File Number:
HR11-D-H

RECEIVED MAY 0 4 2015

U.S. DEPARTMENT OF LABOR

APR 3 0 2015

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,

Jennifer Metrione
Hearing Representative

PAUL H FELSER, ESQ.
FELSER LAW FIRM P.C.
P O 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 number

Merit Consideration of the case file was completed on April 16, 2015. Based on the review, the decision of the district office dated October 16, 2014 is set aside for the reasons set forth below.

The issue for determination is whether the Office properly adjudicated the claim for a schedule award by decision dated October 16, 2014.

born is employed as a with the in She filed Form CA-1 for a timely notice of a Traumatic Injury claimed to have occurred on On this date, while in the performance of duty, she pushed a bulk mail container that would not roll correctly. She also retrieved two tubs of mail out of the container. The claim was initially denied on August 22, 2011 however it was subsequently accepted for a left-sided disc herniation at the L5-S1 level by Reconsideration decision dated September 14, 2011.

An MRI of the lumbar spine was performed on May 26, 2011 which revealed a focal left paracentral disc protrusion at L5-S1 with mild displacement of the central left S1 nerve root.

On the claimant was seen for a neurosurgical consultation with M.D. of On she underwent left L5-S1 semihemilaminectomy, medial facetectomy, proximal foraminotomy, lateral recess decompression, left L5-S1 microdiscectomy, microsurgically assisted dissection and intraoperative interpretation of x-rays. Surgery was performed by Dr.

A repeat MRI was performed on January 12, 2012 and was compared against the prior study of May 26, 2011. Findings revealed persistent or recurrent L5-S1 disc, conjoined L5-S1 left nerve roots, and perineural enhancement along the left S1 nerve root. At the request of Dr. the claimant was evaluated by M.D. on

On the claimant underwent re-exploration L5-S1, posterior lumbar interbody fusion, using PEEF cages, arthrodesis L5-S1, electromyogram (EMG), nonsegmental instrumentation L5-S1 and frameless computer stereotaxis. Surgery was performed by Dr. Lal.

On Ms. filed Form CA-7 for a Schedule Award. Submitted with this form was a impairment rating report from Dr. The claimant was said to have achieved maximum medical improvement as of her last visit and Dr. opined that she had 25-28% impairment due to radiculopathy. No reference was made to the Sixth Edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (the Guides) nor did Dr. Lal explain how he/she arrived at the rating provided. Furthermore, The Sixth Edition of the AMA *Guides* does not provide a separate mechanism for rating spinal nerve injuries for extremity impairments. Recognizing that certain jurisdictions, such as FECA, mandate ratings for extremities and preclude ratings for the spine, the AMA *Guides* has offered an approach to rating spinal nerve impairments consistent with Sixth Edition methodology, pursuant to the AMA *Guides* Newsletter, July/August 2009. OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[1] No reference was made to the *Guides* Newsletter, July/August 2009 in Dr. report.

To afford the claimant every opportunity under the FECA the Office forwarded the report of Dr. to District Medical Advisor (DMA) M.D. In a response dated he noted that the claimant underwent left lumbar fusion surgery on The MRI performed pre-operatively on demonstrated a left-sided herniated disc at the L5-S1 level. The pre-op physical exam performed on noted weakness in the L5-S1 myotome. There was no sensory loss reported. Dr. noted that Dr. offered a rating of 25-28% impairment of the whole person due to radiculopathy. However, he stated that this was not explained or referenced. He opined, "OWCP does not recognize spinal impairment. Only extremity impairment due to deficit of spinal nerve root can be used for impairment (radiculopathy). The tables established in the Guides NEWSLETTER July/August 2009 are used. A moderate (IC) motor deficit of S-1 nerve root=8% PPI LLE." Dr. indicated that the date of maximum medical improvement (MMI) was

In a supplemental report dated Dr. further addressed the MMI date he had selected. He explained, "The letter by Dr. states that he feels that claimant had reached MMI as of her last visit. That would be The tone of the note definitely implies that he is signing off on her case."

