U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ANTHONY J. FLIPPO and DEPARTMENT OF THE ARMY, DUGWAY PROVING GROUND, WEST DESERT TEST CENTER, WD-TS-W, Dugway, UT

Docket No. 98-507; Submitted on the Record;
Issued September 13, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, WILLIE T.C. THOMAS, BRADLEY T. KNOTT

The issues are: (1) whether appellant is entitled to a schedule award for a permanent impairment of the back; and (2) whether appellant is entitled to more than a 10 percent permanent impairment of the right upper extremity, for which he has already received a schedule award.

On January 9, 1994 appellant, then a supervisory engineering technician, filed a traumatic injury claim (Form CA-1) alleging that on November 18, 1994 he experienced severe pain in his middle and lower back, right arm and right leg when he slipped on black ice while walking to his car through a parking lot at the Salt Lake City airport.[1]

By letter dated January 25, 1995, the Office of Workers' Compensation Programs accepted appellant's claim for lumbar strain and contusion of the right elbow. Subsequently, the Office expanded the acceptance of appellant's claim to include ulnar nerve decompression which was performed on March 7, 1995.

On December 9, 1995 appellant filed a claim for a schedule award (Form CA-7) for his employment-related injuries.

The Office received a January 19, 1996 medical report, from Dr. Jonathan H. Horne, a Board-certified orthopedic surgeon and appellant's treating physician, in response to its December 20, 1995 letter, requesting a narrative medical report to support appellant's claim. In this report, Dr. Horne indicated that appellant had a herniated lumbar disc at L4-5 and L5-S1, facet arthropathy in the lumbar spine at L3-4, L4-5 and L5-S1 with mild spondylosis of the L4-5 and L5-S1 discs and anterior tractions spurs and nerve root radiculopathy of the L5 and S1 nerve roots in the right leg. He further indicated that appellant had positive radiculopathy on an electromyogram with motor and sensory slowing of nerve conduction of the right ulnar nerve at

[1] Appellant retired from the employing establishment on disability effective February 1996.

the elbow with an incurred post-traumatic ulnar neuropathy. Dr. Horne then noted appellant's problems with bunions on his foot and various surgeries performed on appellant's back, bunions and right elbow. Using the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, he determined that appellant had a 10 percent whole body permanent impairment secondary to the right leg radiculopathy, as well as, the S1 and L5 nerve root radiculopathy. Dr. Horne further determined that appellant had a 10 percent impairment of the lower extremities secondary to bunions, which equated to a 6 percent whole person impairment in addition to that for the radiculopathy. He noted that appellant had an impairment of the right upper extremity secondary to ulnar nerve neuropathy which had somewhat improved post surgery, but that appellant had residual sensory and motor deficit. Based on Table 15, page 54 of the A.M.A., *Guides*, Dr. Horne determined that appellant had an ulnar nerve neuropathy above the mid-forearm. He then stated that 50 percent was the maximum combined motor and sensory deficit percent impairment and rated appellant as 1/4 of that or 15 percent impairment of the upper extremity. Using Table 3, page 20 of the A.M.A., *Guides*, Dr. Horne determined that 15 percent of impairment of the upper extremity equaled a 9 percent whole person impairment. He then determined that appellant had a 12 percent whole person impairment secondary to lumbar spine herniated discs, surgical excision, degenerative facet and disc disease. Dr. Horne added the above percentages and determined that appellant had a combined 36 percent impairment of the whole person based on the Combined Values Chart in the A.M.A., *Guides.* He concluded that appellant had reached maximum medical improvement and that he should receive a medical retirement from the employing establishment.

An Office medical adviser reviewed the medical evidence of record and indicated that the impairment rating could not be confirmed or calculated based on the information provided in Dr. Horne's report.

The Office then referred appellant along with a statement of accepted facts, a list of specific questions and medical records by letter dated June 3, 1996, to Dr. Alvin Wirthlin, a neurologist, for a second opinion examination to determine the extent of permanent impairment of appellant's accepted employment conditions based on the fourth edition of the A.M.A., *Guides*. By letter of the same date, the Office advised Dr. Wirthlin of the referral.

In a June 20, 1996 medical report, Dr. Wirthlin provided appellant's employment injury, medical treatment and social history, a review of medical records and his findings on physical examination. He diagnosed ulnar nerve contusion, lumbar strain and status post lumbar surgery which was remote. In response to the Office's questions, he stated that appellant had reached maximum medical improvement regarding the accepted conditions of contusion of the right elbow and right ulnar nerve decompression. Concerning an impairment rating for appellant's right upper extremity, Dr. Wirthlin determined that based on the fourth edition of the A.M.A., *Guides*, Table 15, page 54, the maximum percentage of ulnar nerve upper extremity impairment would be 7 percent. Using Table 20, page 151, he determined that the sensory loss or pain would be Class II and that the range of sensory impairment was 1 percent to 25 percent. Dr. Wirthlin stated that he did not believe that this decreased sensation interfered with activity. Multiplying the maximum percentage of upper extremity impairment by the 25 percent from Table 20 and rounding it off, he determined that appellant had a 2 percent upper extremity

impairment. Based on Table 3, page 20, he concluded that appellant had a 2 percent upper extremity impairment which lead to a 1 percent whole person impairment.

