United States Department of Labor
Employees' Compensation Appeals Board

W.C., Appellant	)	
and	)	**Docket No. 20-0691**
	)	**Issued: July 19, 2022**
DEPARTMENT OF THE TREASURY, U.S. MINT, Philadelphia, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On February 20, 2020 appellant, through counsel, filed a timely appeal from an October 15, 2019 merit decision and a January 22, 2020 nonmerit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish more than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On January 23, 2018 appellant, then a 72-year-old police officer, filed a traumatic injury claim (Form CA-1) alleging that on January 19, 2018 he bruised his left eye and left elbow, and experienced pain in his left foot when his foot got caught on a black rolled up carpet and he fell on the floor while in the performance of duty. He did not stop work.

OWCP, by development letter dated June 14, 2018, informed appellant that his claim was initially accepted as a minor injury that resulted in minimal or no lost time from work, but was now being reopened to formally consider the merits of the claim. It reviewed the claim and accepted the claim for strain of the left Achilles tendon, subsequent encounter.

OWCP subsequently received an April 30, 2019 medical report by Dr. Nicholas P. Diamond, an osteopath Board-certified in physical medicine and rehabilitation. Dr. Diamond noted a history of the accepted January 19, 2018 employment injury and appellant's medical treatment. He reported that appellant ambulated with a left lower extremity limping gait with the assistance of a molded ankle foot orthosis at the left foot. A calcaneal and an equinus gait were unable to be performed due to the left ankle and foot. On physical examination of the left foot and ankle, Dr. Diamond reported no tenderness to palpation. Appellant was unable to complete single heel raise. A lower extremity activity scale (LEAS) score for disability was 62. Range of motion (ROM) for the left ankle was measured three times with the greatest left ankle ROM measured at 10 degrees of dorsiflexion, 45 degrees of plantar flexion, 20 degrees of inversion, and 20 degrees of eversion with pain. Dr. Diamond diagnosed post-traumatic left ankle sprain and strain with full-thickness tear of the left Achilles tendon and tear of the posterior tibialis tendon and tendinopathy of the peroneal tendon based on a February 20, 2018 magnetic resonance imaging (MRI) scan, as well as osteoarthritis of the left ankle based on January 16, 2019 x-rays. Under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[3] he calculated 22 percent left lower extremity permanent impairment. Utilizing Table 16-2 (Foot and Ankle Regional Grid), page 507, of the A.M.A., *Guides*, Dr. Diamond found that the class of diagnosis (CDX) for appellant's left ankle arthritis (1.4 millimeters (mm) lateral joint talofibular) resulted in a class 2 impairment with a default value of 20. He assigned a grade modifier for functional history (GMFH) of 3 for LEAS of 62 under Table 16-6, page 516, and a grade modifier for physical examination (GMPE) of 1 under Table 16-7, page 517. Dr. Diamond found that a grade modifier for clinical studies (GMCS) was not applicable under Table 16-8, page 519. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (3 - 2) + (1 – 1[4]) = 1, which resulted in 22 percent permanent impairment of the left lower extremity. Dr. Diamond

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

[4] The Board notes that Dr. Diamond used a CDX of 1 rather than a CDX of 2 in the net adjustment formula.

determined that appellant reached maximum medical improvement (MMI) on the date of his impairment evaluation.

In a June 7, 2019 report, Dr. Diamond amended his April 30, 2019 impairment rating of 22 percent for appellant's left lower extremity to a 27 percent permanent impairment of the left lower extremity, based on the January 16, 2019 left knee x-rays read by Dr. Lisa Marie Sheppard, a Board-certified diagnostic radiologist, on January 30, 2019. He noted that the x-rays revealed a measurement of 3.1 mm for lateral joint space. Dr. Diamond reiterated his prior calculations and determination that appellant had 22 percent permanent impairment due to his left ankle arthritis (1.4 mm lateral joint talofibular). He utilized Table 16-3 (Knee Regional Grid), page 511, and identified a CDX of 1 for left knee primary joint arthritis, which represented a class 1 impairment with a default value of seven percent. Dr. Diamond assigned a GMFH of 0 and a GMPE of 1. He again found that a GMCS was not applicable. Dr. Diamond applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (0 - 1) + (1 - 1) = -1, which resulted in six percent permanent impairment of the left knee. He combined this impairment rating and the six percent left knee impairment rating, which yielded 27 percent permanent impairment of the left lower extremity.

