File Number:
HR10-D-H

RECEIVED MAY 0 6 2019

U.S. DEPARTMENT OF LABOR

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

Date of Injury:
Employee:

Dear

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 02/14/2019. 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 Cleveland 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 9 CLE
LONDON, KY 40742-8300

Sincerely,

Division of Federal Employees' Compensation

PAUL H FELSER
ATTORNEY AT LAW
FELSER LAW FIRM
QUEENSBOROUGH BANK BUULDING
7393 HODGSON MEMORIAL DRIVE SUITE
102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, May 01, 2019

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 Case No.

An Oral Hearing was held on February 14, 2019. As a result, the decisions of the District Office dated August 22, 2018 and January 31, 2019 are hereby set aside, and the case is remanded for additional actions, for the reasons set forth below:

The issues for consideration are (1) whether the claim should be expanded to include additional work-related medical conditions; and (2) whether the claimant is entitled to a schedule award.

The claimant is an employee of She filed form CA-2 "Notice of Occupational Disease" on August 20, 1987 alleging that she developed back problems due to heavy lifting, pushing and carrying in the course of her work for where she worked as both a and for over 23 years. The claim was accepted for exacerbation and permanent aggravation of lumbar disc disease; and cervical herniated disc. Cervical disc surgery was approved and performed in 1988.

On July 20, 2011 Dr. MD, examined the claimant. He noted that the claimant had a work injury in 1987. He stated that the claimant had neck pain and difficulty ambulating. He stated that the claimant had lumbar and cervical issues related to her work injury, and hip issues that were not.

On December 30, 2011 Dr. stated that the claimant had chronic radiculopathy in the upper extremity, C8 bilaterally due to neck cervical stenosis. He stated that the claimant had 15% whole person impairment, or 25% impairment to the right upper extremity. He stated that the claimant also had chronic lower extremity radiculopathy due to lumbar stenosis post-surgery. He stated that she had 17% whole person impairment or 42% lower extremity impairment. Dr. stated that the claimant had bilateral hip osteoarthritis, bilateral knee osteoarthritis, and bilateral carpal tunnel syndrome. He stated that the hip and knee conditions were not related to the claimant's employment.

On May 14, 2012 the claimant filed a claim for Schedule Award.

In a report dated May 4, 2012 Dr. stated, in part, that he believed the carpal tunnel syndrome was related to the claimant's employment.

On October 1, 2012 Dr. wrote that the claimant had reached maximum medical improvement. He stated that the claimant had permanent impairment due to residuals of her aggravation of degenerative disc disease and herniated cervical disc. He stated that the claimant had a degenerative progressive process that was persistent prior to 1992 and had continued.

The claimant was referred for a directed "second opinion" examination with MD, on November 14, 2012. In his narrative report, Dr. discussed the history of injury, past medical records and his own examination findings. He noted that the claimant had markedly limited range of motion in her neck and back related to the original work injury, but her principal problems were her lower extremity osteoarthritis, which was not work related. He stated that the claimant had a 2% whole person impairment based on her pain questionnaire.

On January 7, 2013 Dr. added that he found carpal tunnel syndrome, bilateral adhesive capsulitis, and hip and knee arthritis; but opined these were not related to the work injury because the claimant had not worked since 1992, and there was no evidence whatsoever linking these conditions to the workplace.

In an April 17, 2013 report Dr. stated that he believed that the conditions of adhesive capsulitis, hip and knee arthritis, and right carpal tunnel syndrome were work related. He also stated that he did not believe the lower extremity arthritis was work related.

The Office's District Medical Advisor (DMA) reviewed the case on May 30, 2013. He opined that the evidence did not establish ratable impairment of a scheduled member due to the accepted work injury. He further opined that the evidence did not support expansion of the claim to include additional work-related conditions.

