File Number:
HR10-D-H

RECEIVED APR 0 8 2013

S. DEPARTMENT OF LABOR

APR - 1 2013

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

Date of Injury:
Employee:

Dear Mr. :

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 01/15/2013. As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Chicago District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 10 CHI
LONDON, KY 40742-8300

Sincerely,

Amy E. Towner
Hearing Representative

PAUL H FELSER, ATTORNEY
FELSER LAW FIRM
7 EAST CONGRESS ST
SUITE 400
SAVANNAH, GA 31401

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

U. S. Department of Labor
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U. S. Code 8101 et. seq. of ; claimant, employed by the , case file number . A telephone hearing was held on January 15, 2013.

The issue is whether the weight of medical evidence establishes that the claimant has permanent partial impairment of the left upper extremity beyond the percentages previously awarded, per the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Sixth Edition.

The claimant, born , was employed as a b···ilding equipment mechanic with the in , when he filed a CA1 Notice of Traumatic Injury form claiming that on , he was sitting on a chair and it broke. The Office accepted the claim for left rotator cuff strain and later expanded it for the conditions of cervical stenosis and left shoulder adhesive capsulitis. On June 18, 2004, the claimant underwent C4-5 laminectomy and decompression. On March 11, 2006, the claimant began receiving disability retirement. The Office later expanded the claim for myofascial pain syndrome, dizziness and giddiness, and disc herniation at C4-5.

By initial decision dated December 18, 2008, the Office awarded the claimant 4% permanent partial impairment of the left upper extremity based on the weight of the District Medical Advisor (DMA), , M.D., who applied the findings of treating physician, , M.D., to the Fifth Edition of the AMA *Guides*. By decision dated July 14, 2009, a hearing representative set aside this decision and directed the Office to have the DMA review a new March 31, 2009 impairment report from , M.D., who provided ratings for the upper and lower extremities.

By *de novo* decision dated September 22, 2009, the Office awarded the claimant an additional 11% impairment rating of the left upper extremity based on the same District Medical Advisor's application of the findings to the Sixth Edition of the AMA *Guides*. The DMA explained why he disregarded the reported ratings for the other extremities. By decision dated May 12, 2010, a hearing representative set aside this decision and remanded the case for the District Medical Advisor to review a new April 12, 2010 impairment report from Dr. . The Office was also advised to review the evidence of record in the instant claim, as well as a prior lumbar claim, to consider expansion for

injuries to the right upper extremity and lower extremities[1]. In a June 14, 2010 report, the same District Medical Advisor reviewed Dr new report and opined that the medical record did not support his additional left upper extremity rating. He was not asked to address the other extremities.

The Office referred the claimant to Board-certified orthopedic surgeon, , M.D., on October 9, 2010, to address left upper extremity impairment and whether the claim should be expanded for right upper extremity and lower extremity conditions. The documentation was not clear as to whether Dr. exam was intended as a second opinion or independent medical evaluation. Dr. opined that the claimant had no evidence of any significant upper extremity condition attributable to or consequential to his October 21, 2003 or July 25, 2001 injuries. He also opined that his lower extremity issues were related to the cervical cord compression consequential to the 2003 injury. Dr. reported 8% impairment of the left upper extremity and 38% impairment of both the right and left lower extremity. On December 6, 2010, the same District Medical Advisor disregarded Dr. ratings as he did not show how he arrived at his recommendations, but did state the claimant still had 15% impairment of the left upper extremity. The DMA also opined that the medical evidence did not support that the claimant's lower extremity symptoms were related to any spinal cord abnormality.

By decision dated January 31, 2011, the Office denied entitlement to additional impairment of the left upper extremity beyond the 15% previously awarded. It was noted that the issue of right upper extremity and lower extremity impairment and potential expansion of the claim was pending the outcome of a referee examination. On April 8, 2011, the claimant was seen by Board-certified orthopedist, , M.D. Dr. addressed both claims and opined that the injuries sustained on July 25, 2001 did not result in any significant loss of function of the lower extremities, but that the October 21, 2003 injury resulted in mild loss of motor control in both upper extremities and ataxia and gait disturbance. He provided an 18% whole person impairment rating for ataxia of his gait due to post laminectomy syndrome. Dr. also provided a 3% left upper extremity rating and 5% right upper extremity rating which he opined were related to both post laminectomy syndrome and cervical radiculopathy. He noted no loss of motion due to the accepted left shoulder injuries.