On June 20, 2019 appellant filed a claim for a schedule award (Form CA-7).

On August 1, 2019 OWCP routed Dr. Diamond's April 30 and June 7, 2019 reports, a statement of accepted facts (SOAF), and the case record to Dr. Ari Kaz a, Board-certified orthopedic surgeon serving as a district medical adviser (DMA), for review and a determination of permanent impairment of the left lower extremity in accordance with the sixth edition of the A.M.A., *Guides* and the date of MMI.

In an August 18, 2019 report, Dr. Kaz reviewed the SOAF and the medical record, including the reports of Dr. Diamond. The DMA indicated that instead, he used purely radiographic findings to provide an impairment rating on incidental findings of asymptomatic left knee arthritis and left ankle arthritis. He maintained that, while technically within the rules of impairment ratings based on the rules of apportionment, this approach was clearly not intended in the development of the A.M.A., *Guides* rating process, and thus, was inappropriate. Additionally, the DMA maintained that the evidence did not support a diagnosis of ankle arthritis. He noted that Dr. Diamond based his diagnosis of left ankle arthritis on the left ankle x-rays read by Dr. Sheppard on January 30, 2019. The DMA indicated that based on page 518 of the A.M.A., *Guides* the use of knee x-rays are precluded in the setting of a knee flexion contracture due to distortion of the x-ray beam. He contended that an MRI scan provided a more accurate assessment of the presence of arthritis, noting that the February 20, 2018 MRI scan was thorough and documented numerous findings including, mild arthritis of the intertarsal joints. Noticeably absent was any comment on the presence of ankle arthritis. There was also no documentation of cartilage damage, bone marrow edema, joint effusions, or spurring at the ankle joint. In other words, the MRI scan showed no evidence of ankle arthritis. The DMA maintained that given that the MRI scan was a much more sensitive test than x-rays, it clearly showed that appellant did not have ankle arthritis. He related that it was not appropriate to rate him based on ankle arthritis when the MRI scan clearly did not support the presence of such condition. Given the inherent measurement error in the cartilage interval as measured on x-ray and the highly sensitive nature of the MRI scan, the DMA maintained that it was clear the objective medical evidence of the MRI scan was much stronger than the x-ray evidence. The stronger MRI scan evidence of no ankle arthritis outweighed

the questionable x-ray evidence of arthritis. Therefore, the DMA advised that it was not appropriate to rate the condition of ankle arthritis. Further, he noted that Dr. Diamond rated the asymptomatic knee arthritis based purely on the x-ray that measured the lateral joint space as 3.1 mm. The DMA related that, according to Table 16-3, page 511, a CDX of 1 for knee arthritis was defined as a 3 mm cartilage interval. He advised that as 3.1 mm was greater than 3 mm, it did not qualify for a rating based on radiographic findings. The DMA noted that while the A.M.A., *Guides* instructed an examiner to round measurements for ROM values, no such instructions were given for cartilage intervals.

The DMA determined that the left Achilles tear was the appropriate diagnosis to rate appellant's permanent impairment. He utilized the ROM rating method in Table 16-20, page 549, to find that 20 degrees of inversion yielded two percent permanent impairment and 20 degrees of eversion yielded zero percent permanent impairment. Using Table 16-22, the DMA found that left ankle dorsiflexion of 10 degrees yielded seven percent permanent impairment and plantar flexion of 45 degrees yielded zero percent permanent impairment. He added these values to equal nine percent permanent impairment of the left ankle. Utilizing Table 16-25, page 550, the DMA determined that the nine percent permanent impairment rating represented a CDX of 1, a mild ROM classification. Utilizing the Diagnosis-Based Impairment (DBI) rating method, he found that, under Table 16-1, page 501, a CDX of 1 for a problem with mild motion deficits, which represented a default value of five percent. The DMA agreed with Dr. Diamond's finding of a GMFH of 3 based on a LEAS score of 62. He noted, however, that based on Table 16-6, page 516, an antalgic limp with ankle-foot orthosis (AFO) yielded a GMFH of 2. The DMA maintained that objective evidence of a limp with an AFO was more reliable than the subjective LEAS score, and that a GMFH of 2 was preferred. He noted Dr. Diamond's finding of a GMPE of 1, but determined that based on Table 16-7, page 517, left calf atrophy of 2.5 centimeters yielded a GMPE of 2. The DMA found that a GMCS was not applicable as the MRI scan was used to make the diagnosis of Achilles rupture. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (2 - 1) = 2, which moved the impairment rating two places to the right, resulting in a class 1, grade E rating of seven percent left lower extremity permanent impairment. The DMA noted that the ROM rating did not apply as page 497 of the A.M.A., *Guides* stated that "Most impairments are based on the DBI where impairment class is determined by the diagnosis and specific criteria." "[ROM] is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment." "DBI is the primary method of evaluation of the lower limb." He indicated that it was clear the DBI method should be used for the diagnosis of left Achilles rupture. The DMA concluded that MMI had been reached as of the date of his impairment evaluation.

