United States Department of Labor
Employees' Compensation Appeals Board

B.K., Appellant	)	
and	)	**Docket No. 09-1513**
	)	**Issued: March 4, 2010**
DEPARTMENT OF THE ARMY, FORT RILEY RANGE CONTROL, Fort Riley, KS, Employer	)	

Appearances:
Appellant, 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
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On May 11, 2009 appellant filed a timely appeal of decisions dated May 28, 2008 and May 5, 2009 of the Office of Workers' Compensation Programs denying his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that he is entitled to a schedule award due to an accepted employment injury.

FACTUAL HISTORY

On March 17, 2004 appellant, then a 48-year-old maintenance worker, filed a traumatic injury claim alleging that on that day he fractured his vertebrae after sustaining a fall while tightening ropes on a rope bridge. He stopped work that day. Appellant returned to light duty on May 5, 2004. The Office accepted his claim for right L3 transverse process fracture and right

fourth, fifth and sixth posterolateral rib fractures. It subsequently accepted bilateral restless leg syndrome and displacement of lumbar intervertebral disc without myelopathy.[1]

Appellant submitted an April 2, 2004 attending physician's report from Dr. Todd Vento, a Board-certified internist, who diagnosed multiple rib fractures, transverse process fractures of the thoracic and lumbar vertebral bodies and subpleural hematoma. In reports dated July 29 and August 17, 2004, Dr. Vento diagnosed restless leg syndrome due to withdrawal from morphine that was prescribed following the rib fractures.

An October 13, 2004 report from Dr. Wade Welch, a Board-certified neurologist, noted appellant's complaint of low back pain and right chest pain. On examination, he found coordination intact to gross and fine motor including gait and appendicular testing. Muscle bulk and tone were normal without atrophy or fasciculations. Dr. Welch noted that appellant's restless leg syndrome was precipitated by morphine withdrawal and that his right flank paresthesia was secondary to intercostals neuralgia from multiple rib fractures. Appellant also submitted several physical therapy notes.

On January 23, 2005 appellant accepted a new position as a traffic management specialist.[2]

In an October 24, 2005 report, Dr. Nanda Kumar, a Board-certified neurologist, noted appellant's complaint of pain in the midthoracic spine and over the upper and lower lumbar and sacral region. Examination of the upper and lower extremities showed normal casual gait and no focal muscular atrophy or fasciculations. Dr. Kumar also reported normal electromyogram results. He opined that appellant's symptoms were due to mechanical low back pain from his previous trauma. Dr. Kumar also opined that appellant had musculoligamentous strain over his back with previous transverse process fractures that must have healed by this time. Regarding restless leg syndrome, he recommended diagnostic polysomnogram. In an October 13, 2005 lumbar spine magnetic resonance imaging (MRI) scan report, Dr. Gregory Welle, a Board-certified diagnostic radiologist, found mild degenerative disc disease at L1-2, without stenosis or nerve root impingement and degenerative disc disease and bulging, with a possible small annular tear at L5-S1 but no stenosis or nerve root impingement. In a November 14, 2005 thoracic spine MRI scan report, Dr. Kelly J. Ivestor, a Board-certified diagnostic radiologist, noted several displaced rib fractures in the right rib cage but no other significant abnormalities. The spinal cord was normal. Appellant also submitted reports from Dr. Roger Peck, a Board-certified internist, dated between October 10, 2005 and May 9, 2006. Dr. Peck noted in a March 22, 2006 report that appellant continued having difficulty across the transverse fracture area and into the right low thoracic area.

[1] On January 21, 2005 appellant requested that the Office expand his claim to include treatment for spinal manipulation for a subluxation of the spine. In its February 14, 2005 decision, the Office found that accepting displacement of lumbar intervertebral disc without myelopathy allowed for the requested spinal manipulation treatment.

[2] In a June 28, 2005 decision, the Office reduced appellant's wage-loss compensation to zero finding that his actual earnings as a traffic management specialist fairly and reasonably represented his wage-earning capacity.

