File Number:
HR10-D-H

RECEIVED AUG 23 2013

U.S. DEPARTMENT OF LABOR

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

AUG 15 2013

Date of Injury:
Employee:

Dear Mr. :

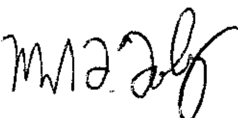
This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on May 17, 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 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,



Mark F. Foley
Hearing Representative

PAUL FELSER, ESQ.
P O BOX 10267
SAVANNAH, GA 31412-0000

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; , Georgia, Case No. A telephone hearing was held on May 17, 2013.

The issue for determination is whether the claimant has established that he sustained greater than 1% left upper extremity permanent impairment, or 1% right upper extremity permanent impairment due to this work injury for which he was paid schedule awards.

, born , is employed as a . On , 2007, the claimant filed Form CA-1, Notice of Traumatic Injury. On this form, he stated that he was doing pull-ups during training when he felt pain in his left shoulder. On April 3, 2007, his claim was initially accepted for a left shoulder sprain, and a left shoulder rotator cuff sprain. On , the claimant stated that he also injured his right shoulder on the same date when he attempted to finish his training exercises on using predominantly his right shoulder after injuring his left shoulder. On , the claimant underwent authorized left shoulder arthroscopic superior labral repair and left shoulder acromioplasty. On January 31, 2008, the District Office expanded the claim to include the accepted condition of a right shoulder subluxation. On June 20, 2008, the claimant underwent authorized right shoulder surgery, including an arthroscopic superior labral repair, arthroscopic acromioplasty, and arthroscopic limited debridement of the right glenohumeral joint. Of note, the claimant also has a prior accepted work-related injury, claim number , for which he was paid schedule awards totaling 16% left upper extremity permanent impairment based upon an accepted left elbow and ulnar nerve injury.

On October 16, 2008, the claimant attended a second opinion examination with Dr. at the direction of the Office. Dr. determined that the claimant had no further residuals of his work injury based upon his objective findings, including full range-of-motion of both shoulders.

On December 4, 2008, the claimant's physician, Dr. , stated that the claimant had reached maximum medical improvement due to his work injuries. He provided diminished range-of-motion measurements, and determined that the claimant sustained 6% permanent impairment of each upper extremity according to the Fifth Edition of the A.M.A.'s Guides to the Evaluation of Permanent Impairment ("The Guides").

On December 6, 2009, the claimant filed Form CA-7, Claim for Compensation, claiming a schedule award. On December 18, 2009, a District Medical Advisor ("DMA") Dr. stated that the claimant reached maximum medical improvement on October 16, 2008, the date of the second opinion examination with Dr. . The DMA determined that, using the diagnosis-based impairment method, the claimant had 0% permanent impairment of the left and right upper extremities according to Table 15-5 of the Sixth Edition of The Guides. The DMA stated that the difference in range-of-motion findings between Dr. and Dr. rendered the measurements unreliable. By decision dated January 13, 2010, the District Office denied the claim for a schedule award based upon the DMA's opinion. The claimant disagreed, and requested a hearing. An oral hearing was held on April 19, 2010. Based upon this hearing, an Office Hearing Representative determined that a conflict in medical opinion existed regarding the physical findings of Dr. and Dr. . The Hearing Representative vacated the Office's schedule award decision, and remanded the case to the District Office for the scheduling of a referee examination to resolve the conflict in medical opinion.

On August 25, 2010, the claimant attended a referee examination with Dr. at the direction of the Office. In his initial report, Dr. stated that the claimant had sustained 6% bilateral upper extremity permanent impairment according to the Sixth Edition of The Guides. He stated this was based upon a limitation of internal rotation movement of both shoulders. Dr. did not explain how he reached this calculation with specific measurements, tables and calculations. On September 10, 2010, the District Office requested a supplemental report from Dr. to explain how he calculated his permanent impairment ratings. On September 23, 2010, Dr. provided completed charts, but did not explain how he applied specific tables and the net adjustment formula to reach his permanent impairment ratings. On September 27, 2010 and September 29, 2010, a DMA Dr. , disagreed with Dr. application of The Guides because he did not explain the degree of motion upon which he based his impairment ratings, nor how he applied specific tables of The Guides.