The District Office declared a conflict in medical opinion between Drs. and pertaining to the issues of whether the claim should be expanded to include additional medical conditions; and whether there was ratable impairment of a scheduled member due to the accepted work injury. As such, the Office arranged for the claimant to undergo an impartial "referee" examination to resolve the conflict. For this purpose, the claimant was referred to the selected referee physician, Dr. Gregory MD, who examined the claimant on April 22, 2014.

In his report dated May 15, 2014, Dr. discussed the medical history, medical records and his examination findings. He found that the claimant did not have adhesive capsulitis of the shoulders, as she had range of motion greater than 30 degrees. Dr. found that the claimant suffered from carpal tunnel syndrome, bilateral hip arthritis, and bilateral knee arthritis; however, he opined that these conditions were not related to the work injury. Dr. Primus indicated that the claimant had chronic degenerative conditions, and there was no evidence prior to December 1992 to support that the claimant had any major complaints during the relevant employment period, except for those pertaining to her spine.

On July 29, 2014 the DMA reviewed the file. He opined noted that the claimant resigned from federal employment in December 1992 due to spinal issues. He concurred with Dr. that

prior to retirement, there was no evidence relating the claimant's numerous other conditions to her employment. There was no evidence of complaints of arthritis at that time. He found no basis for a permanent impairment rating based on the accepted conditions.

On August 14, 2014 the Office issued a formal decision denying the claimant's request to expand the claim to include additional work-related medical conditions: bilateral adhesive capsulitis, bilateral hip arthritis, bilateral knee arthritis, and bilateral carpal tunnel syndrome.

In a separate formal decision dated August 14, 2014, the Office denied the claim for schedule award.

A report from Dr. , MD, dated January 7, 2014, was submitted in which he discussed the claimant's history, and noted her work injuries to the spine. He asserted that the claimant had been having pains in the elbows, wrists, hips and knees prior to the back and neck problems. He maintained that the work injury had contributed to or aggravated many other medical conditions including arthritis in the shoulders, hips and knees, carpal tunnel syndrome and epicondylitis. Dr. provided impairment assessments for both upper extremities and both lower extremities. He identified spinal nerve root impairment as a component in the ratings.

As Dr. was no longer available, the District Office arranged for evaluation of the claimant by a new referee physician, Dr. DO. He was provided with a copy of the Statement of Accepted Facts and the medical evidence of record to use in making his determination between the conflicting opinions of Dr. and Dr.

Dr. provided his report dated June 12, 2016 discussing the history of injury, review of the medical records and his examination findings. He provided an impairment rating of 15% to the whole person based upon conditions present in the cervical spine. He opined that the claimant was at maximum medical improvement for the cervical condition in 1990 based on reports she was able to work without restrictions. He opined that she reached MMI for the lumbar spine in 1992, when she retired, due to her ability to work full time, full duty until the date of retirement. He further opined that the additional conditions of bilateral hip and knee arthritis, bilateral carpal tunnel syndrome, and bilateral adhesive capsulitis of the shoulders were not work related.

Following receipt and review of Dr. report, an addendum was requested in an attempt to secure an opinion on a single date of maximum medical improvement for the accepted conditions, as well as clarification of the permanent impairment rating since whole person impairment is not utilized for schedule awards under the FECA. Dr. was provided reference to the *AMA Guides* July/August 2009 Newsletter to calculate impairment from the accepted spinal conditions.

Dr. responded on August 9, 2016 with handwritten notes added into the margins of the addendum request and his prior June 12, 2016 report. A permanent impairment rating according to the July/August 2009 newsletter and a single date of MMI were not provided in the addendum.

Due to the need for further clarification, the Office requested a second addendum from Dr. . He was asked to provide calculations for permanent impairment stemming from the spine due to the accepted conditions of the case, as well as a date of maximum medical improvement.

Dr. responded with a report dated September 10, 2016 in which he maintained his prior opinions that MMI was reached, separately, for the cervical spine in 1990 and the lumbar spine in 1992. Regarding permanent impairment, he opined that, based upon the utilization of the July/August 2009 Newsletter; the claimant had 0% permanent partial impairment for the accepted conditions.

