U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ANTHONY J. PORVAZNIK and DEPARTMENT OF JUSTICE,
U.S. BORDER PATROL, El Cajon, CA

Docket No. 99-1059; Submitted on the Record;
Issued December 7, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, BRADLEY T. KNOTT,
A. PETER KANJORSKI

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

On October 8, 1997 appellant, then a 33-year-old border patrol agent, filed a notice of traumatic injury and claim for compensation alleging that on September 10, 1997, while conducting a physical training session, he fell into a push-up position from a standing position and landed awkwardly, causing injury to his left shoulder. He complained of pain in the left shoulder socket area when he lifted his arm above his head. The Office of Workers' Compensation Programs accepted the claim for left shoulder tear and authorized surgery. Appellant received compensation for wage loss from December 11, 1997 until January 5, 1998, when he returned to light duty.

In a report dated October 15, 1997, Dr. Thomas W. Harris, an orthopedic surgeon and appellant's treating physician, noted that appellant presented with pain inside the left shoulder joint, originating on September 10, 1997 when appellant fell into a push-up position from a standing position. Dr. Harris noted physical findings and diagnosed impingement syndrome of the left shoulder, possible rotator cuff tear and possible labrum tear. The doctor opined that appellant's left shoulder condition was consistent with the mechanism of injury on September 10, 1997. He placed appellant on a course of physical therapy, but noted that appellant could perform his regular work duties.

An magnetic resonance imaging scan dated November 11, 1997 was interpreted as suggesting an anterior labral and capsular tear with no evidence of a rotator cuff tear.

On December 11, 1997 appellant underwent arthroscopy with Bankart repair, capsular reefing, removal of loose bodies and chronoplasty of the glenoid in the left shoulder. He continued his postoperative treatment with Dr. Harris.

On March 2, 1998 appellant filed a Form CA-7 claim for a schedule award.

In a report dated March 4, 1998, Dr. Harris advised that he had evaluated appellant for the purpose of rating his permanent impairment. He noted that appellant experienced "intermittent slight increasing to greater than slight" left shoulder pain following repetitive work above the shoulder and head level and "constant weakness of the left shoulder girdle that is slight to greater than slight, causing fatigue." The doctor discussed appellant's medical history, reported physical findings and opined that appellant had reached maximum medical improvement on March 4, 1998. Dr. Harris then rated appellant's impairment using the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Harris reported that appellant had a 30 degrees external rotation which was listed as a 1 percent impairment under the A.M.A., *Guides* at Page 45, Figure 44. He referenced a 1 percent impairment based on an abduction measurement of 160 degrees at Page 44, Figure 41 and a 1 percent impairment based on loss of flexion of 170 degrees at Page 43, Figure 38. Dr. Harris further noted that appellant has a weakness in the left shoulder girdle in the area of the rotator cuff that was measured as 4+/5 and that he had active movement against gravity with some resistance. Based on those findings, he stated that appellant had a five percent impairment of motor deficit of loss of strength secondary to his surgical procedure. He concluded that appellant had a total of eight percent total upper extremity impairment.

In a memorandum dated January 8, 1999, Dr. Leonard A. Simpson, an Office medical consultant, reviewed the March 4, 1998 report by Dr. Harris and stated:

> "Subjective complaints are identified as aggravating to greater than aggravating when working on a repetitive base above shoulder and head level. Subjective factors are further described as intermittent slight increasing to greater than slight when working above shoulder and head level. This reviewer would recommend grading these pain complaints a maximal grade II as per the Grading scheme found in Chapter 3, Fourth edition of the A.M.A., *Guides*. This would be a 25 [percent] grade of a maximal 5 percent for the axillary nerve or equivalent to a 1.5 or rounded off to 1 percent impairment for pain factors."

Dr. Simpson next found that appellant had a 1 percent impairment for loss of motion based on 30 degrees loss of external rotation. The doctor noted that appellant's shoulder abduction was rated at 4/5 but disagreed with Dr. Harris that this was the equivalent of a 5 percent motor deficit. Rather, Dr. Simpson determined that the 4/5 rating would fall between a Grade IV and Grade V weakness per table 12. He concluded that this would be the equivalent of falling between 0 and 25 percent motor defect for a mean motor deficit of 12.5 percent. He also determined that for shoulder abduction "one would utilize muscular branches of the axillary nerve, which would be a maximal 35 percent, 12.5 percent of this would be equivalent to a 4.375 or rounded off to 4 percent impairment for loss of function due to weakness of shoulder abduction." Dr. Simpson next referenced the combined values chart, noting that one percent for pain factors combined with the four percent for weakness and the one percent impairment for loss of external rotation would be the equivalent of six percent impairment to the left upper extremity. He concluded that the date of maximal medical improvement was March 4, 1998, approximately three months after appellant's surgery.

In a decision dated January 25, 1999, the Office issued appellant a schedule award for six percent impairment of the left upper extremity. The period of the award was listed as March 4 to July 13, 1998.

The Board finds that this case is not in posture for a decision.

Section 8107 of the Federal Employees' Compensation Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1] 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.[2] Proper use of the A.M.A., *Guides* ensures consistent results and equal justice for all claimants.

In this case, Dr. Harris, appellant's attending physician, rated appellant's impairment under the A.M.A., *Guides* as eight percent impairment of the left upper extremity. In contrast, Dr. Simpson, the Office medical consultant, reviewed Dr. Harris's findings under the A.M.A., *Guides* but rated appellant's impairment as only six percent impairment to the left upper extremity. Dr. Simpson's opinion as to appellant's impairment rating differs from Dr. Harris' opinion since Dr. Simpson did not consider whether appellant had a finding of 1 percent impairment at Table 43, Page 38 of the A.M.A., *Guides* for the measurement of lack of flexion motion at 170 degrees. The doctor's opinions are also in conflict as to whether appellant sustained a five or four percent impairment for sensory and motor deficits caused by peripheral nerve damage to the left upper extremity.[3] Each physician noted appellant's subjective complaints of pain and muscle weakness but reached different conclusions based on the same findings.[4]

Section 8123(a) of the Act provides in pertinent part that; "If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[5]

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[1] 5 U.S.C. § 8107(a).

[2] *James Kennedy, Jr.*, 40 ECAB 620 (1989); *Quincy E. Malone*, 31 ECAB 846 (1980).

[3] Dr. Harris did not specifically explain, with reference to the table and page number of the A.M.A., *Guides,* how he reached his finding of five percent sensory and motor deficit impairment.

[4] The Board notes that both physicians found that appellant had a 1 percent impairment based on a measurement of 30 degrees loss of external rotation. However, Dr. Harris recorded the 30 degree loss of external rotation for appellant's right "uninjured" shoulder and not appellant's left shoulder which sustained the employment injury.

[5] 5 U.S.C. § 8123(a); *see also Charles E. Burke*, 47 ECAB 185 (1995).

Consequently, the case will be remanded so that the Office may refer appellant, together with the case record and a statement of accepted facts, to an appropriate Board-certified specialist or specialists for an examination and a rationalized medical opinion to resolve the medical conflict regarding whether appellant sustained greater than a six percent permanent impairment of the left upper extremity. Following this and other such development the Office deems necessary, the Office shall issue an appropriate decision in the case.

The decision of the Office of Workers' Compensation Programs dated January 25, 1999 is hereby set aside and the case is remanded for further consideration consistent with this opinion.

Dated, Washington, D.C.
December 7, 1999

Michael J. Walsh
Chairman

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member