File Number:
HR10-D-H

RECEIVED OCT 2 4 2013

U S. DEPARTMENT OF LABOR

OCT 1 7 2013

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

Date of Injury:
Employee: I

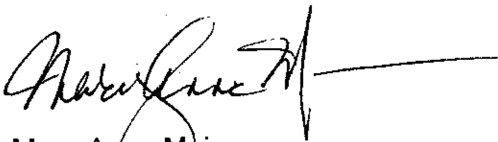
Dear Mr

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 July 16, 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: PO Box 8300, District 06; London, KY 40743-8300.

Sincerely,



Mary Anne Meier,
Hearing Representative
Branch of Hearings and Review

PAUL H FELSER, ESQUIRE
FELSER LAW FIRM, P.C.
PO BOX 10267
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 at Case No Telephonic Hearing was held on July 16, 2013.

The issue for determination is whether the medical evidence demonstrates that the claimant has additional permanent partial impairment of the bilateral lower extremities.

The claimant was employed as an for the at when he sustained a traumatic injury on

The District Office reviewed the medical and factual evidence of file and accepted this claim for lumbar strain; aggravation of displaced lumbar intervertebral disc without myelopathy, and thoracic or lumbosacral neuritis or radiculitis, and all appropriate compensation benefits were paid.

The claimant initially filed a claim for a schedule award on and this claim was denied by decision dated March 17, 2005. Several decisions have been issued on this claim, and they are incorporated herein by reference.

On June 23, 2011, the District Office issued a schedule award decision for 3% permanent partial impairment of the bilateral lower extremities based upon the report of the second opinion physician and the District Medical Advisor.

The claimant disagreed with that decision, and requested an appeal. By decision dated September 13, 2011, the Hearing Representative remanded this file for an impartial examination to determine the claimant's impairment.

The District Office arranged an impartial examination with Dr. who examined the claimant on but he did not submit his report until The District Office then requested that Dr. submit an addendum report addressing the claimant's impairment based upon the *AMA Guides*, 6th Edition; however, Dr. did not respond

The District Office referred the file to the DMA, who opined that Dr. ' impairment rating was not based upon the AMA Guides, 6th Edition, and therefore could not be used to determine the claimant's entitlement to a schedule award. Additionally, he noted that the

claimant had spinal surgery in and that the date of Dr. I examination was the date of maximum medical improvement, since his examination took place six months post surgery.

The District Office issued a decision on February 1, 2013, denying the claim for an additional schedule award.

The claimant disagreed with that decision and requested an oral hearing before an OWCP representative. Accordingly, a telephonic hearing was scheduled and held on July 16, 2013. The claimant was represented by attorney Paul Felser.

Mr. Felser argued that the District Office did not properly identify who the conflict was between, which was confusing for the claimant. He further noted that the District Medical Advisor cannot address or resolve the conflict in medical opinion; therefore, since Dr. did not provide an addendum report, the District Medical Advisor's report should not have been used to issue the denial of an additional impairment rating. He also argued that the District Office has not properly developed this claim to determine if additional conditions should have been accepted.

A copy of the transcript was sent to the employing agency for review and comment, and the record was held open for thirty days to allow for the submission of additional evidence.

Based upon hearing testimony, together with the written evidence of record, I find that the decision of the District Office should be *set aside and remanded* for further development.

The schedule award provisions of the Federal Employees' Compensation Act (FECA) at 5 U.S.C. 8107 and its implementing regulations at 20 C.F.R. 10.404 establish the compensation payable to employees sustaining permanent impairment. 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 with uniform standards applicable to all claimants. The American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment* has been adopted by the Office of Workers' Compensation Programs Division of Federal Employees' Compensation (DFEC) as the appropriate standard for evaluating schedule losses. In January 2008, the AMA published the Sixth Edition of the *Guides*, noting that the Guides are revised periodically to incorporate current scientific clinical knowledge and judgment. This Edition implements substantial reforms to the methodology of calculating permanent impairment. In accordance with its long established practice, the DFEC is moving forward to the most recent version of the Guides and generally utilizes the Sixth Edition in evaluating permanent impairment under the *Guides*. The Sixth Edition substantially revises the evaluation methods used in previous Editions, characterizing the new methodology's objectives as: to be consistent, to enhance relevancy, to promote precision and to standardize the rating process. The AMA describes the Sixth Edition of the *Guides* as implementing a major paradigm shift in the way impairment evaluations are conducted based on five axioms: (1) Adopting terminology and the conceptual framework of disablement outlined by the World Health Organization's (WHO's) International Classification of Functioning, Disability, and Health (ICF); (2) Becoming more diagnosis-based and basing the

diagnoses in evidence; (3) Optimizing rater reliability through simplicity, ease of application and following precedent; (4) Rating percentages are functionally based to the fullest extent possible; (5) Stressing conceptual methodological congruity within and between organ rating systems.[1]