By decision dated October 4, 2010, the District Office denied the claim for a schedule award. The claimant disagreed with this decision, and requested a hearing before an OWCP Representative. A hearing was held on February 7, 2011. On March 8, 2011, the claimant's physician, Dr. , provided an updated impairment rating based upon the Sixth Edition of The Guides. Dr. stated that he examined the claimant on February 24, 2011, with no change from his prior evaluation. Dr. used Table 15-5 of The Guides. Using the Diagnosis-Based Impairment method, Dr. chose the diagnosis of superior labral tears. He found that the claimant sustained a Class 1 impairment following labral repair. He stated that the claimant has residual symptoms consistent with objective findings and/or functional loss with normal motion. He used the "mid-rating" of 6% permanent impairment for each upper extremity for his final calculation. Based upon this hearing, an Office Hearing Representative vacated the District Office decision, and remanded the case to the District Office to request a new supplemental report from Dr. to provide his complete range-of-motion findings, and to review the new report from Dr. . The Hearing Representative ordered

that Dr. provide a diagnosis-based impairment rating for each upper extremity, and to explain his methodology in providing his final impairment ratings.

On June 13, 2011, the claimant was re-examined by Dr. the referee physician, at the direction of the Office. In his examination report, Dr. did not explain his range-of-motion findings or how he calculated the 6% bilateral upper extremity permanent impairment. On July 18, 2011, the District Office determined that Dr. was unable or unwilling to provide a sufficient supplemental report to resolve the conflict in medical opinion, and referred the claimant for a new referee examination.

On September 12, 2011, the claimant attended a new referee examination with Dr. at the direction of the Office. Based upon his review of the case file and examination of the claimant, Dr. termined that the claimant reached maximum medical improvement on December 4, 2008. Using Table 15-5 of The Guides, and the Diagnosis-Based Impairment method, Dr. used the diagnosis of labral lesions, and stated that the claimant sustained Class 1 impairments to each upper extremity due to very slight loss of range-of-motion. Dr. concluded that the claimant sustained 1% permanent impairments of each upper extremity. On September 15, 2011, a DMA Dr. stated that Dr. correctly applied The Guides. On September 21, 2011, a DMA Dr. stated that this 1% permanent impairment for the left upper extremity was in addition to the 16% permanent impairment already paid for the prior injury.

By decision dated September 30, 2011, the District Office determined that the claimant was entitled to schedule awards for 1% permanent impairment of each upper extremity, and that he reached maximum medical improvement on December 4, 2008 as originally stated by Dr. . The claimant disagreed with this decision, and requested a hearing before an OWCP Representative. The Office Hearing Representative determined that the case was not in posture for a hearing because the DMA did not explain why the 1% permanent impairment was in addition to the 16% already paid. The District Office decision was vacated, and the case was remanded to the District Office to request additional explanation from the DMA. On January 12, 2012, a DMA provided a worksheet explaining how the 1% permanent impairment ratings were calculated using Table 15-5 and the net adjustment formula.

By decision dated February 3, 2012, the District Office determined that the claimant was entitled to a schedule award for 1% permanent impairment of each upper extremity. The claimant disagreed with this decision, and requested a hearing before an OWCP Representative. A hearing was held on May 25, 2012. Based upon this hearing, an Office Hearing Representative vacated the District Office's decision, and remanded the case to the District Office for acceptance of additional work-related diagnoses, modification of the statement of accepted facts, and for a supplemental report from Dr. Donati based upon these changes.