Regarding the accepted condition of lumbar strain, Dr. Wirthlin opined that there had been no neurological or sensory loss due to the lumbar strain. Further, he opined that there was no weakness or atrophy and that the reflexes were symmetrical. Dr. Wirthlin concluded that he did not feel his sensory examination was reliable because it did not reflect a nerve root or peripheral nerve distribution. He then concluded that the only condition that a stocking/glove sensory deficit in the feet would mimic would be a polyneuropathy and that he did not believe appellant had a polyneuropathy.

On July 22, 1996 an Office medical adviser reviewed the medical records and agreed with Dr. Wirthlin's findings regarding the date appellant reached maximum medical improvement and appellant's permanent impairment rating for the right upper extremity.

By decision dated July 25, 1996, the Office found that section 8107 of the Federal Employees' Compensation Act did not provide a schedule award for appellant's work-related back condition. In an accompanying memorandum, the Office found that the weight of the medical opinion evidence rested with Dr. Wirthlin's opinion.

On August 5, 1996 the Office granted appellant a schedule award for a 2 percent permanent impairment of the right arm for the period June 20 through August 2, 1996.

In a November 20, 1996 letter, appellant requested reconsideration of the Office's July 25 and August 5, 1996 decisions. Appellant's request was accompanied by a November 5, 1996 medical report of Dr. Thomas E. Soderberg, a Board-certified orthopedic surgeon, indicating a history of the November 18, 1994 employment injury and appellant's medical treatment and his findings on physical examination regarding appellant's back and elbow conditions. Dr. Soderberg opined appellant had persistent pain and numbness in his right lower extremity and right upper extremity as a result of the November 18, 1994 employment injury. He further opined that appellant had a 10 percent permanent impairment of the whole person due to the presence of radiculopathy based on Table 72 in the *Guides*. Dr. Soderberg also opined that appellant had an impairment due to the residual symptoms of ulnar nerve entrapment of a mild degree. According to Table 16, he determined that this was equivalent to a 10 percent impairment of the upper extremity, which was equivalent to a 6 percent impairment of the whole person. Dr. Soderberg then concluded that combining these values resulted in a 16 percent permanent impairment of the whole person due to the November 18, 1994 employment injury.

By decision dated December 12, 1996, the Office denied appellant's request for modification based on a merit review of the claim. In an accompanying memorandum, the Office found that Dr. Soderberg failed to indicate whether he utilized the fourth edition of the A.M.A., *Guides* in determining appellant's impairment rating of the right upper extremity. The Office also found his findings vague as to the objective measurements that he based his estimate on. The Office further found that although Dr. Soderberg's report contained some objective medical data indicating a permanent impairment of the back, he failed to explain how a lumbar sprain could be responsible for the reported impairment and failed to provide the objective medical data required by the fourth edition of the A.M.A., *Guides*.

Dr. Horne submitted a January 30, 1997 medical report, indicating a review of medical records. He determined that in light of appellant's ulnar nerve entrapment at the elbow with a mild persistent neuropathy which was equivalent to a 10 percent impairment of the upper extremity and the persistence of appellant's ulnar nerve entrapment syndrome with a mild residual deficit after the March 7, 1995 surgery, this was an indication for a permanent impairment rating for the ulnar nerve entrapment at the elbow based on Table 16 of the fourth edition of the A.M.A., *Guides*. Dr. Horne then determined that based on Table 3, page 20 of the A.M.A., *Guides*, a 10 percent impairment of the upper extremity secondary to the ulnar nerve and the mild persistent residual ulnar nerve entrapment was equivalent to 6 percent of the whole person. He concluded that the 6 percent impairment rating secondary to the ulnar nerve entrapment in the right upper extremity plus the 15 percent of the whole person impairment secondary to the lumbar disc herniation, epidural fibrosis, herniated disc in the lumbar spine and the radiculopathy of the right lower extremity, resulted in a 20 percent whole person impairment based on the Combined Values Chart on page 322 of the A.M.A., *Guides*.

By letter dated February 10, 1997, the Office advised Dr. Horne that his medical report had been reviewed, but that he was not appellant's authorized representative. The Office then advised Dr. Horne that appellant should review his appeal rights if he disagreed with its decision.

In response to the Office's December 12, 1996 decision, Dr. Soderberg submitted a December 31, 1996 medical report, revealing that he utilized the fourth edition of the A.M.A., *Guides* in calculating an impairment rating for appellant's right upper extremity. He stated that Table 16, page 3/57 of the A.M.A., *Guides* described upper extremity impairment due to entrapment neuropathy of the median nerve at the wrist of a mild degree to be a 10 percent impairment of the upper extremity which was equivalent to 6 percent of the whole body. Dr. Soderberg indicated that appellant continued to have painful numbness in the right lower extremity and determined that based on Table 72, page 3/110 radiculopathy constituted a 10 percent impairment of the whole person. Additionally, he stated that he used touch and a pin prick as objective measurements to test sensory deficit and appellant's perception of painful numbness to be present. Dr. Soderberg then stated that he did not describe specific degrees of limitation of motion because he did not assign permanent impairment due to limited motion. Dr. Soderberg concluded that motion was limited to 50 percent of normal and that normal was described in the A.M.A., *Guides*, but that he did not include it in his rating.

