a schedule award. She submitted a July 30, 2007 report from Dr. Logue, who opined that she sustained a 20 percent impairment of the left lower extremity under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,* (A.M.A., *Guides*).[2] OWCP referred appellant's file to its medical adviser who, in an October 1, 2007 report, concurred that appellant had 20 percent impairment of the left lower extremity in accordance with the A.M.A., *Guides.*[3]

In a decision dated January 30, 2008, OWCP granted appellant a schedule award for 20 percent permanent impairment of the left lower extremity. The period of the award was October 11, 2006 to November 18, 2007.

Appellant continued to be treated by Dr. Logue for left knee pain and giving way. Dr. Logue diagnosed recurrent left knee pain and recommended arthroscopic surgery. On April 16, 2010 he performed a left knee arthroscopy and partial lateral meniscectomy. Dr. Logue diagnosed left knee lateral meniscus tear. In reports dated April 23 and May 14, 2010, he noted that appellant was progressing well postoperatively but lost her footing and fell on her left knee. Dr. Logue noted her complaints of left knee pain. He found no swelling or ecchymosis and noted well-healed incisions. Dr. Logue noted 0 degrees of left knee extension, 125 degrees of flexion, minimal tenderness about the joint line, McMurray test was negative in both compartments, neurovascular examination was grossly intact and the ligaments were stable. He diagnosed status post arthroscopy with partial lateral meniscectomy.

On July 6, 2010 appellant filed a claim for an additional schedule award. In a July 13, 2010 letter, OWCP requested that she submit a permanent impairment rating in accordance with the sixth edition of the A.M.A., *Guides* which it began using effective May 1, 2009.

In a July 16, 2010 report, Dr. Logue noted that appellant's left knee pain was mostly anterior and was worse at the end of the day. He noted left leg flexion of 130 degrees, extension of 0 degrees, mild quadriceps atrophy on the left, no ligament instability, no varus or valgus deformity and no evidence of post-traumatic irregularity or arthritis of the left knee. Dr. Logue listed a history of performing a partial lateral meniscectomy. He opined that appellant had a 20

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[2] A.M.A., *Guides* (5th ed. 2001).

[3] Appellant had previous left knee condition, not work related. OWCP's medical adviser noted that on April 11, 2006 she underwent a left knee arthroscopy and a partial lateral menisctomy; however, the operative report was not in the record.

percent impairment of the left leg with 20 percent loss of shock absorption. Dr. Logue noted that she reached maximum medical improvement on July 16, 2010.

In an August 2, 2010 report, OWCP's medical adviser reviewed Dr. Logue's July 16, 2010 report. He noted that appellant was previously granted 20 percent impairment of the left leg based on x-ray changes consistent with degenerative arthritis. OWCP's medical adviser stated that she underwent a partial lateral meniscectomy on April 16, 2010. Although appellant did well postoperatively, she had subjective complaints of anterior knee pain which was worse at the end of the day. OWCP's medical adviser further noted that physical examination demonstrated all surgical portals had healed and left knee range of motion was 130 degrees with mild quadriceps atrophy. He found two percent impairment for partial lateral meniscectomy according to the Knee Regional Grid -- Lower Extremity Impairment, Table 16-3, page 509-11, of the A.M.A., *Guides* with no change in the award due to the net adjustment formula. OWCP's medical adviser used the Combined Values Charts on page 604 of the A.M.A., *Guides* for a 22 percent impairment of the left lower extremity. He noted that maximum medical improvement was reached on July 16, 2010.

In a decision dated September 9, 2010, OWCP granted appellant a schedule award for 22 percent impairment of the left lower extremity. As appellant previously received an award of 20 percent impairment she was entitled to an additional two percent impairment. The period of the award was from July 17 to August 26, 2010.

On September 14, 2010 appellant requested reconsideration and disagreed that she only had an additional two percent impairment of the left leg. She contended that she was entitled to 22 percent impairment. Appellant submitted copies of OWCP decisions dated January 30, 2008 and September 9, 2010, reports from Dr. Logue dated July 30, 2009 and July 16, 2010 and OWCP's medical adviser's August 2, 2010 report, all previously of record. She submitted postoperative home care instructions dated April 16, 2010.

In a December 14, 2010 decision, OWCP denied appellant's reconsideration request finding that the request was insufficient to warrant review of the prior decision.