[1]Federal (FECA) Procedure Manual, Part 3 -- Medical, Schedule Awards, Chapter 3.700 (January 2010) (Exhibits 1, 4). See also E.P., Docket No. 11-614 (issued November 2, 2011); P.M., Docket No. 11-1072, (issued November 23, 2011).

By decision dated August 15, 2013 the Office issued a Schedule Award for 8% impairment of the left lower extremity. The Office used May 6, 2013 as the date of maximum medical improvement.[2]

The claimant disagreed with the award decision of August 15, 2013 and a Reconsideration was requested through her attorney, Paul Felser, Esq. Along with the appeal request was a report dated July 2, 2014 from physical therapist of the Ms. noted that the claimant reported constant lumbar and left lower extremity pain. She also reported intermittent "pins and needles" sensation in the left lower extremity. She had trouble bending and lifting as well as trouble tolerating prolonged standing, walking or sitting. Ms. referenced the Sixth Edition of the Guides and stated,

> "Mrs. was noted to have decreased left lower extremity sensation ([.5-SI) at the posterior lateral lower leg (lateral calf), lateral foot lateral lower leg, plantar foot, and, anterior foot She was noted to have weakness in her left ankle plantar flexors and left great toe extensors
>
> According to Rating Spinal Nerve Table (Exhibit 3-700-4), she qualifies for Class I mild sensory deficit for L5 of the left lower extremity, This defines a midrange default of 1%. She qualifies for Class 1 mild sensory deficit for S1 of the left lower extremity which also defines a midrange default of 1% She qualifies for Class I motor deficit for L5 of the left lower extremity which defines a midrange default of 5%. She qualifies for Class 1 motor deficit for S1 of the left lower extremity which defines a midrange default of 5% According to Table 17-12 (Functional History Adjustment) on page 594, she qualifies for Grade Modifier 2. Her Pain Disability Score was 87 Please refer to the enclosed form. The Physical Examination Adjustment is not to be used. According to Table 17-4 on page 595 (Clinical Studies Adjustment), she qualifies for Grade Modifier 1. This results in a net adjustment of 1, Please refer to the Net Adjustment formula on page 582 This results in an adjustment of I to the right of the midrange This results in a lower extremity impairment rating of 2% for the sensory deficit at L5, a lower extremity impairment rating of 1% for the sensory deficit at SI, a lower extremity impairment rating of 7% for the motor deficit at L5 and a lower extremity impairment rating of 4% for the motor deficit at SI Using the Combined Values Chart on page 604, results in a total lower extremity impairment rating of 14%."

The Office forwarded a copy of the report from Ms. to DMA Dr. on for review. In a response of the same date the DMA concurred with the assessment outlined in the report. He incorporated his prior response by reference. He again stated that surgery was performed

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[2] The DMA stated that the MMI date should be The claimant had been receipt of wage loss compensation through therefore payment of the Schedule Award did not commence until

[3] A physical therapist is not considered a "physician" as defined under 5 U.S.C. § 8101(2). E.g., David P. Sawchuk, 57 ECAB 316, 320 n.11 (2006).

at L5-S1 (left) on and weakness of the left S-1 myotome was recorded. He reviewed the new assessment as outlined in Ms. report of and concurred that the claimant had L5 sensory loss which equated to 2% impairment, S1 sensory loss which equated to 1% impairment, L5 motor loss which equated to 7% impairment and S1 motor loss which equated to 4% impairment. He indicated that the claimant was entitled to a total of 14% impairment of the left lower extremity however since she already received 8% by decision dated August 15, 2013 she was only entitled to an additional 6%. He maintained that the date of maximum medical improvement was In his report Dr. noted that the impairment rating report of was completed by a physical therapist and had not been co-signed by a qualified physician.

By decision dated October 16, 2014 the Office issued an award for 14% permanent partial impairment of the left lower extremity less 8% impairment previously paid. Therefore, the award was issued for an additional 6% impairment of the left lower extremity.

The claimant disagreed with the decision of October 16, 2014 and an oral hearing was requested by her attorney, Mr. Felser. In accordance with this request, I have conducted an initial review of the file and find that the case is not in posture for a hearing at this time.

