U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DAVID W. CAMPBELL and U.S. POSTAL SERVICE,
POST OFFICE, Hicksville, NY

Docket No. 02-378; Submitted on the Record;
Issued March 17, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that he has more than a 24 percent permanent impairment of his left upper extremity, for which he received a schedule award.

On November 20, 1991 appellant, then a 31-year-old distribution clerk, sustained employment-related internal derangement and rotator cuff syndrome of his left shoulder. In November 1993, he underwent a left shoulder arthroscopy and, in September 1997, underwent a left shoulder deltoplasty, anterolateral acromioplasty, global release of extra-articular adhesions and greater tuberosity osteotomy; both procedures were authorized by the Office of Workers' Compensation Programs. Appellant received compensation for periods of disability; he returned to work for the employing establishment in 1999 after participating in a vocational rehabilitation program. By decision dated September 10, 2001, the Office granted appellant a schedule award for a 24 percent permanent impairment of his left upper extremity. The Office based its award on the August 24, 2001 report of an Office medical adviser.

The Board finds that, due to a conflict in the medical evidence, the case is not in posture for decision regarding whether appellant has more than a 24 percent permanent impairment of his left upper extremity, for which he received a schedule award.

An employee seeking compensation under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence,[2] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[3]

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[1] 5 U.S.C. §§ 8101-8193.

[2] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

[3] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

The schedule award provision of the Act[4] and its implementing regulation[5] set 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 American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*) (5th ed. 2001) has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[6]

In a report dated August 24, 2001, an Office medical adviser evaluated the April 14, 2001 findings of Dr. Frank H. Carr, an attending Board-certified orthopedic surgeon, and concluded that appellant had a 24 percent permanent impairment of his left upper extremity under the relevant standards of the A.M.A., *Guides*. He determined that appellant was entitled to impairment ratings due to limitation of various left shoulder motions: nine percent for flexion; two percent for extension; six percent for abduction; one percent for adduction; five percent for external rotation; and one percent for internal rotation. Dr. Carr concluded that, under the standards of section 16.4 of the fifth edition of the A.M.A., *Guides*, appellant was entitled to a 24 percent impairment rating based on the limited motion of his left shoulder.[7] The Office medical adviser indicated that it would not be appropriate to calculate impairment ratings for sensory and motor loss associated with periphery nerve damage as these ratings would duplicate the deficits accounted for by the rating for limited motion.[8]

In an undated report received by the Office on April 24, 2001, Dr. Carr also determined that appellant had a 24 percent impairment due to limitation of various left shoulder motions: 9 percent for flexion; 2 percent for extension; 6 percent for abduction; 1 percent for adduction; 5

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[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404 (1999).

[6] *See id.*; *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

[7] *See* A.M.A., *Guides* at 476-77, 479, Tables 16-40, 16-43, 16-46 (5th ed. 2001). The Board notes that the fifth edition of the A.M.A., *Guides* provides the appropriate standards for evaluating appellant's permanent impairment as this was the edition in effect at the time appellant's schedule award was granted. *See* FECA Bulletin No. 01-05 (issued January 29, 2001).

[8] A.M.A., *Guides* at 480. The Office medical adviser made reference to the following portion of the fifth edition of the A.M.A., *Guides*:

> "The evaluation of permanent impairment resulting from peripheral nerve disorders is based on the anatomic distribution and severity of loss of function resulting from: (1) sensory deficits or pain; and (2) motor deficits and loss of power. Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, atrophy and vasomotor, tropic, and reflex changes, have been taken into consideration in the estimated impairment values shown in this section. Therefore, when an impairment results strictly from a peripheral nerve lesion, in the absence of CRPS [complex regional pain syndrome], the motion impairment values derived from [s]ection 16.4 are not applied to this section to avoid duplication or unwarranted increase in the impairment estimation." *Id*.

percent for external rotation; and 1 percent for internal rotation.[9] In contrast to the opinion of the Office medical adviser, however, Dr. Carr also determined that appellant had additional permanent impairments: a 12 percent impairment due to loss of strength associated with the suprascapular nerve; a 3 percent impairment for pain associated with the suprascapular nerve; and a 3 percent impairment for pain associated with the axillary nerve.[10] He indicated that, using the Combined Values Chart, appellant had a total impairment of his left upper extremity of 41 percent.[11] In a supplemental undated report received by the Office on August 17, 2001, Dr. Carr again concluded that appellant had a 41 percent impairment of his left upper extremity.