The Board has determined that when the Office undertakes development of the medical evidence, it has a responsibility to obtain an evaluation which will resolve the issues involved in the case.[2]

However, the Board has also held that where the Office secures an opinion from an impartial specialist for the purpose of resolving a conflict in the medical evidence and the opinion requires further clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report. When the impartial specialist's statement of clarification or elaboration is not forthcoming to the Office, or if the physician is unable to clarify or elaborate on the original report, or if the physician's supplemental report is vague, speculative or lacks rationale, the Office must refer appellant to another impartial specialist for a rationalized medical opinion on the issue in question.[3] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Act will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict in medical evidence.[4]

In the instant case, this file was previously remanded by hearing decision dated September 13, 2011, for a referee examination to resolve the conflict in medical opinion regarding the claimant's lower extremity impairment.

The Office referred the claimant for an impartial examination with Dr who assured the Office that he was willing to perform an impairment evaluation using the *AMA Guides*, 6th Edition. However, Dr. did not submit his report for over five months, despite repeated requests, and when his report was received, he had incorrectly noted that the claimant had a whole person impairment. The Office then requested that Dr. provide an impairment rating for the claimant's lower extremities using *The Guides Newsletter for the 6th Edition AMA Guidelines*. When Dr. did not submit a supplemental report, the Office referred the file to the DMA along with the initial report of Dr. and requested that he advise whether or not Dr had correctly applied the *AMA Guides*, 6th Edition.

The DMA, Dr. , opined that the referee physician had incorrectly applied the *AMA Guides*, 6th Edition and had given the claimant a 12% whole person impairment which was not valid under the FECA. The DMA opined that MMI would have been reached on

[1] FECA Bulletin 09-03 (March 15, 2009).
[2] Julia Sherls, 86-1628, (1986).
[3] Terrance R. Stath, 45 ECAB 412 (1994).
[4] Harold Travis, 30 ECAB 1071 (1979).

the date of Dr. examination, which was six months after the claimant had authorized discectomy/laminectomy surgery with fusion in

After reviewing the DMA report, the District Office denied this claim, stating that the claimant had additional spinal surgery after the last schedule award decision, and that the treating physician had failed to submit new evidence to support that the claimant had reached MMI.

The hearing decision dated September 13, 2011, remanded this file for a new impartial examination, when it was determined that the referee report of Dr. was insufficient to resolve the conflict regarding the claimant's impairment. However, the claimant had authorized lumbar surgery in ; therefore, the conflict in medical opinion regarding the claimant's bilateral lower extremity impairment no longer existed at the time of Dr. examination in

The Office denied this claim after determining that the attending physician had not submitted a new medical report stating that the claimant had reached maximum medical improvement; however, the DMA reviewed Dr. report and opined that the medical evidence supported that the claimant had reached MMI as of the date of Dr. examination. The DMA based that opinion on the flexion/extension xrays taken of the lumbar spine by Dr. which demonstrated that the claimant's fusion was stable.

Proceedings under the FECA are not adversarial in nature nor is the Office a disinterested arbiter. The Office has an obligation to see that justice is done.[5] While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[6]

In the instant case, I find that although there is no longer a conflict in medical opinion regarding the claimant's impairment, the District Office must undertake additional development of the medical evidence to determine the claimant's current impairment rating.

Upon receipt of this file, the District Office should first amend the Statement of Accepted Facts and remove the reference to the reason File # was denied, and remove the statement that the claimant "went on regular retirement on _." Also, it is unclear in the SOAF why one portion states: FACTS, and then discusses the prior claim filed in The entire SOAF is a statement of facts; therefore this heading should be removed. Also in the same paragraph that discusses the denied claim under File , it states that the District Medical Advisor authorized lumbar laminectomy and fusion surgery as work-related in This information should be stated in a separate paragraph, after the diagnostic testing is noted. As currently written, it appears to stated that the lumbar surgery was authorized under the denied claim.

[5] Mark A. Cacchione, 46 ECAB 1038, (1994).
[6] Ibid.

When the SOAF has been amended, the Office should then refer the claimant, along with the SOAF and all relevant medical evidence for a second opinion examination to determine whether the claimant has any permanent partial impairment causally related to the accepted work injury. Following receipt of this report and referral to the DMA, the Office should issue a *de novo* decision on the claim for a schedule award.

Consistent with the above findings, the District Office decision of February 1, 2013 is hereby *set aside and remanded* for further development as noted.

DATED: OCT 1 7 2013
WASHINGTON, D.C.

MARY ANNE MEIER
Hearing Representative
For
Director, Office of Workers' Compensation Programs