LEGAL PRECEDENT -- ISSUE1

The schedule award provision of FECA[4] and its implementing federal 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. However, 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

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* will be used.[7]

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).[8] 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).[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides* with OWCP's medical adviser providing rationale for the percentage of impairment specified.[11]

The sixth edition of the A.M.A., *Guides* provides that lower extremity impairments are to be classified by diagnosis and then adjusted by grade modifiers according to the formula noted above.[12] Diagnosis-based impairment is the primary method of evaluation for the lower extremity. Once the impairment class has been determined based on the diagnosis, the grade is initially assigned the default value, which may then be modified slightly based on such nonkey factors as GMFH and GMPE. This process is repeated for each separate diagnosis. In most cases, only one diagnosis in a region, such as the knee, will be appropriate. If a patient has two significant diagnoses, the examiner should use the diagnosis with the highest impairment rating in that region that is causally related.[13]

ANALYSIS -- ISSUE 1

The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Reliability of the diagnosis is essential and the diagnosis should be consistent with the clinical history and findings at the time of the impairment assessment. Selecting the optimal diagnosis requires judgment and experience. If more than one diagnosis in a region can be used, the one that provides the most clinically accurate and

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[6] *Id.* at § 10.404(a).

[7] FECA Bulletin No. 09-03 (issued March 15, 2009).

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

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

[10] *Id.* at 521.

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

[12] *Supra* notes 9, 10.

[13] A.M.A., *Guides* 497 (6th ed. 2009).

causally-related impairment rating should be used. This will generally be the more specific diagnosis. Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[14]

OWCP accepted appellant's claim for tear of the medial meniscus of the left knee. On September 9, 2010 it granted her a 22 percent impairment of the left lower extremity. OWCP noted that on January 30, 2008 appellant was previously granted a schedule award for 20 percent permanent impairment of the left lower extremity for degenerative arthritis and was entitled to an additional award of two percent impairment of the left lower extremity for a partial lateral meniscectomy based on its medical adviser's report.

In a report dated July 16, 2010, Dr. Logue noted left leg flexion of 130 degrees and extension of 0 degrees, mild quadriceps atrophy on the left, no ligament instability, no varus or valgus deformity and no evidence of post-traumatic irregularity or arthritis of the left knee. He opined that appellant sustained a 20 percent impairment of the left lower extremity with 20 percent loss of shock absorption. Dr. Logue, however, did not specifically address how her physical findings correlated with a 20 percent impairment rating according to the A.M.A., *Guides.* OWCP requested that its medical adviser review the medical record and determine if appellant had permanent impairment of the left lower extremity.

OWCP's medical adviser reviewed Dr. Logue's report and opined that appellant had 22 percent left leg impairment. He noted that on January 30, 2008 appellant was previously granted 20 percent impairment of the left lower extremity based on x-ray changes consistent with degenerative arthritis and was entitled to an additional two percent impairment for a partial lateral meniscectomy. The medical adviser explained how the partial lateral meniscectomy of April 16, 2010 warranted two percent leg impairment under Table 16-3, Knee Regional Grid. He noted that appellant would fit a class 1 category, yielding a default grade C for two percent impairment.[15] The medical adviser determined that there was no change to the default rating of two percent impairment after applying the net adjustment formula.[16] He combined the previously awarded 20 percent impairment for degenerative arthritis with the two percent impairment for the partial meniscectomy. This is inconsistent with the methodology of the A.M.A., *Guides* which, as noted, directs the selection of the most applicable single diagnosis in most instances. OWCP's medical adviser did not explain why the arthritis and meniscectomy ratings should be combined in light of the language of the A.M.A., *Guides*. He also did not explain whether the meniscectomy rating or the rating for degenerative arthritis was the most applicable diagnosis. In this situation, the medical adviser should not have combined the two diagnosis-based estimates; rather, he should have selected the diagnosis which provided for the

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[14] *Id.* at 499. *See also R.F.*, Docket No. 11-931 (issued November 9, 2011) (where the Board found that combining the impairments of several diagnoses was inconsistent with the methodology of the A.M.A. *Guides*); *E.S.*, Docket No. 11-1162 (issued November 17, 2011) (where the Board noted that the A.M.A. *Guides* provide that if appellant has two significant diagnoses the examiner should use the diagnosis with the highest impairment rating in the region that is causally related to the impairment calculation).

[15] A.M.A., *Guides* 509-11, Table 16-3

[16] *Id.* at 516-19.

highest impairment rating. In this case, appellant was entitled to 20 percent impairment of the left lower extremity based on x-ray changes consistent with degenerative arthritis.[17]

The Board finds that the medical evidence establishes that appellant has no more than 20 percent impairment of the left lower extremity that was previously awarded. There is no medical evidence consistent with the sixth edition of the A.M.A., *Guides* that supports any greater impairment.