On January 31, 2008 appellant filed a schedule award claim. On February 5, 2008 the Office advised him of the medical evidence necessary to establish permanent impairment of a scheduled body member due to the accepted injury and allowed him 60 days to provide such evidence. In particular, it requested a physician's report indicating that appellant had reached maximum medical improvement with an estimate of the extent of permanent impairment.

In a May 28, 2008 decision, the Office denied appellant's schedule award claim finding the evidence insufficient to establish that he sustained permanent impairment to a scheduled member due to the accepted work injury.

On November 16, 2008 appellant requested reconsideration. He also noted that he continued to be treated by Dr. Peck and Dr. Michael Schuster, a Board-certified physiatrist, for intercostals nerve block injections.

In support of his request, appellant submitted a February 22, 2007 polysomnography report from Dr. Steven Short, a Board-certified otolaryngologist, diagnosed obstructive sleep apnea-hypopnea syndrome, periodic leg motions of sleep and restless leg syndrome. In reports from Dr. Peck dated between August 6, 2007 and June 13, 2008, he diagnosed fatigue and recommended male hormone replacement treatment.

In an October 15, 2007 report, Dr. Schuster noted appellant's complaint of pain over his right ribs. Upon examination, he found restricted range of motion of appellant's thoracic spine and pain to palpation over his anterior rib cage. Dr. Schuster diagnosed status post multiple rib fractures, intercostals neuralgia and thoracic spondylosis with facet syndrome. He recommended right intercostals nerve block. In reports dated between October 30, 2007 and June 11, 2008, Dr. Schuster noted performing intercostals nerve block. On January 23, 2008 he diagnosed intercostals neuralgia, thoracic and lumbar spondylosis and thoracic radiculopathy. Dr. Schuster also recommended radio frequency ablation of the right thoracic and upper lumbar facet joints, which was performed on February 14, 2008. On March 10, 2008 he indicated that appellant had fatigue and joint pain. Dr. Schuster diagnosed costochondritis, intercostals neural and thoracic spondylosis. He recommended reevaluation in four to six weeks as appellant's symptoms became more intense. In an April 14, 2008 report, Dr. Schuster found normal strength of the bilateral major muscle groups of the bilateral upper extremities. He also found no spasticity or rigidity, no tremors or involuntary movements and no swelling of the bilateral lower extremities. Dr. Schuster recommended right intercostals nerve block of ribs 10 through 12. He also advised reevaluation in three to four weeks and a possible repeat nerve block.

Appellant submitted several diagnostic reports of his spine and abdomen dated between November 15, 2005 and July 10, 2007. He also submitted several medical reports already of record. Included in the diagnostic testing reports was a July 6, 2007 lumbar spine MRI scan report from Dr. Welle who noted no significant change from his prior examination. A July 5, 2007 thoracic spine MRI scan report from Dr. Michael Sheffield, a Board-certified diagnostic radiologist, indicated that there were no changes from the previous November 14, 2005 study.

On February 14, 2009 an Office medical adviser reviewed the medical record, noted appellant's accepted condition and opined that the only accepted condition that would potentially be a basis for a schedule award would be displacement of lumbar intervertebral disc without a

myelopathy. He further determined that the medical evidence showed no indication of any lower extremity radiculopathy that would be a basis for finding impairment under Chapter 15 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*). The medical adviser noted that records contemporaneous with appellant's injury indicated that appellant had thoracic pain but no pain extending to the upper or lower extremities. He noted that Drs. Welch and Kumar did not note findings that would be a basis for an impairment rating due to the accepted conditions. The medical adviser found no basis on which to attribute permanent impairment due to the accepted conditions.

In a March 5, 2009 decision, the Office denied modification of its May 28, 2008 decision finding that the additional evidence submitted was insufficient to warrant modification.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulations 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. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. A.M.A., *Guides* has been adopted by the Office for evaluating schedule losses and the Board has concurred in such adoption.[4]

Not all medical conditions accepted by the Office result in permanent impairment to a scheduled member.[5] It is the claimant's burden to establish that he or she sustained a permanent impairment of a scheduled member or function as a result of an employment injury.[6] Office procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of maximum medical improvement), describes the impairment in sufficient detail to include, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation or other pertinent description of the impairment and the percentage of impairment should be computed in accordance with the A.M.A., *Guides*.[7]

[3] 5 U.S.C. §§ 8101-8193. *See* 5 U.S.C. § 8107.