OWCP, by decision dated October 15, 2019, granted appellant a schedule award for seven percent permanent impairment of the left lower extremity. The period of the award ran for 14.35 weeks from April 30 through August 8, 2019, and was based on the opinions of Dr. Diamond and the DMA.

On October 24, 2019 appellant, through counsel, requested reconsideration. Counsel contended that DMA Kaz' opinion was not entitled to the weight of the medical evidence as he did not properly apply the A.M.A., *Guides* to Dr. Diamond's findings related to appellant's diagnoses of left ankle and left knee arthritis. He also contended that OWCP failed to identify the

percentage of impairment awarded to appellant in its October 15, 2019 decision. No new medical evidence was submitted with appellant's request.

By decision dated January 22, 2020, OWCP denied appellant's request for reconsideration of the merits of his claim, pursuant to 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[5] and its implementing regulations[6] 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 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. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[8] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[9]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[10] In determining impairment for the lower extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the foot/ankle, reference is made to Table 16-2 (Foot and Ankle Regional Grid) of the A.M.A., *Guides*.[11] After the CDX is determined from the Foot and Ankle Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[12] Under Chapter 2.3, evaluators are directed to provide reasons

[5] *Id.* at § 8107.

[6] 20 C.F.R. § 10.404.

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

[8] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); *id.*, Chapter 2.808.5a (March 2017).

[9] *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[10] A.M.A., *Guides*, page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[11] *See* A.M.A., *Guides* 501-08, Table 16-2.

[12] *Id.* at 515-22.

for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[13]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[14]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish greater than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

Appellant submitted an April 30, 2019 report from Dr. Diamond to support his claim for a schedule award. Dr. Diamond provided ROM findings for appellant's left ankle and knee. However, he did not provide an impairment rating based upon the ROM methodology. Rather, Dr. Diamond applied the DBI rating methodology pursuant to Table 16-2, page 507, of the A.M.A., *Guides*, for a diagnosis of arthritis (1.4 millimeters (mm) lateral joint talofibular). He assigned grade modifiers and applied the net adjustment formula to find a net adjustment of +1, which yielded 22 percent left lower extremity permanent impairment. In a June 7, 2019 report, Dr. Diamond amended his 22 percent left lower extremity permanent impairment rating to reflect a 27 percent left lower extremity permanent impairment rating, due to a diagnosis of left knee arthritis based on January 16, 2019 x-rays. He restated his prior calculations and determination that appellant had 22 percent permanent impairment due to his left ankle arthritis. Additionally, Dr. Diamond applied the DBI rating methodology pursuant to Table 16-3, page 511, for a diagnosis of left knee primary joint arthritis based on x-ray findings. He assigned grade modifiers and applied the net adjustment formula to find a net adjustment of -1, which yielded six percent left knee permanent impairment. Dr. Diamond combined the 22 percent left ankle impairment rating and six percent left knee impairment rating, which yielded 27 percent permanent impairment of the left lower extremity. The Board notes that OWCP has not accepted work-related left ankle and left knee arthritis conditions and the medical evidence of record does not otherwise establish the existence of such conditions, whether preexisting or work related in nature.[15] The Board further notes that Dr. Diamond also diagnosed post-traumatic left ankle sprain and strain with full-thickness tear of the left Achilles tendon, but did not provide an impairment rating based on this condition.

