File Number: 062264920
HR11-D-H
RECEIVED OCT 2 5 2013

U S. DEPARTMENT OF LABOR

OCT 2 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 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 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 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,

Amy E. Towner
Hearing Representative

PAUL FELSER
FELSER LAW FIRM, P.C.
POST OFFICE BOX 10267
SAVANNAH, GA 31412

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

Merit consideration of the case file was completed. Based on this review, the decision of the district office dated April 29, 2013, is set aside for the reasons set forth below.

The issue is whether the Office appropriately established work-related schedule award entitlement.

The claimant, born was employed as a with the in when she filed a CA2 Notice of Occupational Disease form on claiming a torn rotator cuff and severe pain in the left hip, which she attributed to lifting/twisting/closing LLV door repeatedly. The claimant indicated she first became aware of her disease or illness in December 2009 and realized it was related to her employment on On the claimant underwent right shoulder arthroscopic debridement of the labrum, arthroscopic subacromial decompression, incision distal clavicle, and mini-open rotator cuff repair. By reconsideration decision dated July 9, 2012, the Office accepted the claim for complete rotator cuff rupture, right, and bursitis of the left hip.

On the Office received a CA7 Claim for Compensation form claiming a schedule award. A medical report from M.D., was submitted in which he made the statement that "using the AMA Guide to Permanent Partial Impairment she has a fifteen percent impairment of her right shoulder secondary to her rotator cuff and subsequent surgery."

The Office referred the case to the District Medical Advisor (DMA) to conduct a review as procedurally required. In a report, DMA M.D., advised that Dr. had assigned 15% for the right shoulder with no basis, and that the correct right upper extremity impairment rating was equal to 7% based on the AMA *Guides* and using the diagnosis-based impairment method. The District Medical Advisor completed a worksheet referencing Table 15-5, page 403, Class 1, with a default grade C equal to 5%. He then assigned grade modifiers of 2 for functional history, physical examination, and clinical studies, and calculated a net adjustment of +3, moving grade C to E, to arrive at the final rating of 7%. He stated the date of Maximum Medical Improvement (MMI) was the date of Dr. report.

On March 15, 2013, the Office issued a development letter to the claimant advising that the District Medical Advisor arrived at a different percentage and outlined the general medical evidence needed to assess impairment per the AMA *Guides*, Sixth Edition.

An medical report was received from Dr. in which he stated the claimant had reached MMI as of that date, and that she had "15% impairment of her right shoulder based on the AMA Guide to Permanent and Partial Impairment Fifth Edition, page 476 due to lack of full abduction, forward flexion, internal rotation, and external rotation of the right shoulder." This report was not forwarded to the District Medical Advisor for review.

By decision dated April 29, 2013, the Office awarded the claimant 7% permanent partial impairment of the right upper extremity, with the date of Maximum Medical Improvement as based on the weight of medical evidence of the District Medical Advisor. The claimant disagreed with this decision and by letter postmarked May 2, 2013, through her attorney, requested an oral hearing.

Based on my preliminary review, the case is not in posture for hearing and the April 29, 2013 decision should be set aside for the reasons set forth below.

Section 8107 of the Federal Employees' Compensation Act[1] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[2] For Office decisions issued on or after May 1, 2009, the Sixth Edition of the AMA *Guides* is used for evaluating permanent impairment.[3]

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).[4]

It is a well established notion that maximum medical improvement or MMI arises at the point at which an injury has stabilized and will not improve further. This determination is based on factual and medical evidence.[5] The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the Office.[6]

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[1] 5 U.S.C. § 8107.
[2] 20 C.F.R. § 10.404 (1999).
[3] FECA Procedure Manual, Part 2, Chapter 2.808.6.6(a)
[4] A.M.A., *Guides* 494-531.
[5] See *Peter C. Belkind*, 56 ECAB 580 (2005)
[6] *Mark A. Holloway*, 55 ECAB 321 (2004).

When the attending physician fails to provide an estimate of impairment conforming to the current AMA *Guides*, his/her opinion is of diminished probative value in establishing the degree of impairment and the office may rely on the DMA to apply the *Guides* to the findings reported by the attending physician.[7] As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The CE must ensure, however, that the DMA properly considers all reported findings, gives rationale, and uses the AMA *Guides* correctly in computing the percentage.[8]

In the instant case, the claimant's treating physician provided a medical statement in a report that she had 15% impairment of the right shoulder per the AMA *Guides*. This report did not include the date Maximum Medical Improvement had been reached, a description of any examination findings, or any explanation as to how Dr. arrived at this percentage. The District Medical Advisor reviewed this report and advised there was no basis for the 15% reported by Dr. The DMA instead calculated a right upper extremity impairment rating referencing the AMA *Guides*, Sixth Edition. He also accepted that MMI had been reached on the date of Dr. report. The Office issued a development letter to the claimant to give her the opportunity to have her physician provide additional medical evidence addressing impairment. In an report, Dr. stated the claimant had reached MMI as of and the 15% rating was based on the Fifth Edition and range of motion deficits. This report was not reviewed by the District Medical Advisor, and the Office proceeded with the issuance of a schedule award for 7% impairment of the right upper extremity based the initial review and impairment calculation by the DMA.

However, I find that the District Medical Advisor's report cannot be used as the weight of medical evidence for several reasons. First, he did not identify the actual exam findings he was accepting as definitive for impairment purposes and upon which he based his grade modifier assignments. As such, it cannot be verified that the findings were properly applied to the *Guides* criteria. Second, since Dr. report did not contain any examination findings, the District Medical Advisor failed to give any explanation to support the selection of this date as the date of MMI. Procedurally, persuasive argument must be made for why a retroactive date was chosen and must be based on contemporaneous retroactive medical evidence. The Board requires persuasive proof of maximum medical improvement for selection of a retroactive date of maximum medical improvement.[9] Third, the Office did not refer the report of Dr. to the District Medical Advisor for review prior to issuing a decision to establish that the DMA had considered all reported findings, especially given that Dr. had reported MMI had been reached as of that date, not For these reasons, further medical development is necessary.

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[7] *See Linda Beale*, 57 ECAB 429 (2006)

[8] FECA Procedure Manual 2-0810-7

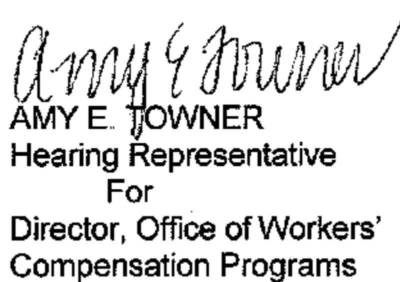
[9] *J.C.*, 58 ECAB___(Docket No. 06-1018, issued January 8, 2007); *James E. Earle*, 51 ECAB 567 (2000)

On remand, the pertinent medical evidence should be referred back to the District Medical Advisor to specifically identify the examination findings he used to assign each grade modifier to calculate impairment. The DMA should explain why the findings support each assignment based on the criteria set forth in the AMA *Guides*, Sixth Edition, to confirm that he considered all reported findings and used the *Guides* correctly. The District Medical Advisor should also address the established date of Maximum Medical Improvement as it is usually considered to be the date of the evaluation by the physician which is accepted as definitive by the Office. If a retroactive date is chosen, the DMA needs to provide persuasive argument based on contemporaneous medical evidence. After any additional development deemed necessary, *de novo* decision should be issued addressing the MMI date and the level of injury-related right upper extremity impairment.

Accordingly, the April 29, 2013 decision is hereby set aside and returned to the district office for further medical development as outlined above.

DATED: OCT 21 2013

WASHINGTON, D.C.



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