Section 8123(a) of the Act provides in pertinent part: "If there is 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."[12] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[13]

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[9] Dr. Carr applied the standards of the fourth edition of the A.M.A., *Guides* in reaching this determination. Although Dr. Carr inappropriately used the fourth edition, the standards for evaluating limited shoulder motion under the fourth edition are essentially the same as those contained in the fifth edition. Therefore, this error is harmless in the context of the present case. Compare A.M.A., *Guides* 43-45, Figures 38, 41, 44 (4th ed. 1993) with A.M.A., *Guides* 476-77, 479, Tables 16-40, 16-43, 16-46 (5th ed. 2001).

[10] Dr. Carr arrived at his calculations by identifying strength and pain grades associated with the suprascapular nerve and a pain grade associated with the axillary nerve. He then multiplied these figures times the maximum values for strength and pain loss associated with the suprascapular nerve and the maximum value for pain loss associated with the axillary nerve. Although Dr. Carr applied the standards of the fourth edition of the A.M.A., *Guides*, the standards for performing this evaluation under the fourth edition are essentially the same as those contained in the fifth edition of the A.M.A., *Guides*. Compare A.M.A., *Guides* at 47-49, 54, Tables 10-12, 15 (4th ed. 1993) with A.M.A., *Guides* at 482, 484-85, 492, Tables 16-10, 16-11, 16-12a, 16-15 (5th ed. 2001).

[11] In deciding to include impairment ratings due to sensory and motor loss, Dr. Carr ostensibly applied a portion of the fourth edition of the A.M.A., *Guides* which is essentially similar to the above-noted portion of the fifth edition of the A.M.A., *Guides* which the Office medical adviser interpreted as not allowing the inclusion of such impairment ratings:

> "To evaluate impairment resulting from the effects of peripheral nerve lesions, it is necessary to determine the extent of loss of function due to (1) sensory deficits or pain (Table 11, p. 48); and (2) motor deficits (Table 12, p 49). Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, atrophy, and vasomotor, trophic, and reflex changes, have been taken into consideration in preparing the estimated impairment percents shown in this section.
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> "*If an impairment results strictly from a peripheral nerve lesion, the physician should* not *apply impairment percents from [s]ections 3.1f through 3.1j (pp 24 through 45) of this chapter*, and *this section, because a duplication and an unwarranted increase in the impairment percent would result."* (Emphasis in the original.)

[12] 5 U.S.C. § 8123(a).

[13] *William C. Bush*, 40 ECAB 1064, 1075 (1989).

For the above-noted reasons, the Board finds that there is a conflict in the medical evidence between the opinions of the Office medical adviser and Dr. Carr regarding the extent of the permanent impairment of appellant's left arm. In essence, the Office medical adviser and Dr. Carr disagreed regarding whether impairment ratings for sensory and motor loss should be included in calculating the total impairment of appellant's left arm. Consequently, the case must be referred to an impartial medical specialist to resolve the conflict in the medical opinion evidence between the Office medical adviser and Dr. Carr regarding appellant's left arm impairment. On remand the Office should refer appellant, along with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation and report including a rationalized opinion on this matter. After such further development as the Office deems necessary, the Office should issue an appropriate decision regarding appellant's claim.

The September 10, 2001 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board.

Dated, Washington, DC
March 17, 2003

Alec J. Koromilas
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member