The decision of the District Office dated October 16, 2014 should be *SET ASIDE and REMANDED* for the reasons set forth below.

Section 8107 of the Federal Employees' Compensation Act[4] 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 A.M.A., Guides.[5] The OWCP adopted the Third Edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised Third Edition of the Guides effective September 1, 1991; the Fourth Edition effective November 1, 1993; the Fifth Edition effective February 1, 2001; and the Sixth Edition effective May 1, 2009.[6]

The Sixth Edition of the AMA *Guides* does not provide a separate mechanism for rating spinal nerve injuries for extremity impairments. Recognizing that certain jurisdictions, such as FECA, mandate ratings for extremities and preclude ratings for the spine, the AMA *Guides* has offered an approach to rating spinal nerve impairments consistent with Sixth Edition methodology, pursuant to the AMA *Guides* Newsletter,

[4] 5 USC § 8107.
[5] 20 CFR § 10.404 (2002).
[6] Federal Employees' Compensation Act Procedure Manual 2-1601-8(c).

OWCP has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[7]

The claims examiner must utilize the DMA if the claims examiner is adjudicating a schedule award claim and requires a calculation of the percentage of impairment in order to establish the schedule award.[8] The DMA's opinion may constitute the weight of medical opinion in schedule award cases. If an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the AMA Guides, an opinion by the DMA which gives a percentage based on reported findings and the AMA Guides may constitute the weight of the medical evidence. 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. The DMA should also explain any difference between his or her findings and the findings of the AP report upon which the DMA is basing his or her opinion. This is necessary to determine whether weight can be assigned to the DMA or whether a conflict of medical opinion exists. If the AP misapplied the AMA Guides, no conflict would exist because the AP report would have diminished probative value and the DMA's opinion would constitute the weight of medical opinion. However, if the DMA and the AP disagreed on, for instance, the level of impairment in a sliding scale, this could constitute a conflict of medical opinion.[9]

In the instant case the claimant had initially received an impairment rating for 8% impairment of the left lower extremity by schedule award decision dated August 15, 2013. The opinion of DMA Dr. was cited as the controlling evidence as he calculated the rating according to the *Guides Newsletter July/August 2009*. The claimant disagreed with this decision and a Reconsideration was requested. On appeal, the claimant submitted a narrative report from physical therapist Ms. who performed a physical examination and found that the claimant had 14% impairment of the left lower extremity. Again, this report was signed by a physical therapist however it did not contain the co-signature of a qualified physician as is required under the FECA. Nevertheless, this report was forwarded to Dr. for review. He noted that the report was completed by a physical therapist and had not been co-signed by a physician however he relied upon the findings within this report to assess whether the claimant sustained ratable impairment secondary to the accepted condition on the claim. He concurred with Ms. that the claimant had L5 sensory loss, S1 sensory loss, L5 motor loss and S1 motor loss which equated to 14% permanent partial impairment of the left lower extremity. He maintained that the claimant had achieved maximum medical improvement as of April 24, 2013 for the

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, Schedule Awards, Chapter 3.700 (January 2010) (Exhibits 1, 4). See also E.P., Docket No. 11-614 (issued November 2, 2011); P.M., Docket No. 11-1072, (issued November 23, 2011).

[8] Federal Employees' Compensation Act Procedure Manual 2-810-8(d).

[9] Federal Employees' Compensation Act Procedure Manual 2-810-8(j).

reasons previously explained above. Dr. made no reference to the Sixth Edition of the Guides or the *Guides Newsletter July/August 2009*. As noted above, the DMA's opinion may constitute the weight of medical opinion in schedule award cases. Specifically, if an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining *physician*, but the percentage by this physician is not based on the AMA Guides, an opinion by the DMA which is calculated according to the Guides may constitute the weight of the medical evidence. In the instant case, the DMA's opinion was not based upon findings of a qualified physician. Rather it was based upon the findings of a physical therapist.

It is well established that, to constitute competent medical opinion evidence, the medical evidence submitted must be signed by a qualified physician.[10] Chapter 3-0100(3) of the FECA Procedure Manual states that by statute, the term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors within the scope of their practice as defined by state law.

