United States Department of Labor
Employees' Compensation Appeals Board

GREGORY A. KRYWY, Appellant	)	
and	)	**Docket No. 05-1098**
	)	**Issued: August 12, 2005**
DEPARTMENT OF HOMELAND SECURITY, BUREAU OF CUSTOMS & BORDER PROTECTION, Chula Vista, CA, Employer	)	

Appearances:
Gregory A. Krywy, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
DAVID S. GERSON, Judge

JURISDICTION

On April 19, 2005 appellant filed a timely appeal of the Office of Workers' Compensation Programs' merit schedule award decision dated January 19, 2005. 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 more than 10 percent impairment of his left upper extremity for which he has received schedule awards.

FACTUAL HISTORY

On January 5, 2003 appellant, then a 31-year-old border patrol agent, filed a traumatic injury claim, alleging that on that dated he slipped in the performance of duty injuring his left shoulder. The Office accepted his claim for sprains and strains of the left shoulder on March 13, 2003.

Dr. Thomas W. Harris, a surgeon, performed a left shoulder arthroscopy with extensive glenohumeral debridement, subacromial decompression and insertion of pain pump on March 18, 2003.

On December 8, 2003 Dr. Harris found that appellant was permanent and stationary. He provided his range of motion of the left shoulder noting: 30 degrees of extension; 175 degrees of flexion; 60 degrees of internal rotation; 80 degrees of external rotation; 175 degrees of abduction and 20 degrees of adduction. Dr. Harris found no evidence of atrophy of the rotator cuff muscles, but mild tenderness to palpation over the greater tuberosity in the area of the supraspinatus tendon on the left. He stated that appellant had subjective factors of disability consistent with constant slight left shoulder pain. Dr. Harris found that he had a ratable impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[1] He noted that, in situations were impairment ratings are not provided, the A.M.A., *Guides* suggest that physicians use clinical judgment, comparing measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.[2] Dr. Harris stated:

> "In [appellant's] case [he] has a ratable impairment, using paragraph 16.7 and clinical judgment with comparison to the population normal, the patient has 12 [percent] left upper extremity impairment."

The Office medical adviser reviewed this report on March 22, 2004 and found that appellant had one percent impairment due to loss of shoulder flexion, one percent impairment due to loss of shoulder adduction, two percent impairment of loss of shoulder internal rotation for a total of four percent impairment due to loss of range of motion. He found that appellant had Grade 3 pain/decreased sensation that interferes with some activity of the axillary nerve of the deltoid muscle or three percent impairment of the left upper extremity for pain that interferes with activity. The Office medical adviser concluded that appellant had seven percent impairment of his left upper extremity.

By decision dated April 21, 2004, the Office granted appellant a schedule award for seven percent impairment of his left upper extremity.

Appellant requested reconsideration on December 7, 2004 and submitted additional medical evidence. In a report dated June 3, 2004, Dr. Michael R. Lenihan, a Board-certified orthopedic surgeon, described appellant's factual and medical history and noted that he experienced pain in his left shoulder approximately 50 percent of the time. On physical examination he noted that he was tender to palpation in the anterior shoulder and over the anterior lateral acromion. Dr. Lenihan also found a trace Neer sign and arc impingement test. He provided appellant's left shoulder range of motion as: forward flexion 170 degrees; abduction 170 degrees; adduction 20 degrees, external rotation 50 degrees; and internal rotation of 50 degrees. Dr. Lenihan indicated that on manual motor testing appellant had 4/5 strength in the right shoulder and that he had lost 25 percent of his shoulder flexion strength.

[1] A.M.A., *Guides* (5th ed. 2000).

[2] A.M.A., *Guides* at 11.

Dr. Lenihan applied the A.M.A., *Guides* to his findings on physical examination and concluded that appellant had a Grade 3 or 60 percent sensory deficit of the axillary nerve or 3 percent impairment of the left upper extremity for pain that interferes with some activity. He found that he had four percent impairment for loss of range of motion and six percent impairment for loss of strength in shoulder flexion. Dr. Lenihan concluded that appellant had 13 percent impairment of his left upper extremity.

In a report dated August 9, 2004, Dr. Harris stated that appellant continued to report intermittent mild to greater than mild pain in his left shoulder. He noted that he reported that this pain occurred with increased physical activity, weightlifting and repetitive activities.

The Office medical adviser reviewed the new medical evidence on January 5, 2005 and found that appellant had four percent impairment due to loss of range of motion, three percent impairment due to mild weakness of shoulder flexion, and three percent impairment due to pain. He concluded that combining these impairments reached 10 percent impairment of the left upper extremity.

By decision dated January 19, 2005, the Office modified the April 21, 2004 decision to reflect an additional 3 percent impairment for a total impairment rating of 10 percent.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[3] and its implementing regulation[4] sets 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. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to 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* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses. Effective February 1, 2001, the Office adopted the fifth edition of the A.M.A., *Guides* as the appropriate edition for all awards issued after that date.[5]

Before the A.M.A., *Guides* can be utilized, a description of appellant's impairment must be obtained from his physician. In obtaining medical evidence required for a schedule award, the evaluation made by the attending physician must include a description of the impairment including, 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 descriptions of the impairment. This description must

[3] 5 U.S.C. § 8107.