In a February 17, 1997 letter, appellant requested reconsideration of the Office's decision. Appellant's request was accompanied by Dr. Soderberg's December 31, 1996 medical report and Dr. Horne's January 30, 1996 medical report.

The Office referred the medical evidence of record to an Office medical adviser to determine whether appellant had any additional impairment of the right arm. On March 20, 1997 an Office medical adviser reviewed the medical records and determined that appellant had reached maximum medical improvement on December 31, 1996. The Office medical adviser also determined that appellant had a 10 percent impairment of the right arm based on Table 16. The Office medical adviser also determined that appellant had a 2 percent permanent impairment of the right leg.

By decision dated March 27, 1997, the Office denied appellant's request for modification based on a merit review of the claim. In an accompanying memorandum, the Office modified its previous schedule award to reflect an award for an additional eight percent permanent impairment of appellant's right arm. The Office found the medical evidence that appellant's impairment of the lower extremities was not accepted as a result of the November 18, 1994 employment injury.

On March 31, 1997 the Office granted appellant a schedule award for an additional eight percent permanent impairment for the loss of use of the right arm for the period December 31, 1996 through June 23, 1997.[2]

The Board finds that appellant is not entitled to a schedule award for a permanent partial impairment of the back.

The Act provides that compensation shall be paid for an employment injury when it results in total or partial disability for work.[3] The Act also provides for a payment of a schedule award for permanent impairment of specified members and functions of the body.[4] However, as the Board has consistently held, there is no authority for paying a schedule award for an impairment of a portion of the body not enumerated in the schedule.[5] For this reason, a schedule award may not be made for an impairment of the back.[6] Appellant would be entitled to compensation only if it were established that his back impairment resulted in disability for work during the period of his absence from work.[7]

The Board further finds that appellant is not entitled to more than a 10 percent permanent impairment of the right upper extremity, for which he has already received a schedule award.

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[2] The Board notes that subsequent to the Office's March 31, 1997 decision, the Office received additional medical evidence. The Board, however, cannot consider evidence that was not before the Office at the time of the final decision; *see* 20 C.F.R. § 501.2(c)(1).

[3] 5 U.S.C. §§ 8105-8106.

[4] 5 U.S.C. § 8107.

[5] *William Edwin Muir*, 27 ECAB 579 (1976) (this principle applies equally to body members that are not enumerated in the schedule provision as it read before the 1974 amendment and to organs that are not enumerated in the regulations promulgated pursuant to the 1974 amendment); *see also Ted W. Dietderich*, 40 ECAB 963 (1989); *Thomas E. Stubbs*, 40 ECAB 647 (1989); *Thomas E. Montgomery*, 28 ECAB 294 (1977).

[6] 5 U.S.C. § 8101(19); *Eli J. Entrikin*, 30 ECAB 375 (1979); *Franklin Fox, Sr.*, 30 ECAB 342 (1979); *Billy Ray Beasley*, 28 ECAB 74 (1976).

[7] While a schedule award is not payable for the back impairment, the leg is a member of the body covered by the schedule provisions. Dr. Soderberg opined in his November 5, 1996 medical report, that appellant continued to have painful numbness in the right lower extremity due to the November 18, 1994 employment injury and determined that appellant had a 10 percent whole person impairment based on Table 72 of the fourth edition of the A.M.A., *Guides* due to radiculopathy. The Office medical adviser determined that appellant had a two percent impairment of the right lower leg. The record reveals, however, that this impairment rating was not due to the accepted lumbar strain, but due to conditions that were not accepted by the Office.

The schedule award provision of the Act[8] and its implementing regulation,[9] set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.[10] However, neither the Act nor the regulations specify the manner, in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice under the law for 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. The A.M.A., *Guides* have been adopted by the Office and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.[11]

Utilizing Dr. Soderberg's measurements in his December 31, 1996 medical report, the Office medical adviser determined that appellant had a 10 percent permanent impairment based on Table 16 of the fourth edition of the A.M.A., *Guides*. Inasmuch as the Office medical adviser properly applied the A.M.A., *Guides*, the Board finds that appellant is not entitled to no more than a 10 percent permanent impairment of the right upper extremity, for which he has already received a schedule award.

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[8] 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

[9] 20 C.F.R. § 10.304.

[10] 5 U.S.C. § 8107(c)(19).

[11] *See James J. Hjort*, 45 ECAB 595 (1994); *Luis Chapa, Jr.*, 41 ECAB 159 (1989); *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

The March 31 and 27, 1997 and the December 12, 1996 decisions of the Office of Workers' Compensation Programs are hereby affirmed.

Dated, Washington, D.C.
September 13, 1999

George E. Rivers
Member

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member