Physical therapists are not physicians under the Federal Employees' Compensation Act (FECA) and therefore their opinions do not constitute medical opinion evidence and have no weight or probative value on medical matters.[11]

In the case of *C.G.*, Docket No. 13-1519 issued OWCP indicated that the claimant's schedule award was based on its medical adviser's approval of a impairment rating conducted by a physical therapist for the physical therapy firm of On the document was signed without comment by Dr. and Dr. two of appellant's attending Board-certified orthopedic surgeons. OWCP's medical adviser concluded that appellant had a 7 percent permanent impairment of his left arm, 5 percent permanent impairment of his right arm and 12 percent permanent impairment of his right leg, but his impairment rating appears to have been based on nonmedical evidence, *i.e.*, an impairment rating calculation conducted by Mr. Pearson, a physical therapist. Moreover, the record does not currently contain any other medical evidence on which a schedule award may be based. A document produced by a physical therapist with which was signed by him on references tables of the sixth edition of the A.M.A., *Guides* and concludes that appellant has 19 percent permanent impairment of his left arm, 14 percent permanent impairment of his right arm and 20 percent permanent impairment of his right leg. Although the document was signed by Dr. and Dr. on and these physicians later produced letters approving of the impairment ratings contained within, none of the documents pertaining to this impairment rating contains a rationalized explanation of how the impairment rating was derived under the relevant standards of the sixth edition of the A.M.A., *Guides*. At a minimum a document which purports to be the opinion of a physician must clearly show that it was written and reviewed by a physician. The presence of a doctor's initials or signature,

[10] Vickey C. Randall, 51 ECAB (Docket No. 98-855, issued March 10, 2000).
[11] *C.E.*, Docket No. 14-710 (issued August 11, 2014); *Jane A. White*, 34 ECAB 515, 518-19 (1983).

without evidence that the doctor prepared or reviewed the report is not sufficient to establish it as a medical opinion under FECA.

In the instant case, the report from Ms. was not co-signed by a physician. However, even if it were there would need to be evidence that the physician prepared or reviewed the rating report prior to its submission.

Conclusively, the claimant submitted an impairment rating report dated however the physical examination and report were completed by a physical therapist, which is not considered a qualified physician under the FECA. Despite this, the report from Ms. was then forwarded to the District Medical Advisor who specifically acknowledged the fact that the report had been completed by a physical therapist and was not co-signed by a qualified physician. Nevertheless, the DMA referred to the findings of Ms. and opined that he agreed with her assessment. I find that this was improper.

For the reasons outlined above, I find that additional medical development is warranted to accurately assess whether the claimant has ratable impairment secondary to her accepted condition based upon the Sixth Edition of the AMA Guides and the *Guides Newsletter July/August 2009*. Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[12] While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence and has the obligation to see that justice is done.[13]

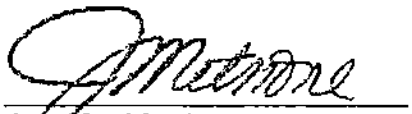
On remand, the Office should prepare a Statement of Accepted Facts and refer the claimant for a second opinion examination with a board certified specialist. The examiner should be requested to provide an impairment rating using the Sixth edition of the A.M.A Guides and the *Guides Newsletter July/August 2009*. He/she should also be asked to indicate whether maximum medical improvement has been achieved, and if so, when. Upon receipt, the report should be sent back to the DMA for review. Following receipt and review, the Office should take any further development action necessary, and issue a *de novo* decision on entitlement to a schedule award. Once the *de novo* decision has been issued the Office should consider the prior awards and address any potential overpayment, if applicable.

Accordingly, the decision of the District Office dated October 16, 2014 is hereby set aside, and the case is ***remanded*** to the district office for further development as outlined.

DATED: APR 30 2015

WASHINGTON, D.C.

[12]See Vanessa Young, 55 ECAB 575 (2004).
[13]See Richard E. Simpson, 55 ECAB 490 (2004).



Jennifer Metrione
Hearing Representative
For
Director, Office of Workers'
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