[4] 20 C.F.R. § 10.404 (1999).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(a) (August 2002).

be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[6]

ANALYSIS

Appellant requested a schedule award based on the December 8, 2003 report of Dr. Harris, a surgeon, who provided his findings on physical examination, but did not correlate these findings with the appropriate provisions of the A.M.A., *Guides*. Instead he relied on a general statement in the A.M.A., *Guides* that where impairment ratings for specific conditions are not provided, then the evaluating physicians should use clinical judgment, comparing the measurable impairment resulting from the unlisted condition to measurable impairments resulting from similar conditions with similar impairment of function in performing activities of daily living.[7] He also relied on a section of the A.M.A., *Guides* addressing impairment of the upper extremities due to other bone and joint disorders such as lateral deviation, rotational deformity or subluxation.[8] Dr. Harris did not provide any description of the "similar condition" he utilized in reaching his impairment rating of 12 percent or any other medical rationale for reaching this rating and also failed to provide any explanation of why he believed the provisions of the A.M.A., *Guides* he cited more accurately reflected appellant's impairment rating as opposed to the specific provisions for loss of range of motion and pain as described in his report of physical findings. It is the responsibility of the evaluating physician to explain in writing why a particular method to assign the impairment rating was chosen.[9] For this reason, the Board finds that his report does not provide sufficient detail so that those reviewing the file can visualize the impairment with its resulting restrictions and limitations[10] to reach the allotted rating and is, therefore, not sufficient to establish his impairment rating of 12 percent.

Dr. Lenihan, a Board-certified orthopedic surgeon, examined appellant on June 3, 2004 and indicated that his forward flexion was 170 degrees, 1 percent impairment;[11] that his adduction 20 degrees, 1 percent impairment;[12] that external rotation was 50 degrees, a 1 percent impairment;[13] and that he exhibited internal rotation of 50 degrees, a 2 percent impairment.[14] The Board notes that his impairment rating due to loss of range of motion is five percent rather than the four percent found by the Office medical adviser.

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[6] *Robert B. Rozelle*, 44 ECAB 616, 618 (1993).

[7] A.M.A., *Guides* at 11.

[8] *Id*. at 498, 16.7.

[9] *Tara L. Hein*, 56 ECAB ___ (Docket No. 05-91, issued April 4, 2005).

[10] *Robert B. Rozelle*, *supra* note 6.

[11] A.M.A., *Guides*, 476, Figure 16-90.

[12] *Id*. at Figure 16-43,

[13] *Id*. at 479, Figure 16-46.

[14] *Id.*

Dr. Lenihan applied the A.M.A., *Guides*, and concluded that appellant had a Grade 3 or 60 percent sensory deficit[15] of the axillary nerve, which has a value of 5[16] or 3 percent impairment of the left upper extremity for pain that interferes with some activity. The Office medical adviser concurred with this finding. The A.M.A., *Guides* warn that the classification of the upper extremity due to a sensory deficit or pain resulting from a nerve disorder[17] is only applicable to pain that is due to nerve injury or disease that has been documented with objective physical findings or electrodiagnostic abnormalities and not for pain in the distribution of a nerve that has not been injured.[18] Dr. Lenihan did not provide any objective findings to document nerve injury or disease and, therefore, it does not appear that he based his impairment rating for shoulder pain on a proper application of the A.M.A., *Guides*.[19]

Dr. Lenihan further indicated that on manual motor testing appellant had lost 25 percent of his shoulder flexion strength, 6 percent impairment.[20] The A.M.A., *Guides* provide that decreased strength cannot be rated in the presence of decreased motion or painful conditions[21] and that strength deficits measured by manual muscle testing should only rarely be included in the calculation of upper extremity impairment.[22] Dr. Lenihan did not explain why he utilized this provision of the A.M.A., *Guides*. The Board notes that appellant is not entitled to receive both five percent for loss of range of motion and six percent for loss of muscle strength as determined by manual muscle testing.

In his January 5, 2005 report, the Office medical adviser combined appellant's impairment ratings for loss of range of motion, weakness and pain to reach the combined impairment rating of 10 percent. The Board finds that this impairment rating is not in accordance with the A.M.A., *Guides*. As noted above, appellant's various impairment ratings cannot be combined, he is entitled to only the greater of the two evaluation methods.[23]

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[15] *Id*. at 482, Table 16-10.

[16] *Id*. at 492, Table 16-15.

[17] The A.M.A., *Guides* further provide that where impairment results strictly from a peripheral nerve lesion, motion impairment values are not applied. The A.M.A., *Guides* further note that if restricted motion cannot be attributed strictly to a peripheral nerve lesion, then motion impairment values are combined with the peripheral nerve system impairment.

[18] A.M.A., *Guides*, 482; *Patricia J. Penney-Guzman*, 55 ECAB __ (Docket No. 04-1052, issued September 30, 2004) (nting that there were no objective findings on physical examination to support a peripheral nerve injury).

[19] *Id.* at 480.

[20] *Id*. at 510, Table 16-35.

[21] *Id*. at 508 and 526, Table 17-2; *Patricia J. Horney*, 56 ECAB __ (Docket No. 04-2013, issued January 14, 2005). The A.M.A., *Guides* further note that motor weakness associated with disorders of the peripheral nerve system are evaluated in accordance with Chapter 16.5. A.M.A., *Guides*, 508, 480. This is not the evaluation method utilized by the Office medical adviser and Dr. Lenihan.

[22] *Cerita J. Slusher*, 56 ECAB ___ (Docket No. 04-1584, issued May 10, 2005).

[23] *Juantia L. Spencer*, 56 ECAB ___ (Docket No. 05-527, issued June 21, 2005).

Therefore, he is either entitled to six percent impairment due to loss of strength or five percent due to loss of range of motion.

CONCLUSION

The Board finds that there is no medical evidence of record based on a comprehensive application of the A.M.A., *Guides* to establish that appellant has more than 10 percent impairment of the left upper extremity for which he received a schedule award. Accordingly, the Board finds that appellant had no more than 10 percent impairment of his left upper extremity.

ORDER

IT IS HEREBY ORDERED THAT the January 19, 2005 and April 21, 2004 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 12, 2005
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board