This report, along with the medical evidence of record and the statement of accepted facts, were sent to the DMA in order to review the impairment rating of Dr. to ensure it was calculated in accordance with the AMA guides and the July/August 20019 newsletter.

The case was referred to the DMA for review and opinion on the issues under consideration, with attention to the narrative reports provided by Dr. The DMA responded with a report dated September 30, 2016 in which he stated he disagreed with the MMI dates provided by the referee physician, asserting that the more accurate date of MMI would be June 12. 2016, when the claimant was seen for evaluation for permanent impairment by Dr. Regarding calculations for permanent impairment, the DMA concurred with the findings of Dr. and found 0% ratable impairment of the bilateral upper and lower extremities stemming from the accepted, work-related spinal conditions.

The Office issued a formal *de novo* decision on October 26, 2017 denying the request for expansion of the claim to include additional medical conditions with a finding that the weight of medical evidence resided with the opinion of the referee physician, Dr. who provided his well-reasoned opinion on the matter, based on a complete and accurate history, indicating that there were no additional work-related conditions.

On October 27, 2016, the Office issued a *de novo* decision denying the claim for schedule award because the medical evidence failed to demonstrate a measurable impairment of a scheduled member due to the accepted work injury. The weight of medical evidence was afforded to the referee physician, Dr. with a finding that he correctly utilized the 6th edition *AMA Guides* and the July/August 2009 newsletter to calculate impairment to the bilateral upper and lower extremities stemming from the accepted spinal conditions, which was determined to be 0%.

The claimant disagreed with the decisions dated October 26 and October 27, 2016 and requested an appeal in the form of an Oral Hearing before the Branch of Hearings and Review. A Hearing was held by telephone on June 16, 2016. As a result of the Hearing, the Branch of Hearings and Review issued a formal decision dated August 31, 2017 that set aside the prior decisions of October 26, 2016 and October 27, 2016 and remanded the case for further medical development.

The decision of August 31, 2017 explained that the opinions expressed by the referee physician, Dr. were not sufficiently reasoned, and therefore of lessened probative value, and insufficient to represent the weight of medical evidence. Dr. provided only vague responses to questions posed to him; and little in the way of medical reasoning to explain how he reached his conclusions that additional diagnosed conditions were not causally related to federal employment. Also, Dr. provided an impairment rating in terms of whole person impairment, which was not acceptable under the FECA. After several requests for clarification, he opined the claimant had 0% impairment due to her accepted injuries based on *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009); but offered no explanation as to how he applied the principles therein to his specific examination findings to arrive at this figure. He indicated his figures were in line with those provided by Dr. however, Dr. found significant permanent impairment to the upper and lower extremities. The DMA reviewed the impairment rating provided by Dr. but provided no specific calculations and no medical reasoning to explain why his impairment rating was correct.

The opinion of the referee physician was insufficient to determine whether there were additional work-related medical conditions; or whether the claimant sustained permanent impairment of a scheduled member due to the accepted work injury. The conflict in medical opinion therefore remained unresolved. As several attempts were made to obtain a sufficiently reasoned opinion from Dr. to no avail, a referral for a new referee opinion was warranted to resolve the conflict. Prior to this, the Statement of Accepted Facts (SOAF) was to be amended to reflect the claimant's work duties as both a and to describe the employment periods the claimant held each of as this was critical information for an examining physician to consider when rendering an opinion as to whether specific work duties caused or contributed to a diagnosed medical condition in an occupational disease claim. Furthermore, the section of the SOAF identifying additional "concurrent conditions" that were not accepted as work-related was to be omitted from the SOAF, as such language could potentially influence the opinion of the referee physician, who would be considering the specific issue of whether or not additional conditions were, in fact, work-related. Upon receipt of the report of the new referee physician, the District Office was to undertake any additional development of the evidence as warranted, and issue a *de novo* decision on whether the claim should be expanded to include additional work-related medical conditions; and whether the claimant is entitled to a schedule award.

