U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of PHILIP L. SUMRELL and DEPARTMENT OF THE NAVY, NAVAL STATION FIRE DEPARTMENT, Norfolk, Va.

*Docket No. 97-2188; Submitted on the Record;*
*Issued July 2, 1999*

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DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM, BRADLEY T. KNOTT

The issue is whether appellant has more than a 5 percent impairment of the upper left extremity for which he received a schedule award.

On June 17, 1994 appellant, then a 47-year-old fireman, was injured when his left elbow was hit by a door in the performance of duty. Appellant went to the local emergency room where he was x-rayed, diagnosed with a contusion and given a sling for his arm. The Office of Workers' Compensation Programs accepted the claim for left elbow contusion. Appellant was off work from June 17 to 20, 1994 when he returned to light duty. Because appellant was under a medical restriction that he not work more than 8 hours a day, his schedule was reduced from 72 to 40 hours a week effective August 3, 1994. Appellant received compensation for loss of premium pay and FLSA.[1]

Appellant has been under the care of Dr. Douglas U. Kells, a Board-certified orthopedic surgeon. In support of his claim, appellant submitted a series of attending physician reports dating from July 18, 1994 through October 13, 1995, which were signed by Dr. Kells and diagnosed traumatic lateral epicondylar contusion and an ulnar nerve contusion of the left elbow.

In treatment notes dating from July 6 to December 8, 1994, Dr. Kells noted appellant's history of injury and his complaints of radiating pain in the left arm and occasional numbness in the fourth and fifth fingers of the left hand. Physical findings included positive Tinel's sign medial epicondyle over ulnar nerve and groove radiating down the hand. Dr. Kells diagnosed traumatic lateral epicondylar contusion and a contusion of the ulnar nerve on the left side. He placed appellant on light duty with restrictions and recommended physical therapy.

Nerve conduction studies confirmed a mild, nonlocalized ulnar neuropathy with no evidence of a radial nerve injury or cervical radiculopathy.

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[1] Extra pay authorized under the Federal Standard Leave Act.

Dr. Kells referred appellant to Dr. Michael R. Slattery, a Board-certified neurologist. In reports dated August 31, September 30 and November 28, 1994, Dr. Slattery noted appellant's history of injury and that appellant suffered from intermittent severe pain in the left arm starting from the elbow and radiating down the ulnar aspect of the hand, tingling in the fourth and fifth fingers and worsening grip in the left hand. Dr. Slattery made physical findings and opined that appellant had a left post-traumatic ulnar neuropathy. He recommended that appellant continue light duty and physical therapy, avoid heavy lifting and extensive left elbow flexion/extension activity.

The Office referred appellant for a second opinion evaluation with Dr. Frank W. Gwathmey, a Board-certified orthopedic surgeon. In a September 27, 1995 report, Dr. Gwathmey diagnosed a subluxed ulnar nerve lying on the left medial epicondyle which he noted as being quite sensitive when palpated. He opined that appellant had reached maximum medical improvement unless surgery was considered. He acknowledged that even with surgery it was unclear whether appellant could ever resume his firefighting duties.[2]

In a report dated October 5, 1995, Dr. Kells indicated that appellant had reached maximum medical improvement and noted that he should have limited activity with his left arm. Dr. Kells' restrictions included no lifting, pushing, or pulling with the left arm, no climbing and no crawling.

For the purpose of determining a schedule award, appellant was examined by Dr. Kells on May 21, 1996. In a May 30, 1996 report, Dr. Kells described appellant's work injury and noted that the nerve conduction studies showed an ulnar neuropathy on the left at the elbow with no evidence of radial nerve injury or cervical radiculopathy. On physical examination, Dr. Kells indicated that range of motion was measured according to Chapter 3 of the A.M.A., *Guides*, pages 39 and 40, figures 30 and 33. The range of motions of the elbow were found to be supination 80 degrees, pronation 65 degrees, flexion 140 degrees and extension 35 degrees from rotating full extension. Dr. Kells also noted that appellant's muscle strength was 5/5 with some decrease sensation in the ulnar side of the hand. He calculated appellant's degree of impairment based on figure 35, Page 41, Chapter 3 and figure 32, Page 40, Chapter 3, finding that appellant had 1 percent impairment given for loss of pronation and 4 percent impairment given for loss of extension, for a total of 5 percent permanent partial impairment to the left upper extremity.

