U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOSEPH DE SORBO and U.S. POSTAL SERVICE,
POST OFFICE, New Haven, Conn.

Docket No. 96-299; Submitted on the Record;
Issued May 22, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has established that he sustained greater than a five percent permanent impairment of the left upper extremity, for which he received a schedule award.

The Office of Workers' Compensation Programs accepted that appellant, then a 48-year-old letter carrier, sustained a strained left trapezius muscle on January 31, 1985 in the performance of duty. He returned to work approximately one month later to modified duty as a special delivery letter carrier and remained under medical treatment by Dr. John M. Aversa, an attending Board-certified orthopedic surgeon, who maintained appellant on light duty.[1] On January 20, 1989 appellant claimed a schedule award.

Dr. Aversa first mentioned a permanent impairment rating in a January 15, 1991 report, opining that appellant had reached maximum medical improvement as of February 1989,[2] and had a 15 percent permanent impairment of the left arm according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.) (hereinafter, A.M.A.,

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[1] Dr. Aversa treated appellant for the January 31, 1985 injury beginning on February 6, 1985 and submitted periodic progress reports and physical therapy notes through 1989. A March 4, 1985 x-ray report by Dr. Gerald S. Freedman showed "early degenerative changes associated with the acromioclavicular joint. The osseous structures are unremarkable." September 9, 1985 x-rays interpreted by Dr. Freedman, compared to March 4, 1985 studies, showed the "previously described early degenerative changes of the acromioclavicular joint." April 12, 1988 x-rays showed "more calcific density adjacent to the glenoid," and recommended decompression acromioplasty. April 14, 1988 x-rays interpreted by Dr. William Allen showed, including films with weight bearing, "no evidence for osseous or joint abnormality," and "no interval change when compared with the previous films of September 1985."

[2] In a January 20, 1989 report, Dr. Aversa diagnosed a frozen left shoulder with impingement and recommended surgical decompression, noting appellant was on limited duty since the January 31, 1985 injury. Dr. Aversa noted left shoulder atrophy on November 14, 1990 with slight acromioclavicular joint degeneration by x-ray, opining on January 10, 1991 that appellant's shoulder pain was due to acromioclavicular and early shoulder joint arthritis. He continued to recommend surgery through March 1995.

Guides), due to shoulder pain and weakness. He restricted frequent use of the left arm, heavy lifting or repetitive overhead work.

In a June 6, 1991 report, Dr. John M. Shine, a Board-certified orthopedic surgeon and impartial medical examiner, found a full range of left arm motion and no work-related loss of function, but noted work restrictions. Dr. David I. Krohn, an Office medical adviser and Board-certified internist, reviewed this report on November 25, 1991 and found no basis for a schedule award.

Thus, by the December 16, 1991 decision, the Office denied appellant's schedule award claim. Appellant requested a hearing, held on May 19, 1992. He submitted a May 13, 1992 report from Dr. Aversa noting that left shoulder x-rays showed "developing degenerative changes of the AC [acromioclavicular] joint with decreased joint space and sclerosis." Dr. Aversa noted measurements of 80 degrees abduction, 120 degrees flexion, 40 degrees extension, a loss of 10 degrees internal rotation and 20 degrees external rotation.

By decision dated and finalized August 12, 1992, the Office's hearing representative affirmed the denial of a schedule award. Appellant requested reconsideration, enclosing March 15 and 24, 1993 reports from Dr. Aversa. Dr. Aversa stated that appellant had a 15 percent permanent impairment of the left shoulder according to attached copies of figures 36 through 44 of the A.M.A., *Guides*, addressing loss of function of the upper extremity. He diagnosed a chronic degenerative left shoulder condition affecting the acromioclavicular and humeral glenoid joints, with "decreased joint space and sclerosis" visible on 1990 and May 13, 1992 x-rays. He noted "limitation of shoulder motion and pain with stress on the rotator cuff," and that appellant remained on modified duty.

By June 30, 1993 decision, the Office denied modification. Appellant requested reconsideration and enclosed an August 6, 1993 report from Dr. Aversa noting abduction and internal rotation of 80 degrees, external rotation of 30 degrees, flexion of 110 degrees and extension of 60 degrees. Dr. Aversa opined these measurements constituted a 15 percent permanent impairment of the left upper extremity according to figures 38, 41 and 44 of the A.M.A., *Guides* and enclosed relevant excerpts from the A.M.A., *Guides*. In figure 38, "[u]pper [e]xtremity [i]mpairments [d]ue to [l]ack of [f]lexion and [e]xtension of [s]houlder," Dr. Aversa highlighted 110 degrees flexion, equaling a 5 percent impairment due to loss of flexion and a zero percent impairment of loss of extension. In figure 41, "[u]pper [e]xtremity [i]mpairment [d]ue to [l]ack of [a]bduction and [a]dduction of [s]houlder," Dr. Aversa highlighted 80 degrees abduction, equaling a 5 percent impairment. In figure 44, "[u]pper [e]xtremity [i]mpairments [d]ue to [l]ack of [i]nternal and [e]xternal [r]otation of [s]houlder," Dr. Aversa highlighted 80 degrees internal rotation, equaling a 0 percent impairment and 30 degrees external rotation, equaling a 1 percent impairment for loss of external rotation. Dr. Aversa added the two 5 percent impairments for loss of abduction and flexion and the 1 percent impairment for loss of external rotation, totaling an 11 percent impairment. He then added a 4 percent impairment due to loss of strength, but did not specify the tables on which he relied or the relevant measurements. He noted this rating did not consider the degenerative acromioclavicular changes or appellant's need for surgery.