On August 14, 2012, the District Office expanded this claim to include the accepted conditions of bilateral labral tears, bilateral shoulder impingement, bilateral shoulder

dislocation, and bilateral rotator cuff tear. The Office also updated the statement of accepted facts to include these changes. On October 22, 2012, the claimant attended a re-examination with Dr. at the direction of the Office. In his examination report, Dr. stated that his prior opinion was unchanged based upon the updated statement of accepted facts and re-examination. Dr. found full range of motion of both shoulders both actively and passively. He stated that the labral tears were the only basis for permanent impairment despite the additionally accepted conditions, and that the claimant sustained 1% permanent impairment of each upper extremity as previously calculated. This opinion based upon the new examination was not reviewed by a DMA

By decision dated November 8, 2012, the District Office determined that the claimant had not established entitlement to any additional schedule awards greater than the 17% permanent impairment paid for the left upper extremity, and 1% permanent impairment paid for the right upper extremity. The District Office based its opinion on Dr. opinion. The claimant disagreed with this decision, and requested a hearing before an OWCP Representative.

An oral hearing was held on May 17, 2013 via telephone. The claimant was represented at the hearing by Attorney Paul Felser. As required by Office procedures, a copy of the hearing transcript was forwarded to the employing agency to afford them the opportunity to comment on the claimant's testimony. No comments have been received from the employing agency, and the time allotted to all parties for the submission of additional evidence has now passed.

At the hearing, the claimant's Attorney argued that all prior arguments and evidence be incorporated into the record. He argued that the claimant had multiple conditions, which rendered the claimant's permanent impairment greater than what was determined by the Diagnosis-based Impairment method using the diagnosis of labral tears. He argued that the alternative Range-of-Motion method may be more appropriate in this case. He argued that the claimant being sent back for a reexamination with Dr. , after the claimant's criticisms of Dr. were reflected in the case file, subjected the claimant to a biased opinion from the referee physician. He argued that Dr. most recent opinion was not reviewed by a DMA as required by Office procedures. The record was held open for 30 days to allow the claimant time to submit additional evidence. However, no new evidence was received.

Based upon a careful review of the evidence of record, I find that additional medical development is necessary.

Under section 8107 of the FECA[1] and section 10.404 of the Office's implementing regulations[2], schedule awards are payable for permanent impairment of specified body members, functions or organs. The FECA, however, does not specify the manner in which the percentage of impairment shall be determined. For consistent results and to

[1] 5 U.S.C. § 8107.
[2] 20 C.F.R. § 10.404.

ensure equal justice under the law for 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.'s Guides to the Evaluation of Permanent Impairment ("The Guides") has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[3] After May 1, 2009, impairment ratings based upon the Sixth Edition of The Guides shall be used in determining schedule awards.[4] It is the claimant's burden to establish that he sustained any additional impairment based upon the work-related conditions than that which he was awarded.[5]

The Employees' Compensation Appeals Board ("ECAB") has held that where The Guides specifically allow, based upon diagnosis, for the use of the alternative Range-of-Motion method in assessing impairment, the District Office and its Medical Advisor may not determine the claimant's impairment rating to be deficient solely because the Range-of-Motion method was used in lieu of the Diagnosis-Based Impairment method.[6] However, if impairment is determined using the Range-of-Motion method, that impairment rating must stand alone, and cannot be combined with an impairment rating using the Diagnosis-Based Impairment method.[7] Furthermore, the range-of-motion method involves the taking of active and passive range of motion findings, and then comparing the two types of motion in order to evaluate credibility issues. Range-of-motion is measured after a warm up in which the individual moves the joint through its maximum range-of-motion at least three times.[8] These procedures are designed to ensure the credibility of the range of-motion testing.[9] If reliable and credible range-of-motion measurements cannot be obtained of the upper extremity in conformance with The Guides, the Range-of-Motion method should not be used in lieu of the Diagnosis-Based Impairment method.[10]