In a July 11, 1996 decision, the Office awarded appellant a schedule award for a 5 percent left arm impairment for the period of June 23 to July 20, 1996.

The Board finds that the case is not in posture for a decision.[3]

[2] The record contains a series of physical therapy treatment notes and a report from a hand therapist discussing appellant's impairment in relation to the A.M.A., *Guides*. Since a physical therapist is not a physician for the purposes of the Federal Employees' Compensation Act, s*ee Jane A. White*, 34 ECAB 515 (1983), the physical therapy treatment notes submitted by appellant are not considered to be "medical" evidence for the purpose of evaluating appellant's schedule award.

[3] Appellant submitted evidence on appeal. The Board has no jurisdiction to review evidence submitted for the first time on appeal; *see* 20 C.F.R. § 501.2(c).

Under section 8107 of the Act[4] and section 10.304 of the implementing federal regulations,[5] schedule awards are paid for the loss or permanent disability of certain specified body members, functions or organs. Neither the Act nor the regulations specify the manner, in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Board has authorized 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 Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[6]

In order to meet his burden, appellant must submit sufficient medical evidence to show a permanent impairment causally related to his employment that is ratable under the A.M.A., *Guides*. The Office's procedures discuss the type of evidence required to support a schedule award. The evidence must show that the impairment has reached a permanent and fixed state and indicate the date this occurred, describe the impairment in detail and contain an evaluation of the impairment under the A.M.A., *Guides*.

The Office requested that Dr. Kells, appellant's treating physician, determine appellant's impairment rating under the A.M.A., *Guides*. In his May 21, 1996 report, Dr. Kells diagnosed that appellant had traumatic lateral epicondylar condylistis of the left elbow. He provided measurements of appellant's range of motion and correctly correlated the measurements to the A.M.A., *Guides* as follows: supination of 80 degrees correlated to a 0 percent loss; pronation of 65 degrees correlated to a 1 percent loss; flexion of 140 degrees correlated to a 0 percent loss, and extension of 36 degrees correlated to a 4 percent loss. Dr. Kells correctly totaled the losses for a finding of 5 percent permanent partial impairment of the left lower extremity.

The Board notes, however, that Dr. Kells also diagnosed that appellant had a post-traumatic ulnar neuropathy of the left elbow related to his employment injury. Under the A.M.A., *Guides*, permanent impairment related to the upper extremity secondary to neuropathy entrapment. may be measured according to the sensory and motor deficits described at Chapter 3, section 3.1k, Tables 11 to 15, pages 46 to 56, or measured alternatively under Table 16, page 57. The A.M.A., *Guides* provide that restrictions of motions may result from peripheral spinal nerve impairments, and that consideration was given to such impairments when the percentage values set forth in the section on impairments due to peripheral nervous system disorders was derived. As such, if an impairment results strictly from a peripheral nerve lesion, the evaluator should not apply the impairment values from both the sections of the A.M.A., *Guides* relating to range of motion, pages 24 through 45 and the section on peripheral nervous system disorders, pages 46 through 57, because a duplication and an unwarranted increase in the impairment rating would result. If restricted motion cannot be attributed to a peripheral nerve lesion alone, the impairment should then be evaluated according to sections 3.1f through 3.1j (pages. 24 through 45) and the section on peripheral nerve impairment. Thereafter, the motion impairment should be combined with the peripheral nerve system impairment percent.

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.304.

[6] *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

Because no physician has discussed appellant's permanent impairment rating in relation to his peripheral nerve injury, the Board will set aside the Office's decision awarding a 5 percent permanent impairment of the left lower extremity, and remand the case for further development and evaluation of appellant's permanent impairment under the A.M.A., *Guides*. After such further medical development as the Office deems necessary, the Office shall issue a *de novo* decision on appellant's entitlement to a schedule award.

The decision of the Office of Workers' Compensation Programs dated July 11, 1996 is hereby set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, D.C.
July 2, 1999

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member