In accordance with these instructions, the District Office amended the SOAF and referred the claimant for a new referee examination. Dr. a Board-certified orthopedic surgeon, was selected as the referee physician. Dr. examined the claimant on June 11, 2018. He provided his detailed narrative report dated June 11, 2018 discussing the history of injury and his review of the medical records, with attention to prior operative reports and diagnostic testing, treatment records, independent medical evaluations and DMA reports. He provided his detailed examination findings. He noted the claimant suffered from considerable difficulty with both her cervical and lumbar spine as well as carpal tunnel syndrome of her upper extremities. Neck surgery at the C3-4 level in 1983 was declared a work-related injury. Dr. oted she also had surgery on her low back in 2010 which he found was typical of degenerative lumbar spinal stenosis and he opined this was not work-related. He noted the

claimant suffers from bilateral carpal tunnel syndrome and he opined this condition was not work-related. He noted the claimant had surgery on her cervical spine 40 years ago and she had not worked since 1992, so the progression of cervical pathology had progressed since her last employment of 26 years ago. Her spine has undergone progressive degeneration, very typical of DISH or ankylosing spondylitis pathology that was definitely not work-related. Her lumbar spine required surgery 28 years after she quit working in 1992, culminating in surgery in 2010. He opined that if she did not need the surgery when she retired in 1992, it was difficult at best to say the progression of her lumbar stenosis, which finally lead to surgical intervention 18 years later, was work-related. Since the claimant began to develop significant symptoms of numbness in her hands long after she quit working at the post office, it was difficult at best to say this was work-related.

Dr. opined that maximum medical improvement had been achieved for the spine. The claimant would be entitled to a permanent partial impairment rating for the cervical disc herniation and the November 25,1988 diskectomy. This impairment rating was assessed using the 6th edition of the *AMA Guides to Evaluation of Permanent impairment*, page 564, Table 17-2, class 2, for a permanent partial impairment rating of 10% to the whole person.

On August 22, 2018, the District Office sent a letter to Dr. requesting an addendum to provide clarification of his first report. He was asked to give a date for Maximum Medical Improvement (MMI) and provide his rationale for assigning the date. He was informed that whole person impairment is not valid under the FECA and he should provide an appropriate impairment to an extremity. He was again provided given the relevant information to calculate permanent impairment to an extremity stemming from conditions in the spine as per the July/August 2009 newsletter supplement to the 6th edition of the *AMA Guides*.

In a formal decision dated August 22, 2018, the District Office denied the claimant's request to expand the claim to include the additional diagnoses of bilateral carpal tunnel syndrome and ankylosing spondylitis/DISH as accepted, work-related medical condones. The weight of medical evidence of record was afforded to the opinion of the referee physician, Dr. who opined that these medical conditions were not causally related to the established work injury. The claim remained accepted for only the following medical conditions: degeneration of lumbar or lumbosacral intervertebral disc; displacement of cervical intervertebral disc without myelopathy.

On October 19, 2018 Dr. esponded with an addendum report in which he opined the MMI date was June 11, 2018, the date of his examination. He also opined there was upper extremity impairment based upon the cervical spinal regional grid, table 17.2 of the *AMA guides*. Using Table 1: Spinal nerve impairment, the claimant would by rated 4% upper extremity impairment, Grade C5, class 1, due to moderate sensory deficit as documented in the clinical notes reviewed post the 1988 discectomy at C3-4.

The District Office found D opinion on permanent impairment was deficient. He did not cite the results of his own examination or diagnostic testing as his basis for assigning impairment. He did not provide calculations to support the assigned 4% upper extremity

impairment and he did not specify which extremity was impaired. As a result, the District Office again wrote to Dr. to request further clarification.