[13] *Id*. at 23-28.

[14] *See supra* note 8 at Chapter 2.808.6(f) (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

[15] It is well established that, in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments of the body are to be included. *M.C.*, Docket No. 19-1428 (issued February 3, 2020); *D.H.*, Docket No. 17-0530 (issued July 2, 2018); *D.F.*, 59 ECAB 288 (2007); *Kenneth E. Leone*, 46 ECAB 133 (1994).

OWCP properly referred the evidence of record to a DMA, Dr. Kaz. In his August 18, 2019 report, the DMA reviewed Dr. Diamond's reports and rated appellant's permanent impairment of the left ankle under Table 16-20 and Table 16-22, page 549, for a ROM rating based on the diagnosis of left Achilles tear. Under Table 16-20, the DMA found two percent impairment for 20 degrees of inversion and zero percent impairment for 20 degrees of eversion. Under Table 16-22, he found seven percent impairment for 10 degrees of dorsiflexion and zero percent impairment for 45 degrees of plantar flexion. The DMA added these values to equal nine percent permanent impairment of the left lower extremity. Referring to Table 16-25 on page 550, he determined that these ROM measurements represented a CDX of 1, a mild ROM classification. The DMA also utilized the DBI rating method in Table 16-2, page 501, and found that a CDX of 1 for a problem with mild motion deficits represented a default value of five percent impairment. He agreed with Dr. Diamond's finding of a GMFH of 3 based on a LEAS score of 62. The DMA noted, however, that based on Table 16-6, page 516, an antalgic limp with AFO yielded a GMFH of 2. He maintained that objective evidence of a limp with an AFO was more reliable than the subjective LEAS score, and that a GMFH of 2 was preferred. The DMA disagreed with Dr. Diamond's finding of a GMPE of 1 and determined that, under Table 16-7, page 517, left calf atrophy of 2.5 centimeters yielded a GMPE of 2. He advised that a GMCS was not applicable as the MRI scan was used to make the diagnosis of Achilles rupture. The DMA applied the net adjustment formula to find a net adjustment of 2, which yielded seven percent left lower extremity permanent impairment. He correctly explained that the ROM methodology was not applicable as page 497 of the A.M.A., *Guides* provides that loss of ROM is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment. The DMA concluded that the use of the DBI rating method was an appropriate method for determination of impairment in appellant's case as appellant had a clearly defined DBI for his diagnosis of left Achilles rupture. He disagreed with Dr. Diamond's 27 percent left lower extremity permanent impairment rating due to the diagnosis of left ankle and left knee arthritis. The DMA reasoned that the left ankle and left knee x-rays Dr. Diamond relied upon revealed asymptomatic left knee arthritis and incidental left ankle arthritis. He maintained that an MRI scan was a more accurate assessment of the presence of arthritis than x-rays. The DMA noted that the February 20, 2018 left ankle MRI scan did not reveal any objective findings of arthritis. He further noted that the left knee x-rays read on January 30, 2019 revealed a lateral joint space measurement of 3.1 mm while a CDX of 1 for knee arthritis as found by Dr. Diamond under Table 16-3, page 511, represented a cartilage measurement of 3 mm. The DMA maintained that since the 3.1 mm measurement was greater than 3 mm, it did not qualify for an impairment rating based on radiographic findings. Further, he related that while the A.M.A., *Guides* allowed ROM measurements to be rounded up it did not address whether cartilage intervals measurements could be rounded up. The DMA thus, concluded that Dr. Diamond incorrectly rated impairment of appellant's left ankle based on a diagnosis of arthritis.

The Board finds that the DMA properly applied the A.M.A., *Guides* to find that appellant had no more than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award. Dr. Kaz' report is detailed, well rationalized, and based on a proper factual background, and thus his opinion represents the weight of the medical evidence. As such, the Board finds that appellant has not met his burden of proof to establish greater left lower extremity permanent impairment than what was previously awarded.