In a November 12, 1993 decision, the Office denied modification. Appellant requested reconsideration, and enclosed a December 15, 1993 report from Dr. Aversa. Dr. Aversa stated that the medical record contained no evidence of preexisting degenerative arthritis and that the 15 percent impairment of the left upper extremity was due to chronic shoulder pain, weakness and restricted motion resulting from the January 31, 1985 injury. He opined that degenerative arthritis was precluded as there was no interval change between February 8, 1985 and April 12, 1988 x-rays.[3]

In an August 11, 1994 report, Dr. Harold Simon, a Board-certified radiologist and second opinion physician, found no changes in the acromioclavicular joint in x-rays obtained from February 8, 1985 to April 12, 1988. He noted minimal acromioclavicular joint changes consistent with appellant's age, not suggestive of "degenerative arthritis of any significance."

In an October 11, 1994 report, Dr. Krohn reviewed the medical record and agreed with Dr. Aversa that appellant had reached maximum medical improvement in February 1989. Referring to Dr. Aversa's August 6, 1993 report and the A.M.A., *Guides*, Dr. Krohn found no impairment for loss of 10 degrees of abduction according to figure 41, 10 degrees of internal rotation and 20 degrees of external rotation according to figure 44. Dr. Krohn found a 1 percent impairment each for loss of 10 degrees of flexion and for loss of 20 degrees of extension of the left shoulder according to figure 38. Dr. Krohn noted the involved area of the shoulder was supplied by the axillary nerve, with a maximum percent impairment of 5 percent by Table 15. Using Table 11, Dr. Krohn graded appellant's pain at 60 percent, with 5 percent times 60 equaling 3 percent. He combined one percent plus one percent plus three percent to equal a five percent total impairment of the left upper extremity. Dr. Krohn noted no impairment for weakness, and opined that appellant did not have degenerative arthritis of the acromioclavicular joint or a rotator cuff tear.

By decision dated October 27, 1994, the Office granted appellant a schedule award for a five percent permanent impairment of the left upper extremity. Appellant disagreed, requested reconsideration, and submitted a March 22, 1995 report from Dr. Aversa reiterating his August 6, 1993 calculations.[4] The Office issued a July 31, 1995 denial of modification on the grounds Dr. Aversa's March 22, 1995 report was repetitious and incorrectly interpreted A.M.A., *Guides*, and was therefore insufficient to warrant modification.

The Board finds that the case is not in posture for decision due to a conflict of medical opinion between Dr. Aversa, for appellant, and Dr. Krohn, for the government.

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[3] In an April 25, 1994 report, Dr. Barry Levine, a Board-certified internist and second opinion physician, noted a conflict of opinion between Dr. Freedman and Dr. Aversa regarding the presence of degenerative arthritis of the acromioclavicular joint. Dr. Levine also noted Dr. Strichman's July 11, 1985 report of a nonoccupational acute left rotator cuff strain. Dr. Levine opined that these reports indicated a preexisting left shoulder problem and possible acromioclavicular arthritis.

[4] In a March 22, 1995 letter, appellant's authorized representative asserted that there was a conflict of opinion between Dr. Aversa and Dr. Krohn. The representative also asserted that Dr. Krohn failed to review Dr. Aversa's December 15, 1993 report as, while Dr. Krohn stated in an October 11, 1994 report that he reviewed the record, he referred only to Dr. Aversa's August 6, 1993 report, but not the December 15, 1993 report, which included copies of the appropriate tables of the A.M.A., *Guides* explaining the impairment rating.

Under section 8107 of the Federal Employees' Compensation Act[5] and section 10.304 of the implementing regulations,[6] schedule awards are payable for permanent impairment of specified body members, functions or organs. 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 for all claimants, the Office has adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment, and the Board has concurred in such adoptions.[7]

Dr. Aversa, an attending Board-certified orthopedic surgeon, submitted an August 6, 1993 report calculating a 15 percent schedule award according to the tables and grading schemes of the A.M.A., *Guides*. Using Dr. Aversa's range of motion measurements, Dr. Krohn, the Office medical adviser and a Board-certified internist,[8] found a five percent permanent impairment using the same tables and grading schemes of the A.M.A., *Guides*. Also, Dr. Aversa noted an impairments for weakness, while Dr. Krohn opined that appellant had no loss of strength. Further, Dr. Aversa diagnosed a degenerative condition of the left acromioclavicular joint due to the January 31, 1985 injury, while Dr. Krohn stated that appellant had no such condition. Thus, using identical measurements and the same means of evaluation, the two physicians have arrived at markedly different conclusions regarding the presence and significance of clinical findings, and the degree of permanent impairment.

The Federal Employees' Compensation Act, at 5 U.S.C. § 8123(a), in pertinent part, provides: "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."

Consequently, the case must 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 for an examination and a rationalized medical opinion to resolve the medical conflict. Following such further development as the Office deems necessary, the Office shall issue an appropriate decision in the case.

The decision of the Office of Workers' Compensation Programs dated July 31, 1995 is hereby set aside and the case remanded for further development consistent with this decision and order.

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[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.304.

[7] *Leisa D. Vassar*, 40 ECAB 1287, 1290 (1989); *Francis John Kilcoyne*, 38 ECAB 168, 170 (1986).

[8] The Board notes that Dr. Aversa is a Board-certified orthopedic surgeon, a specialist in a field of practice germane to appellant's condition. However, Dr. Krohn, the Office medical adviser, is a Board-certified internist, and is not a specialist in a field of medicine as directly pertinent to appellant's condition. The Board has held that the opinions of physicians who have special training and knowledge in a specialized medical field have greater probative force on the question of causal relationship of a condition peculiar to the field than the opinions of nonspecialists or others who have no training in the particular field; *see Effie Davenport (James O. Davenport)*, 8 ECAB 136 (1955).

Dated, Washington, D.C.
May 22, 1998

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member