In relation to the January 31, 2011 left upper extremity decision, a hearing was held on June 20, 2011. In a September 15, 2011 remand decision, the hearing representative found that the DMA's opinion concerning the left upper extremity did not create a conflict, and that the report of Dr. could not be used as a second opinion report as it was incorrectly scheduled as an independent medical evaluation. However, the hearing representative remanded the case back to the Office for the District Medical

[1] Under 102002657, the claimant had filed a CA1 Notice of Traumatic Injury form claiming that on July 25, 2001, after he and a coworker put a 200 pound compressor into a tight area, his back started to hurt. This claim was accepted for lumbar strain and displacement of disc at L4/5. The claimant was awarded 11% permanent partial impairment of the left lower extremity under this claim

Advisor to review Dr. report for its "intrinsic value". The Office was advised that if Dr. Trotter's report was found insufficient then a second opinion examination should be obtained to address impairment of the left upper extremity. No mention was made of Dr. Erickson's report. It was noted that the Office had undertaken development of the expansion of the claim for the other extremities but that no formal decision had been issued yet.

On October 17, 2011, the same District Medical Advisor reviewed Dr. report as well as the IME report of Dr. . The DMA did not address Dr. 8% upper extremity rating and disregarded his lower extremity ratings as the table he used was for whole person, which was not recognized. The District Medical Advisor also reported that the previous left upper extremity award would not change based on Dr. left shoulder exam findings. While the DMA indicated that the claimant's gait abnormalities and lower extremity spasticity were likely secondary to damage to the cervical spinal cord as a result of his work injury, he explained this was only classified under the gait station disorder table in the AMA *Guides*, which only awarded whole person impairment. The District Medical Advisor indicated that because there was no peripheral nerve involvement and lower extremity strength and sensation were normal, no lower extremity permanent partial impairment could be awarded.

As Dr. report was not sufficient, the Office referred the claimant for a second opinion examination with Board-certified orthopedist, , M.D., on February 22, 2012. Dr. was advised to limit his exam to the issue of permanent partial impairment of the left upper extremity. Dr. initially provided a total 21% combined upper extremity impairment rating based on loss of range of motion. However, in an addendum report, Dr. advised that he had corrected his impairment values, showing 3% flexion, 0% extension, 3% abduction, 1% adduction, 0% internal rotation, and 4% external rotation (moderate severity). He showed his net modifier adjustment calculations, arriving at final 12% left upper extremity impairment.

By decision dated May 11, 2012, the Office denied entitlement to an increased schedule award for the left upper extremity based on Dr. second opinion report. By remand decision dated August 8, 2012, a hearing representative set aside that finding and directed the Office to have the District Medical Advisor review Dr. second opinion report as procedurally required to confirm the application of the findings to the Sixth Edition, AMA *Guides* criteria. On August 30, 2012, DMA , M.D., noted that diagnosis-based impairment ratings were given under the Sixth Edition unless the clinical picture did not correlate to a specific diagnosis. The District Medical Advisor confirmed Dr. second 12% calculation.

By decision dated October 2, 2012, the Office denied entitlement to a schedule award for the left upper extremity beyond the 15% previously awarded based on the weight of medical evidence from second opinion specialist, Dr. , with concurrence by the District Medical Advisor. The claimant disagreed with this decision and by letter postmarked October 2, 2012, through his attorney, requested an oral hearing.

This hearing was held telephonically on January 15, 2013, with the claimant's attorney, Paul Felser, Esquire. Mr. Felser renewed his prior request that the instant claim and be combined due to multiple injuries and overlapping medical evidence. He contended that the issue had been incorrectly narrowed to only the left upper extremity, and that the claimant had yet to receive an award for the right upper extremity. Mr. Felser questioned whether all accepted conditions had been considered, referencing Dr. report and the diagnoses of post laminectomy syndrome and cervical radiculopathy affecting both upper extremities. He also questioned whether Dr. was advised to only address impairment in terms of the shoulder and/or whether the accepted cervical conditions were omitted. It was advised that the record would remain open for thirty days. Post hearing, Mr. Felser provided a February 25, 2013 letter brief further outlining their arguments.

Based on my review of the evidence and testimony of record, the October 2, 2012 decision should be set aside for the reasons set forth below.