[4] *See* 20 C.F.R. § 10.404; *R.D.*, 59 ECAB ___ (Docket No. 07-379, issued October 2, 2007).

[5] *Thomas P. Lavin*, 57 ECAB 353 (2006).

[6] *Tammy L. Meehan*, 53 ECAB 229 (2001).

[7] *J.P.*, 60 ECAB ___ (Docket No. 08-832, issued November 13, 2008); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

ANALYSIS

The Office accepted that appellant sustained right L3 transverse process fracture; right fourth, fifth and sixth posterolateral rib fractures; bilateral restless leg syndrome and displacement of lumbar intervertebral disc without myelopathy. However, the back is not listed as a scheduled member under the Act.[8] While an injury to the spine or back may cause impairment in an extremity, such as an arm or a leg, the Board finds that the medical evidence is insufficient to establish that appellant's accepted back condition caused any permanent impairment to a scheduled member of the body.[9] It also finds insufficient medical evidence to establish that appellant's other accepted conditions entitles him to a schedule award.

The Board notes that none of the medical reports submitted by appellant support that he has a permanent impairment of a scheduled member of the body or that he has reached maximum medical improvement.[10] Dr. Schuster's reports noted appellant's diagnosed conditions and described the treatment methods for those conditions. However, he did not evaluate appellant for schedule award purposes in any of these reports. For example, Dr. Schuster did not explain how any of appellant's accepted conditions caused a permanent impairment of a scheduled body member, such as the arms or the legs, pursuant to the A.M.A., *Guides*. Similarly, the reports of other physicians, such as Drs. Peck and Short, do not address whether appellant sustained any permanent impairment, pursuant to the A.M.A., *Guides*, due to the accepted injuries.

The Office medical adviser, in his February 14, 2009 report, is the only physician who addressed whether appellant has a permanent impairment of a scheduled body member causally related to the accepted conditions. The medical adviser noted reviewing the medical record and determined that the medical evidence did not indicate that any of the accepted conditions caused impairment to scheduled members such as the arms or legs that was ratable under the A.M.A., *Guides*. He found that appellant had no permanent impairment due to any of his accepted conditions.

On appeal, appellant asserts that his accepted conditions remain symptomatic requiring regular treatment, that the Office is unresponsive to his inquiries about benefits and that his quality of life has changed due to his accepted conditions. The Board notes that this appeal pertains to whether the Office properly denied appellant's claim for a schedule award. The Office has not issued any decision regarding any other benefits. The Board only has jurisdiction over final decisions of the Office.[11] Furthermore, the Board notes that factors such as

[8] *See* 5 U.S.C. § 8101(19); *see also George E. Williams*, 44 ECAB 530 (1993) (finding that as neither the Act nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back, no claimant is entitled to such an award).

[9] *See J.Q.*, 59 ECAB ___ (Docket No. 06-2152, issued March 5, 2008) (the schedule award provisions of the Act include the extremities and a claimant may be entitled to a schedule award for permanent impairment to a lower extremity even though the cause of such impairment originates in the spine).

[10] *See D.S.*, 60 ECAB ___ (Docket No. 08-885, issued March 17, 2009) (it is well established that a schedule award cannot be paid until a claimant has reached maximum medical improvement). The Board has explained that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. *Mark A. Holloway*, 55 ECAB 321 (2004).

[11] *See* 20 C.F.R. § 501.2(c).

employability or limitations on daily activities have no bearing on the calculation of a schedule award.[12]

CONCLUSION

The Board finds that appellant has not established that he is entitled to a schedule award due to an accepted employment injury.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated May 5, 2009 and May 28, 2008 are affirmed.

Issued: March 4, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[12] *J.H.*, 60 ECAB ___ (Docket No. 08-2432, issued June 15, 2009).