On December 17, 2018, Dr. provided his second addendum report. In this report, he provided his findings upon examination and noted that his opinions were based upon the extensive medical evidence of record and the examination he performed. He opined there was 4% impairment to each upper extremity. He noted the claimant complained of bilateral hand numbness, which was consistent with carpal tunnel syndrome as diagnosed on the EMG/NCS of August 20, 2006. There also was evidence of a right C8 radiculopathv. mild and chronic. This was the sensory deficit related to the cervical injury and surgery. Dr. [provided no further explanation or calculations as to how he arrived at 4% bilateral upper extremity impairment, stating it was calculated as delineated in the October 19, 2018 addendum.

The case file record was referred to the District Medical Advisor (DMA) for review and opinion on whether the medical evidence was sufficient to establish permanent partial impairment of a scheduled member due to the accepted work injury based on proper application of the 6th Edition *AMA Guides*.

A written response was received from DMA MD dated January 17, 2019. Dr. discussed the medical reports of record, with attention to the recent reports by the referee physician, Dr. recommending 4% bilateral upper extremity impairment. The DMA opined that the reports of Dr. did not follow the FECA procedures or the method outlined in the 6th edition *AMA guides* for establishing permanent impairment. The DMA noted that 4% upper extremity impairment is not available for a moderate sensory deficit in the C5 cervical spine as opined by Dr. The DMA also noted that Dr. did not provide grade modifiers or calculation of the net adjustment in his reports. For these reasons, DMA opined that Dr. report cannot be accepted as probative and he should be contacted and offered the opportunity to submit a corrective supplemental report addressing the aforementioned concerns.

In a formal decision dated January 31, 2019, the District Office denied the claim for schedule award with a finding that the weight of medical evidence of record was insufficient to establish permanent partial impairment of a scheduled member due to the accepted work injury. It was noted that the DMA concluded that Dr. report cannot be accepted as probative. Dr. was unable to provide a viable impairment rating based upon the 6th Edition of the *AMA Guides* after being afforded two opportunities to address the deficiencies in his reports. Based on the review of the DMA, the opinion by Dr. was determined to be of no probative value in determining any permanent impairment stemming from the accepted injury. The DMA concluded that the evidence did not demonstrate a permanent, measurable, scheduled impairment.

The claimant disagreed with the decisions dated August 22, 2018 and January 31, 2019. Through her representative, she requested an appeal in the form of an Oral Hearing before the Branch of Hearings and Review. A Hearing was held on February 14, 2019. The claimant did not attend the Hearing. In her place, her authorized representative, Attorney Paul Felser,

offered argument on the record. There was no employing agency representative present to observe the proceedings.

At the Hearing, Attorney Felser argued that the opinion of the referee physician, Dr. could not be afforded the weight of medical evidence in this case. He noted that there had been a prior Hearing on the same issues, resulting in a remand of the claim after a finding that the opinion of the referee physician was of no probative value. The decision noted that the prior referee physician, Dr. failed to provide a sufficient opinion on these matters. After three tries to obtain a sufficient report from Dr. it was determined that a new referee physician must be selected to properly address these matters with a sufficient medical opinion.

A new referee was scheduled with Dr. however, he showed the same deficiencies as the prior referee, Dr. He did not respond to requests for information, did not follow instructions and did not complete his report. Dr. was given a SOAF and a memorandum dated April 18, 2018 identifying the conflict in medical opinion and outlining what was information was required for his report. He wrote an initial report that was reviewed and found insufficient. He did not address issues that were asked. He did not address them completely or appropriately. He was supposed to address the expansion of the claim for additional medical conditions, but skipped past it. He was told to use specific charts for calculation of impairment, and he did not do it. The District Office made a request for an addendum report addressing these issues. In his second report, Dr. again failed to address the issues. He was asked for a third report, an addendum, to rectify the same deficiencies as his prior report. In his third report, he again failed to use the proper charts to calculate impairment. The District Office made no attempt at further clarification with the referee physician before issuing the denial decisions. Attorney Felser argued that, after three attempts with this referee physician to get a proper report, it was time to move on to a new doctor.

