File Number:
HR11-D-H

U.S. DEPARTMENT OF LABOR

RECEIVED JUN 10 2014

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

JUN - 6 2014

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 preliminary review has been completed, and it has been determined that the case is not in posture for a hearing at this time. The decision of the District Office has been vacated and returned to the district office for further action as explained in the attached Remand Order.

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,

Rashawnda Snell
Hearing Representative

PAUL H FELSER, ATTORNEY
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 No.

Merit consideration of the case file was completed in Washington, D.C. Based on this review, the decision of the District Office dated is VACATED for the reasons set forth below.

The issue for consideration is whether the claimant has a greater ratable impairment related to the accepted condition.

The District Office accepted that the claimant, , born , was injured in the performance of his Building Equipment Mechanic duties on , . The Office accepted the claim for left rotator cuff strain, cervical stenosis and left shoulder adhesive capsulitis. The claimant underwent Office-approved C4-5 surgery in . The claim was subsequently expanded and accepted for myofascial pain syndrome, dizziness and giddiness and C4-5 herniated disc. The claimant was awarded 4% impairment of the left upper extremity in a decision. On appeal before the Branch of Hearings and Review (BHR), the Hearing Representative directed the Office to refer the medical records to include report, to the DMA for a discussion of a greater impairment. By decision dated , the Office awarded the claimant an additional 11% impairment of the left upper extremity, 15% total left upper extremity impairment. On appeal before the BHR, the Hearing Representative, in a decision, found that report was sufficient to require further review of the medical evidence. The Office was directed to refer the medical records to the District Medical Advisor for discussion of a greater left upper extremity impairment. In a letter decision, the Office expanded the claim accepting a C4-5 disc herniation. The Office denied the claim for a greater impairment in a decision. On appeal before the BHR, the Hearing Representative, in a decision, noted that there was some question as to the status of evaluation although the DMA, in a report, explained that report should be disregarded. The Hearing Representative explained that the DMA disagreed with report, however, found that the DMA's report was not sufficient to create a conflict of medical opinion but directed the Office to request that the DMA (re-)review report. The Hearing Representative stated it was unclear whether the DMA had reviewed report completely and if the report was found insufficient to establish a greater impairment, the claimant should be referred

for a new second opinion evaluation.[1] In an report, the DMA found that the claimant had no greater impairment than 15%, as previously awarded. In accordance with the remand order, the Officer referred the claimant to , who in a second opinion evaluation report, calculated that the claimant had an additional 7% left upper extremity impairment (21% total). In his supplemental report, concluded that the claimant had 4% impairment and in his addendum statement, he calculated that the claimant had a 12% total left upper extremity impairment. The Office denied the claim for a greater impairment in a decision. In an merit decision, the Hearing Representative directed the Office to have the DMA review reports and explain whether the claimant had a greater left upper extremity impairment. Following an review by the DMA, the Office, in an decision, denied the claim for a greater upper extremity impairment.

On appeal before the BHR, the Hearing Representative, in an decision, found that neither nor the DMA had explained why the range of motion method was used versus the preferred diagnosed-based method to calculate impairment. The Office was directed to refer the claimant back to for re-examination and discussion of whether there were additional diagnoses causally related to the injury, whether the condition(s) resulted in a work-related ratable impairment of the *other* extremities and an explanation of the calculation of a left upper extremity impairment greater than 15%, as awarded, specifically addressing the selection of one method versus another method. In an file memorandum, the Office explained that report was not sufficient and the claimant was referred to for a new second opinion evaluation.

In his report, concluded that the left rotator cuff strain, left shoulder adhesive capsulitis, lumbar back sprain, and cervical stenosis and cervical and lumbar discs were aggravated as a result of the employment injury. Following EMG/NCS, in his supplemental report, concluded that the claimant had a 11% left upper extremity impairment.

By decision dated , the Office denied the claim for a greater impairment to the left upper extremity. The Office further explained that found that there was no evidence of radiculopathy of the neck and back and spinal conditions to result in an impairment of the other extremities. The claimant disagreed with the decision and through his attorney requested a hearing with an OWCP Representative.

I find that further development of the record evidence is warranted.

The schedule award provisions of the Federal Employees' Compensation Act set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the

[1] The Hearing Representative explained that was not considered a referee or second opinion evaluator, however, the report could be considered for its "intrinsic value".

members of the body listed in the schedule.[2] However, the Act does not specify the manner in which the percentage of loss of a member shall be determined. The Employees' Compensation Appeals Board (the Board) has held, however, that 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 Office has adopted the AMA Guides for determining the extent of permanent impairment.[3]

Before the Guides can be utilized however, the Board has held a description of impairment must be obtained from an attending physician which includes a detailed description of the impairment including, where applicable, the loss in degrees of active and passive motion of the affected member or function, the amount of any atrophy or deformity, decreases in strength or disturbance of sensation, or other pertinent descriptions of the impairment. This description must be in sufficient detail so that the claims examiner and others reviewing the file will be able to clearly visualize the impairment with its resulting restrictions and limitations.[4]

In the present case, the Office accepted that the claimant sustained left upper extremity conditions and cervical disc injuries as a result of performing his duties on . The claimant was awarded 15% left upper extremity impairment. Under claim , the Office accepted that the claimant was injured on , sustaining a lumbar back sprain and lumbar intervertebral disc without myelopathy for which he received 11% impairment of the left lower extremity. The claimant filed a claim for a greater award and following multiple appeals and directives for additional development of the medical evidence, to include development of causal relationship of additional conditions and related impairment to the right upper and bilateral lower extremities, the Office referred the claimant to , who in his report and supplemental report opined that the claimant had no greater impairment of the left upper extremity and no additional impairment of the additional extremities.

provided a well-discussed report addressing his review of the records, outlining his findings and explaining his conclusion of impairment citing his references to the Guides, 6th Ed. While report is detailed regarding his assessment, the DMA did not have the opportunity to review the second opinion evaluation report and EMG/NCS results to explain or discuss whether properly considered the Guides, 6th Ed., and determined that the claimant did not have any additional impairment of the left upper extremity or other extremities as a result of the accepted conditions based on the record evidence.[5] The DMA is responsible for taking the calculations

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[2] 5 U.S.C. §§ 8107-8109.

[3] The use of the *Guides,* 6th Ed , became effective on May 1, 2009. FECA Bulletin No 09-03 (iss'd March 15, 2009).

[4] *Robert B. Rozelle,* 44 ECAB 616 (1993).

[5] The Office should ensure that the DMA has an opportunity to provide a discussion of whether the work injury caused or contributed to any permanent impairment or greater schedule award. *J.T.* Dkt. No. 11-

provided by the examining physician and arriving at an overall impairment percentage rating.[6]

Upon return of the case record, the Office should request that the DMA review second opinion evaluation reports and the record evidence and explain whether the findings are supportive of a greater left upper extremity impairment. As well, the DMA should address whether the evidence establishes a ratable impairment of the right upper and/or lower extremities. The DMA should be asked to explain any discrepancies and address his conclusions in accordance with the Guides, 6th Ed., stating whether any calculated rating is in addition to that previously awarded or total impairment. Following any further development considered necessary, the Office should provide the claimant with a new decision regarding a greater impairment of the left upper extremity, right upper or lower extremities.

Consistent with the above findings, the District Office's decision is set aside and the case is **remanded** for further medical development.

Dated: JUN - 6 2014
Washington, D.C.

Rashawnda L. Snell
Hearing Representative
for
Director, Office of
Workers' Compensation Programs

1934, iss'd June 12, 2012
[6] FECA Bulletin No 96-17.