On appeal, appellant asserts that her left knee condition and April 16, 2010 surgery are work related and she was entitled to an additional 20 percent impairment as her current impairment was different than her previously accepted impairment. While she argues that the previous award was for a different injury, section 8107 provides that schedule awards are payable for permanent impairment of specified body members, functions or organs, not for specific injuries.[18] FECA provides for reduction of compensation for subsequent injury to the same body member. It provides that schedule award compensation under section 8107 is reduced by the compensation paid for an earlier injury where the compensation in both cases are for impairment of the same member or function and where it is determined that the compensation for the later disability in whole or part would duplicate the compensation payable for the preexisting disability.[19] As explained, the medical evidence does not support any greater left leg impairment than that for which appellant has already received schedule awards.

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

Under section 8128(a) of FECA,[20] OWCP has the discretion to reopen a case for review on the merits. It must exercise this discretion in accordance with the guidelines set forth in section 10.606(b)(2) of the implementing federal regulations, which provides that a claimant may obtain review of the merits of his or her written application for reconsideration, including all supporting documents, sets forth arguments and contain evidence that:

> "(1) Shows that OWCP erroneously applied or interpreted a specific point of law; or
>
> "(2) Advances a relevant legal argument not previously considered by OWCP; or

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[17] The Knee Regional Grid on page 511 of the A.M.A., *Guides* sets forth impairment ranges for the leg due to arthritis in the knee.

[18] *P.W.*, Docket No. 09-1289 (issued March 24, 2010); *see* 5 U.S.C. § 8107.

[19] 5 U.S.C. § 8108; 20 C.F.R. § 10.404(c).

[20] 5 U.S.C. § 8128(a).

"(3) Constitutes relevant and pertinent new evidence not previously considered by OWCP."[21]

Section 10.608(b) provides that any application for review of the merits of the claim which does not meet at least one of the requirements listed in section 10.606(b) will be denied by OWCP without review of the merits of the claim.[22]

ANALYSIS -- ISSUE 2

OWCP's December 14, 2010 decision, denied appellant's reconsideration request finding that it was insufficient to warrant a merit review. In her September 14, 2010 application for reconsideration, appellant did not show that OWCP erroneously applied or interpreted a specific point of law. She did not identify a specific point of law or show that it was erroneously applied or interpreted. Appellant did not advance a new and relevant legal argument. She disagreed with OWCP's decision granting her 22 percent impairment of the left lower extremity. Appellant noted that OWCP granted her an additional 2 percent impairment when she believed she was entitled to another 22 percent impairment. However this assertion has no reasonable color of validity.[23] FECA contemplates that reduction of schedule compensation for subsequent injury to the same body member.[24] Appellant's general statements and allegations on reconsideration have not otherwise shown that OWCP erroneously applied or interpreted a point of law nor did it advance a point of law or fact not previously considered by OWCP. Consequently, she 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).

Appellant submitted a copy of OWCP decisions dated January 30, 2008 and September 9, 2010, reports from Dr. Logue dated July 30, 2009 and July 16, 2010 and OWCP's medical adviser's report dated August 2, 2010, all previously of record. The Board notes that this evidence is duplicative of evidence already contained in the record and was previously considered by OWCP.[25] Therefore, OWCP properly determined that this evidence did not constitute a basis for reopening the case for a merit review. Appellant submitted new postoperative home care instructions dated April 16, 2010. However, the underlying issue in the case is whether she was entitled to an additional schedule award for the left lower extremity. The postoperative instructions are not relevant to appellant's claim for a schedule award. Therefore, OWCP properly determined that this evidence did not constitute a basis for reopening the case for a merit review.

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[21] 20 C.F.R. § 10.606(b)(2).

[22] *Id*. at § 10.608(b).

[23] While the reopening of a case may be predicated solely on a legal premise not previously considered, such reopening for further review of the merits is not required where the legal contention does not have a reasonable color of validity. *Arlesa Gibbs*, 53 ECAB 204 (2001).

[24] *See supra* notes 18, 19.

[25] Evidence that repeats or duplicates evidence already in the case record has no evidentiary value and does not constitute a basis for reopening a case; *see Daniel Deparini,* 44 ECAB 657 (1993); *Eugene F. Butler,* 36 ECAB 393, 398 (1984); *Bruce E. Martin,* 35 ECAB 1090, 1093-94 (1984).

The Board finds that OWCP properly determined that appellant was not entitled to a review of the merits of her claim as she did not present evidence or argument satisfying any of the three regulatory criteria, under section 10.606(b)(2), for obtaining a merit review.

CONCLUSION

The Board finds that appellant has no more than 20 percent left lower extremity impairment. The Board finds that OWCP properly denied her request for reconsideration.

ORDER

IT IS HEREBY ORDERED THAT the December 14, 2010 the Office of Workers' Compensation Programs' decision is affirmed and the September 9, 2010 decision is affirmed as modified.

Issued: January 23, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board