Appellant may request a schedule award or increased schedule award at any time 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

Section 8128(a) of FECA vests OWCP with discretionary authority to determine whether to review an award for or against compensation. The Secretary of Labor may review an award for or against compensation at any time on his own motion or on application.[16]

To require OWCP to reopen a case for merit review pursuant to FECA, the claimant must provide evidence or an argument which: (1) shows that OWCP erroneously applied or interpreted a specific point of law; (2) advances a relevant legal argument not previously considered by OWCP; or (3) constitutes relevant and pertinent new evidence not previously considered by OWCP.[17]

A request for reconsideration must be received by OWCP within one year of the date of OWCP's decision for which review is sought.[18] If it chooses to grant reconsideration, it reopens and reviews the case on its merits.[19] If the request is timely, but fails to meet at least one of the requirements for reconsideration, OWCP will deny the request for reconsideration without reopening the case for review on the merits.[20]

ANALYSIS -- ISSUE 2

The Board further finds that OWCP properly denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

In his timely request for reconsideration, appellant, through counsel, disagreed with DMA Dr. Kaz' opinion that he had seven percent permanent impairment of the left lower extremity. Counsel contended that the DMA did not properly apply the A.M.A., *Guides* to Dr. Diamond's findings related to appellant's diagnoses of left ankle and left knee arthritis. As discussed above, OWCP has not accepted appellant's claim for either left ankle or left knee arthritis as work related. Moreover, as found above, the DMA properly applied the appropriate tables and grading schemes

[16] 5 U.S.C. § 8128(a); *see L.D.*, Docket No. 18-1468 (issued February 11, 2019); *see also V.P.*, Docket No. 17-1287 (issued October 10, 2017); *D.L.*, Docket No. 09-1549 (issued February 23, 2010); *W.C.*, 59 ECAB 372 (2008).

[17] 20 C.F.R. § 10.606(b)(3); *see L.D.*, *id.*; *see also L.G.*, Docket No. 09-1517 (issued March 3, 2010); *C.N.*, Docket No. 08-1569 (issued December 9, 2008).

[18] *Id.* at § 10.607(a). The one-year period begins on the next day after the date of the original contested decision. For merit decisions issued on or after August 29, 2011, a request for reconsideration must be received by OWCP within one year of OWCP's decision for which review is sought. *Supra* note 8 at Chapter 2.1602.4 (February 2016). Timeliness is determined by the document receipt date of the request for reconsideration as indicated by the received date in the Integrated Federal Employees' Compensation System (iFECS). *Id.* at Chapter 2.1602.4b.

[19] *Id.* at § 10.608(a); *see also M.S.*, 59 ECAB 231 (2007).

[20] *Id.* at § 10.608(b); *E.R.*, Docket No. 09-1655 (issued March 18, 2010).

of the A.M.A., *Guides* to the examination findings and determined that appellant had seven percent left lower extremity permanent impairment.

The Board further finds that appellant has not submitted relevant and pertinent new evidence not previously considered relative to the issue of whether he has established greater than seven percent left lower extremity permanent impairment. The underlying issue is whether he submitted sufficient evidence to establish that he had more than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award, thereby warranting an increased or additional schedule award. This is a medical question that requires rationalized medical opinion evidence to resolve the issue.[21] However, appellant did not submit any additional evidence with his request for reconsideration. Because he did not provide any relevant and pertinent new evidence, he is not entitled to a review of the merits based on the third requirement under 20 C.F.R. § 10.606(b)(3).[22]

The Board, accordingly, finds that appellant has not met any of the requirements of 20 C.F.R. § 10.606(b)(3). Pursuant to 20 C.F.R. § 10.608, OWCP properly denied merit review.[23]

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than seven percent permanent impairment of the left lower extremity, for which he previously received a schedule award. The Board further finds that OWCP properly denied appellant's request for reconsideration of the merits of his claim pursuant to 5 U.S.C. § 8128(a).

[21] *J.B.*, Docket No. 17-0628 (issued June 28, 2017).

[22] 20 C.F.R. § 10.606(b)(3)(iii).

[23] *D.G.*, Docket No. 19-1348 (issued December 2, 2019); *S.H.*, Docket No. 19-1115 (issued November 12, 2019); *M.E.*, 58 ECAB 694 (2007); *Susan A. Filkins*, 57 ECAB 630 (2006).

ORDER

IT IS HEREBY ORDERED THAT the October 15, 2019 and January 22, 2020 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: July 19, 2022
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board