United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 09-888**
	)	**Issued: May 25, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Cape Coral, FL, 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
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 19, 2009 appellant timely appealed the January 22, 2009 merit decision of the Office of Workers' Compensation Programs, which denied her claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the schedule award claim. Although appellant did not specifically request review, the Board also has jurisdiction over the Office's April 21, 2008 merit decision.

ISSUES

The issues are: (1) whether the Office properly declined to reimburse appellant for certain medical expenses incurred between November 2001 and December 2004; and (2) whether appellant is entitled to a schedule award for permanent impairment of the left lower extremity.

FACTUAL HISTORY

This case was previously on appeal. Appellant, a 54-year-old rural carrier associate, was involved in an employment-related motor vehicle accident (MVA) on February 2, 1996. Her claim was initially accepted for cervical strain, left leg contusion and left wrist fracture.

Appellant resumed work following her February 2, 1996 injury. On March 31, 1998 the Office expanded the claim to include panic disorder.[1]

Appellant stopped work on October 21, 2001. She was briefly hospitalized later that same month for treatment of recurrent major depressive disorder with psychosis. Appellant filed a claim for wage-loss compensation (Form CA-7) for the period October 21, 2001 through October 2, 2002, which the Office denied. She also filed a separate occupational disease claim with an October 22, 2001 date of injury, which was similarly denied (xxxxxx341). Appellant has not returned to work since her October 2001 hospitalization.

When the case was previously on appeal, appellant sought reimbursement for various medical expenses.[2] On October 17, 2006 the Director, on behalf of the Office, moved to remand the case so that the Office could combine appellant's two claims and ascertain whether she had timely requested reimbursement. Because the disputed medical bills were not part of the record submitted on appeal, the Board was unable to properly adjudicate the medical reimbursement issue, and therefore, it granted the Director's motion.[3]

On remand, the Office again denied appellant's request for reimbursement. However, the Branch of Hearings & Review set aside the Office's January 24, 2007 decision because the Office had not attempted to obtain copies of appellant's medical bills as it had indicated it would in its October 17, 2006 motion to remand. In her January 18, 2008 decision, the hearing representative directed the Office to fully comply with the Board's November 1, 2006 order.

In an April 21, 2008 decision, the Office itemized 36 separate requests for reimbursement, the majority of which were for services rendered during calendar year 2004. The services included family practice office visits (9), prescription reimbursements (8), psychiatric treatment (11), including two psychiatric office visits in March 2002, and several unspecified office visits (8).[4] The Office denied reimbursement for the claimed services on the basis that there was no evidence indicating that appellant had timely requested reimbursement. In addition, it noted that any psychiatric bills were denied because "we have not accepted a psychiatric condition...."

On June 6, 2008 appellant filed a claim for an increased schedule award. She had previously received an award for 30 percent impairment of the left upper extremity. In support of her latest claim, appellant submitted a June 6, 2008 form report from Joseph P. Pagano, MD,

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[1] At the time, appellant was under the care of Dr. Jerry S. Kantor, a Board-certified psychiatrist. After her employment-related MVA, appellant experienced panic attacks while driving her mail truck. She had been seeing Dr. Kantor since August 15, 1996. In a March 9, 1998 report, Dr. Kantor indicated that appellant was receiving treatment for post-traumatic stress disorder (PTSD), panic disorder, simple phobic disorder and early major depressive disorder, all of which were related to her February 2, 1996 MVA. While the Office authorized Dr. Kantor to treat appellant for panic disorder, it did not otherwise comment on his diagnoses of employment-related PTSD, simple phobic disorder and early major depressive disorder. The Office authorized psychotherapy for only six months.

[2] Docket No. 06-1133.

[3] The Board's November 1, 2006 order is incorporated herein by reference.

[4] These nonspecific "office visit[s]" were with the Florida Clinical Practice Association, Inc.

who found 20 percent impairment of the left lower extremity ostensibly due hip, knee and ankle pain.

Dr. H.P. Hogshead, a Board-certified orthopedic surgeon and district medical adviser (DMA), reviewed the claim on June 16, 2008 and advised that the medical record did not contain sufficient objective findings from which to base an evaluation of orthopedic impairment of the left lower extremity. The DMA recommend a second opinion examination by an orthopedist.

By letter dated June 18, 2008, the Office advised appellant of the DMA's finding. It further indicated that it planned to schedule her for a second opinion medical examination. Ultimately, the Office did not schedule appellant for a second opinion examination, but instead issued a January 22, 2009 decision based on the existing evidence of record. It found that appellant had not established entitlement to a schedule award in excess of the 30 percent left upper extremity award she received on February 7, 2000.