The schedule award provision of the Federal Employees' Compensation Act,[2] and its implementing federal regulations, 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 for all claimants, the Office has adopted the AMA *Guides* as the uniform standard applicable to all claimants.[3] For Office decisions issued on or after May 1, 2009, the Sixth edition of the AMA *Guides* is used for evaluating permanent impairment.[4]

The Sixth edition requires identifying the impairment class for the diagnosed condition (CDX), which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE) and clinical studies (GMCS). The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[5]

The AMA *Guides* do provide for range of motion based rating. However, application of such a rating is limited. The AMA *Guides,* Sixth Edition, state at Section 15.2, page 387, that impairments should be rated based on diagnosis-based impairment (DBI) using the appropriate regional grid. The section also states, *"Range of motion is used primarily as a physical examination adjustment factor and only to determine actual impairment values when a grid permits its use as an option."* (emphasis in original)

Further, the Sixth Edition of the AMA *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as under the Act, mandate ratings for extremities and preclude ratings for the spine, the AMA *Guides* has offered an approach to rating spinal nerve

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[2] 5 U.S.C. § 8107.
[3] 20 C.F.R. § 10.404.
[4] FECA Procedure Manual, Part 2, Chapter 2.808.6.6(a)
[5] A.M.A., *Guides* 494-531.

impairments consistent with Sixth Edition methodology.[6] The Office has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[7] This newsletter, which has been reproduced with the permission of the AMA, is Exhibit 4 in the FECA Procedure Manual, 3-0700.

In the instant case, the Office has only addressed left upper extremity impairment as a result of the October 21, 2003 work injury, which was accepted for numerous left shoulder and cervical conditions. Extensive medical development has been undertaken, which included referral to Dr. and Dr. to address the left upper extremity, as well as to address expansion of the claim for additional diagnoses and/or impairment to the right upper extremity and lower extremities. The claimant's attorney contended that the claimant has impairment of the upper extremities and lower extremities due to residuals of the accepted cervical conditions and additional conditions, mainly referencing the IME report of Dr. . The Office has yet to make a formal determination as to whether the accepted work injury has caused permanent impairment to the other extremities or whether it should be expanded for additional diagnoses. However, in a prior September 15, 2011 hearing decision it was found that Dr. report could not be used as a formal second opinion examination as it was incorrectly scheduled as an IME when there was no conflict. It would follow that Dr. IME evaluation was also scheduled obtained incorrectly and prematurely.

While the Office referred the claimant for a new second opinion examination with Dr. , his examination was limited to the left upper extremity only. Dr provided a current impairment rating based on range of motion deficits, which was confirmed by the District Medical Advisor and was less than the 15% previously awarded. However, after a more thorough review neither Dr. nor the DMA gave sufficient explanation as to why the range of motion method was used over the preferred diagnosis-based method to evaluate left upper extremity impairment. Further, neither physician addressed whether the accepted cervical conditions resulted in any extremity impairment per the criteria set forth in the adopted AMA *Guides Newsletter*.

It is well established that proceedings under the Federal Employees' Compensation Act are not adversarial in nature, and, while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[8] Once the Office undertakes development of the record, it has the responsibility to do so in a proper manner.[9] When OWCP refers a claimant for a second opinion evaluation and the report does not adequately address the relevant issues, it should secure an appropriate report on the relevant issues.[10]

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[6] Rating Spinal Nerve Extremity Impairment Using the Sixth Edition, the AMA *Guides Newsletter* (AMA *Guides* Chicago, IL), July/August 2009.

[7] FECA Procedure Manual, Part 3, Chapter 3.700 (January 2010) (Exhibit 1, 4).

[8] *See Udella Billups*, 41 ECAB 260 (1989).

[9] *See Henry G. Flores, Jr.*, 43 ECAB 901 (1992).

[10] *See Robert Kirby*, 51 ECAB 474, 476 (2000); *Mae Z. Hackett*, 34 ECAB 1421 (1983); *Richard W. Kinder*, 32 ECAB 863 (1981).

On remand, the Office should refer the claimant back for re-examination with Dr. to address whether there are any additional diagnoses causally related to the work injury and for a complete assessment of impairment of the extremities as a result of all injury-related conditions. Dr. should fully describe all examination findings/testing and show his application of these findings to the criteria established under the AMA *Guides*, Sixth Edition, including whether there is any impairment to the extremities resulting from the accepted cervical conditions per the adopted *Newsletter* guidelines. Full calculations should be shown. If Dr. still bases impairment of the extremity (ies) on range of motion, detailed medical rationale should be provided to support the selection of this method versus the diagnosis-based method. Following receipt of this report and any additional development deemed necessary, a *de novo* decision should be issued as to whether the medical evidence establishes left upper extremity impairment beyond 15%. The Office should also issue a decision as to whether there is any ratable injury-related impairment to the other extremities.[11]

Accordingly, the October 2, 2012 decision is set aside and the case is returned to the district office for further development as outlined above.

DATED: APR - 1 2013

WASHINGTON, D.C.

AMY E. TOWNER
Hearing Representative
For
Director, Office of Workers'
Compensation Programs

[11] The attorney has requested doubling of the claimant's two claims. The Office should address whether the claims should be doubled once the hearing decision pending under concerning impairment is received.