File Number:
HR10-D-H

RECEIVED MAY 23 2011

U.S. DEPARTMENT OF LABOR

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

MAY 16 2011

Date of Injury:
Employee:

Dear Ms. :

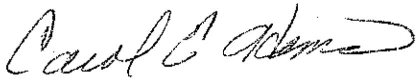
This is in reference to your workers' compensation claim Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review

A hearing was held on 02/14/2011. 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 Jacksonville 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 6 JAC
LONDON, KY 40742-8300

Sincerely,



Carol E. Adams
Hearing Representative

PAUL H FELSER
ATTORNEY AT LAW
FELSER LAW FIRM, P.C.
7 EAST CONGRESS ST, STE 400
PO BOX 10267
SAVANNAH, GA 31412

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 number . A hearing was held on February 14, 2011.

The issue for determination is whether the claimant has permanent impairment of a schedule member.

The claimant is employed by the as a . She filed a traumatic claim of injury for date of injury of . Her case was accepted for right hip, knee, elbow, shoulder and buttock contusions; and displacement of lumber intervertebral disc at the L5-S1 with left sided radiculopathy.

On September 23, 2005, the claimant had authorized surgery performed at the L5-S1 level of spine.

The claimant returned to full duty as a .

On June 18, 2010, the claimant completed a claim for schedule award for permanent impairment.

A report dated December 17, 2009 was received from a physical therapist who found that the claimant had 37% permanent impairment of the left lower extremity. The therapist indicated the AMA Guides, 6th edition was used to provide the rating.

The therapist sent the rating to Dr for his review.

In a letter dated March 24, 2010, to the claimant's attorney, Dr. advised that he agreed with the physical therapist permanent impairment rating.

The Office determined that there was insufficient evidence to support permanent impairment. Therefore, on June 28, 2010 the Office wrote to Dr. for additional information.

In accordance with Office procedures, the case file was referred to a District Medical Advisor (DMA). On July 1, 2010 the DMA reviewed the evidence and found that a second opinion was needed in order to obtain a proper rating that was based on the AMA Guides, 6th edition.

On August 20, 2010 the Office received additional information from Dr. . Dr. , on the June 28, 2010 Office letter, noted that the claimant had a 15% whole person rating, which

converted to a 37% lower extremity impairment rating. He indicated he used paresthesias leg with radiculopathy as the basis for his impairment rating of the extremity.

In a report received on November 2, 2010, Dr. indicated that he saw the claimant on August 9, 2010. He noted, "She [the claimant] had the appropriate impairment rating based on the AMA guidelines that was provided on a separate piece of paper."

As recommended by the DMA, the Office sent the claimant for a second opinion evaluation. On September 2, 2010 the claimant was seen by Dr. . Dr. determined there was no impairment of a schedule member.

The case record again was sent to the DMA for review and rating for permanent impairment. The DMA reviewed the second opinion report and found that the claimant had no permanent impairment of a schedule member. The DMA indicated that he used the AMA Guides, 6th edition Newsletter to determine the rating.

By decision dated September 21, 2010, the Office denied the claim for schedule award.

The claimant disagreed with the decision and, through her attorney, requested a hearing before an OWCP representative.

A hearing was held on February 14, 2011. The claimant was represented by attorney Paul Felser.

A copy of the hearing transcript was sent to the employer for comment. No comments were submitted.

Mr. Felser argued that the claimant had permanent impairment because she had radiculopathy. He believed that the second opinion physician's report lacked sufficient information. He pointed out that Dr. indicated the claimant did not have any atrophy but failed to support his finding with any measurements. In regards to the radiculopathy, Mr. Felser stated that Dr. indicated that he found nerve encroachment on review of the MRI but on examination found no radiculopathy from the nerve root encroachment.[1] Mr. Felser pointed out that there was evidence on record to support atrophy and radiculopathy and that Dr. did not provide adequate reasoning or examination findings to support his conclusion that the claimant had no permanent impairment.

Mr Felser also argued that the claim should be expanded to include the acceptance of degenerative disc disease (DDD).[2] Mr. Felser pointed out that even Dr. provided an impression that the claimant had lumbar disc disease status post 2005, L5, S1 hemilaminectomy with discectomy.

A review of the evidence has been undertaken.

[1] See Hearing transcript of February 14, 2011 hearing page 8
[2] See hearing transcript page 9

Dr. in his report stated as follows:

> In answer to the 2 question, she does have residual lumbar disc disease as indicated in the MRI scan, which was done last November. In the body of this report, I do note her subjective complaints. Also I noted she was having no problem with her right elbow, right knee, right shoulder, at this time.

In regards to permanent impairment, Dr. stated,

> Using the Guides Newsletter, there is no impairment. She did complete a PDQ today, with a score of disability 33, which is considered mild.

The Board has stated "... 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) + (GMCS –CDX)."[3]

In the same decision cited above, the Board also held that the DMA's report was inadequate since he did not explain how he arrived at the rating. The Board pointed out that the DMA only referred to the table used without providing any explanation of diagnosis category, class rating or evaluation of grade modifiers. The Board explained that grade modifiers should be considered for functional history, physical examination and clinical studies and that these grade modifiers can change the extent of a given impairment rating.[4]

I find that the Dr. did not provide any calculation or explanation as to how he used the Guides to determine that the claimant had no impairment of a schedule member. I also find that the second opinion's report is inadequate in that he did not provide complete findings on examination. He did not provide complete range-of-motion findings or provide measurements of the claimant's lower extremities to support that no atrophy existed. In addition, Dr. did not provide sufficient rationale to support that the claimant did not have any impairment due to nerve root injury, especially, in light of the fact that the claimant was reported to have radiculopathy in numerous reports and encroachment of the nerve root per the MRI of November 2009.

Also, in this case, the DMA only states that he used the Newsletter to determine that the claimant had no impairment. He recites the second opinion findings but provides no diagnosis category, class rating or evaluation of grade modifiers with explanation, as required by the Board. He appears to have just agreed with the second opinion evaluator.

After review of the evidence, including the attorney's arguments at the hearing, I find the decision of the Office must be set aside and the case remanded for further development.

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[3] *G.N.*, ECAB ___ (Docket No. 10-850, issued November 12, 2010).
[4] *Id.*

On remand the Office should write to the Dr. and request that he provide complete findings of range-of-motion and measurements of the lower extremities. He should also explain his impairment rating as required by the Board and provide his rationale for his calculations. If the doctor needs to reexamine the claimant, it should be authorized. Also, since Dr. indicated that the DDD at the L5-S1 was a residual of the injury, be should provide an explanation as to why he believed the DDD was a residual of the injury or the surgery performed for the work injury. Also, the doctor should be asked if the DDD caused an impairment of the lower extremities. The doctor should also explain whether the L4-L5 lumbar condition is in any way connected to the work injury either consequentially, directly or by way of aggravation or acceleration and whether the condition caused any impairment of the lower extremities

After completion of the above development and any other development that the Office deems necessary, a new decision should be issued.

In accordance with the above findings, the decision of the Office dated September 21, 2010 is set aside and the case **remanded for further development**.

MAY 13 [illegible]

Date:
Washington, D.C.

Carol Adams
Hearing Representative
for
Director, Office of Workers' Compensation Programs