Section 8123(a) of the FECA provides that "if there is a 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," known as a referee physician.[11] After obtaining all necessary medical evidence, the file should be routed through the Office medical advisor for an opinion concerning permanent impairment in accordance with The Guides, with the DMA providing rationale for the specified percentage of impairment.[12] If a case has been

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[3] Id.
[4] See FECA Procedure Manual 2-808.6(a).
[5] See C.K., ECAB Docket No. 10-1926, issued July 8, 2011.
[6] See T.T., ECAB Docket No. 13-0258, issued April 17, 2013 (The Board determined that the DMA's report was deficient because it disregarded the claimant's impairment rating solely because it was based upon the range-of-motion method, even where that method was allowed by The Guides for a rotator cuff tear diagnosis).
[7] Id.
[8] See A.R., ECAB Docket No 12-1937, issued April 19, 2012 (The Board was referencing pages 461-464 of The Guides).
[9] Id.
[10] See C.H., ECAB Docket 11-0910, issued November 18, 2011.
[11] 5 U.S.C. § 8123(a).
[12] See FECA Procedure Manual, 2-0808.6(f); see also D.W., ECAB Docket No. 10-1000, issued January

referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the DMA to review the calculations to ensure that the referee physician appropriately used the guides.[13] However, the District Medical Advisor's opinion cannot resolve the conflict in medical opinion.[14] The DMA should not attempt to clarify or expand upon the referee's opinion, and cannot substitute his judgment for that of the referee physician.[15]

In the instant case, the claimant has accepted bilateral shoulder conditions. The claimant has only provided one permanent impairment rating from a physician, Dr. , using the Sixth Edition of The Guides. The Office has also received two additional examination reports, from Drs. and regarding the claimant's bilateral upper extremity permanent impairment according to the Sixth Edition of The Guides. On March 8, 2011, Dr. chose to use the Diagnosis-Based Impairment method rather than the Range-of-Motion method. Dr. chose to use the diagnosis of bilateral superior labral tears as the basis for his impairment ratings. Dr. tated that the range for this diagnosis is between 1% and 13%, and chose the 6% permanent impairment rating in the middle of this range to reach his conclusion. Dr. did not sufficiently explain in this report how he arrived at that calculation using the net adjustment formula, but rather somewhat arbitrarily chose the middle of this range. Thus, Dr. opinion is insufficient to establish the claimant's bilateral upper extremity impairment without additional rationale.

Similarly, Dr. , the initial referee physician, found that the claimant sustained 6% permanent impairment for each upper extremity due to different shoulder conditions. However, Dr. used the Range-of-Motion method without sufficiently describing how he reached his calculations, or how he determined such calculations were reliable in accordance with The Guides. He did not state whether he took three measurements after a warm-up, or explain how he otherwise measured the Range-of-Motion in a credible way. Dr. further did not explain how he calculated these final impairment ratings using the Range-of-Motion method, nor did he explain how he applied the net adjustment formula. Thus, Dr. s opinion was correctly determined to be insufficient to determine the claimant's bilateral upper extremity permanent impairment, and a new examination was necessary.

Finally, the claimant was examined by Dr. on September 13, 2011 and October 22, 2012. On September 13, 2011, Dr. Donati specified why he was using the Diagnosis-Based Impairment method, and explained how he reached his final impairment rating based upon his physical findings. After receiving an amended statement of accepted facts, new medical evidence, and a new examination, Dr. found that the claimant showed full range-of-motion, thus rendering consideration of the Range-of-Motion method moot. Using the Diagnosis-Based Impairment Method, Dr. chose the labral tears, and explained why he chose this diagnosis as the most

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24, 2011.

[13] FECA Procedure Manual 2-0810.8(k).

[14] See Richard R. Lemay, 56 ECAB 341 (2005).