LEGAL PRECEDENT -- ISSUE 1

An injured employee is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which the Office considers necessary to treat the work-related injury.[5] To be considered for payment, medical bills must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when the Office first accepted the claim as compensable, whichever is later.[6]

ANALYSIS -- ISSUE 1

The record includes several medical reimbursement forms (CA-915) dated March 12, 2008, which the Office received on April 22, 2008. From this information, the Office culled 36 unpaid medical expenditures ostensibly incurred between March 2002 and December 2004.[7] According to it, not one of the 36 expenditures was timely filed. The Board notes, however, that appellant timely filed invoices for office visits on November 13, 2001 and March 6, 2002. The Office received both invoices (explanation of benefits) on December 19, 2002. While the above-noted invoices were timely filed, the record does not clearly demonstrate that the medical services appellant received on November 13, 2001 and March 6, 2002 were for the treatment of her work-related injury. Both invoices simply note the doctor's name and "office visit" as the type of service rendered. There is no other information on the invoice/explanation of benefits that related the particular service to either a specific medical diagnosis or appellant's February 2, 1996 employment injury. Absent this type of clarification, one cannot reasonably conclude that the medical services were for the treatment of a work-related injury. As to the remaining 34 requests for reimbursement from March 18, 2002 through December 13, 2004, the record does

[5] 20 C.F.R. § 10.310(a) (2008).

[6] *Id.* at §§ 10.336 and 10.803. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the work-related injury, the employee should consult with the Office prior to obtaining it. *Id.* at § 10.336.

[7] The Office mistakenly identified one $15.00 expenditure for a "Psy Visit" as occurring on November 13, 2004 instead of November 13, 2001.

not establish that appellant submitted any of the requests by the end of the calendar year after the year when the expense was incurred, as required under 20 C.F.R. § 10.336. Accordingly, the Board affirms the Office's decision to deny reimbursement for the 36 itemized medical expenditures between November 2001 and December 2004.[8]

LEGAL PRECEDENT -- ISSUE 2

Section 8107 of the Federal Employees' Compensation Act sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[9] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the appropriate standard for evaluating schedule losses.[10] Effective February 1, 2001, schedule awards are determined in accordance with the A.M.A., *Guides* (5th ed. 2001).[11]

ANALYSIS -- ISSUE 2

In February 2000, appellant received a schedule award for 30 percent impairment of the left upper extremity. She filed her latest claim on June 6, 2008. The Office contacted appellant's treating physician, Dr. Pagano, and explained the type of medical evidence required to substantiate the claim for a schedule award. Dr. Pagano submitted three form reports, which the Office provided him for calculating impairment of the hip, knee and ankle. On each of the forms, Dr. Pagano noted 20 percent lower extremity impairment due to pain. He did not provide a narrative report or otherwise identify specific objective and subjective findings that supported his 20 percent impairment rating. Dr. Pagano also did not specifically reference the A.M.A., *Guides* (5th ed. 2001). When Dr. Hogshead, the DMA, reviewed Dr. Pagano's findings, he concluded that the medical record did not contain sufficient objective findings from which to base an evaluation of orthopedic impairment of the left lower extremity.

Dr. Pagano provided no objective basis for his pain-related left lower extremity impairment rating of 20 percent. Furthermore, he did not provide any explanation of how a left leg contusion sustained some 12 years prior would currently manifest itself as joint pain in the hip, knee and ankle. Dr. Pagano did not provide an impairment rating in accordance with the A.M.A., *Guides* (5th ed. 2001). The record is also devoid of sufficient medical findings that

[8] The Office's statement that a psychiatric condition had not been accepted is clearly erroneous. The record indicates that the Office accepted the condition of panic disorder in 1998. There is also medical evidence dating back to 1998 that links several other psychiatric diagnoses to appellant's February 2, 1996 employment-related MVA. The Office's finding with respect to the acceptance of any psychiatric conditions albeit incorrect, was superfluous given that the refusal to reimburse appellant for the above-noted medical expenses can be affirmed on an alternative basis.

[9] For a total loss of use of a leg, an employee shall receive 288 weeks' compensation. 5 U.S.C. § 8107(c)(2) (2006).

[10] 20 C.F.R. § 10.404.

[11] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 (June 2003).

would enable the DMA to provide an impairment rating with respect to appellant's left lower extremity. Although it is not entirely clear why the Office did not refer appellant for a second opinion examination, the Board notes that the onus is not on the Office to develop appellant's schedule award claim.[12] Accordingly, the Office properly denied appellant's claim for a schedule award with respect to her left lower extremity based on the record.

CONCLUSION

Appellant has not established entitlement to a schedule award for her left lower extremity. The Board further finds that the Office properly denied appellant's request for reimbursement for certain medical expenditures incurred between November 2001 and December 2004.

ORDER

IT IS HEREBY ORDERED THAT the January 22, 2009 and April 21, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 25, 2010
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

[12] An employee seeking benefits under the Act has the burden of proof to establish the essential elements of her claim. *Amelia S. Jefferson*, 57 ECAB 183, 187 (2005).