[15] See J.B., ECAB Docket No. 10-0973, issued January 11, 2011.

impairing diagnosis. He explained that his calculations had not changed from his prior examination report. I find that, notwithstanding any of the procedural history of this case, Dr. is the only physician who sufficiently explained how he reached his final impairment rating. The claimant has not provided sufficiently rationalized medical evidence from a physician regarding permanent impairment to meet his burden of proof to establish additional impairment than has been awarded. Thus, Dr. opinion, regardless of his status, represents the current weight of the medical opinion in this case regarding the claimant's upper extremity permanent impairment.

The claimant and his Attorney have provided copious statements arguing against the Office's development of the medical evidence in this case. The claimant and his Attorney have argued that the initial second opinion examination by Dr. was biased and invalid. The claimant and his Attorney have argued that Dr. opinion was insufficient, and perhaps biased due to the claimant's criticism of Dr. examination. However, the claimant has not shown actual evidence of bias beyond his suppositions.[16] The claimant's mere disagreement with the tests performed on him, his disagreements with the physicians' opinions, and his suspicions about the referee physician's state of mind do not rise to the level of showing actual bias. Moreover, the claimant himself has not provided sufficiently rationalized medical evidence from a physician to establish any additional permanent impairment under the Sixth Edition of The Guides. The claimant provided his own thoroughly rationalized opinion, but he is not a physician, and cannot provide a medical opinion regarding his permanent impairment. Therefore, Dr. opinion is currently the best medical evidence of record and sufficiently rationalized to establish his opinion regarding the claimant's current permanent impairment ratings. Any arguments made regarding additional impairment, without additional rationalized medical evidence to the contrary according to the Sixth Edition of The Guides, are nor ripe for consideration.

However, I do agree with one argument made at the hearing. Office procedures require that all necessary medical evidence regarding permanent impairment be routed through a DMA for review and an opinion regarding permanent impairment. Even in cases with a referee examination resolving a conflict in medical opinion, the DMA can review the case file to determine whether the referee physician properly applied The Guides. Dr. most recent examination report was not reviewed by a DMA, and, importantly, was based upon an entirely new examination with new physical findings. The District Office's decision was procedurally deficient in this regard. Therefore, I find that Dr. most recent examination report must be reviewed by a DMA before a complete decision can be issued in this case.

Upon return of the case file, the District Office should forward a complete and accurate statement of accepted facts, Dr. most recent examination report, and Dr. prior examination report showing his permanent impairment calculations to a DMA for review and an opinion regarding the claimant's bilateral upper extremity permanent impairment. The DMA should be asked to explain whether Dr. has

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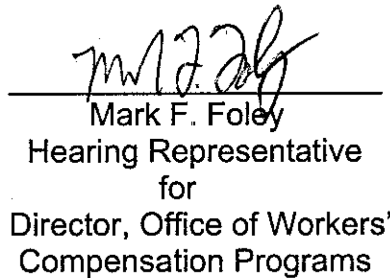
16 See E.H., ECAB Docket No. 10-1334, issued March 11, 2011 (The Board stated its principle that mere allegations of bias are insufficient, and evidence of actual bias must be provided).

correctly applied the Sixth Edition of The Guides based upon his most recent examination. The DMA should be asked to explain how the final impairment rating is calculated using the net adjustment formula, and whether the Diagnosis-based impairment method or Range-of-Motion impairment method are or are not applicable, respectively, in this case. If the DMA disagrees with Dr. application of The Guides, the DMA should be asked to thoroughly explain this difference. After this development, and any additional development the District Office deems necessary, the District Office should issue a de novo decision regarding the claimant's entitlement to schedule awards for bilateral upper extremity impairment.

Therefore, additional medical development is necessary in this case. Accordingly, the decision of the District Office dated November 8, 2012 is hereby **set aside**, and returned to the District Office for actions consistent with this decision.

Dated: AUG 15 2013
Washington, D.C.



Mark F. Foley
Hearing Representative
for
Director, Office of Workers' Compensation Programs