Attorney Felser argued that the revised SOAF dated April 18, 2018 was still deficient when compared to the list of required revisions in the prior remand and the requirements for a SOAF identified in the *Procedure Manual*. The questions posed to the referee physician were in error, as it instructed him to review the SOAF dated September 4, 2012 and not the revised SOAF. The SOAF of September 4, 2012 was factually incorrect, as it did not recognize permanent work-related aggravation of lumbar degenerative disc disease that had been accepted. The revised SOAF from April 2018 correctly identified a permanent aggravation. Dr. committed error when he refused to recognize the accepted condition of permanent aggravation of lumbar disc disease was work-related, as identified in the SOAF. He violated the basis tenant of his instructions and went beyond the scope of his role. In the same memo of April 18, 2018, Dr. was given a list of nine conditions and was asked to address whether these were work-related. He failed to do this. He only addressed bilateral carpal tunnel. He did not offer good medical reasoning to support his opinions negating causal relationship.

Attorney Felser argued that the referee physician must be held to a higher standard than other physicians. In this case, he did not follow the SOAF. He did not acknowledge the accepted

conditions. He did not properly address the questions posed to him three times, and failed to provide the necessary information. The prior remand threw out a previous referee exam for the same reasons. The same standards should apply now. The findings of the referee were equivocal and deficient. In many instances, the referee stated the issue was difficult to determine, without making a firm opinion on the matter. This was an incomplete report. The referee physician did not follow the standards of the Office in assessing permanent impairment of the extremities due to spinal injury. He recognized the cervical injury was work-related, and noted in his December 10, 2018 addendum there was bilateral hand numbness diagnosed on EMG on August 20, 2008 with evidence of right C-8 radiculopathy, mild and chronic, sensory deficit related to the accepted cervical injury and surgery. On this basis, he should have given an impairment rating for the upper extremities. If additional medical evidence was needed, the District Office was obligated to obtain it, as per the prior remand order.

Attorney Felser asked that the record remain open for 30 days after the conclusion of the Hearing, to allow for the submission of any additional medical evidence or a legal argument brief. The request was granted and the record held open. Copies of the transcript were released to the claimant, her representative and the employer; and their comments were invited. As of this date, no comments on the transcript have been received. Also, no additional medical evidence was received to the record after the Hearing.

Based on my careful consideration of the evidence of record, I find that the decisions of the District Office dated August 22, 2018 and January 31, 2019 must be set aside. The opinion of the referee physician, Dr. is deficient; and therefore cannot constitute the weight of medical evidence. Additional development of the medical evidence is warranted before decisions are rendered on the issues under consideration at this time: (1) whether the claim should be expanded to include additional work-related medical conditions; and (2) whether the claimant is entitled to a schedule award.

The current occupational disease claim is accepted for exacerbation and permanent aggravation of lumbar disc disease L5-S1 and cervical herniated disc C3-4 due to heavy lifting, pushing and carrying working for the as both a and for over 23 years. Approved cervical disc surgery was performed in 1988. In 2010, the claimant underwent lumbar surgery that was not approved by the Office.

A conflict in medical opinion was declared between the claimant's physician and the second opinion physician regarding whether the claim should be expanded to include additional work-related medical conditions; and whether the claimant has permanent partial impairment due to the accepted work injury that would lend entitlement to a schedule award. To resolve the conflict in medical opinion, the District Office arranged for examination of the claimant by an impartial "referee" physician.

A prior decision by the Branch of Hearings and Review dated August 31, 2017 made a finding that both the Statement of Accepted Facts (SOAF) and the opinion of the referee physician were deficient. As the District Office had made several prior attempts to obtain clarification of the referee physician's opinion without success, the case was remanded for amendment of the

SOAF and referral to a new referee physician, to examine the claimant and provide a reasoned medical opinion sufficient to resolve the conflict in medical opinion.

These instructions were followed. The SOAF was amended to a new version dated April 18, 2018. Dr. was selected as the new referee physician. He examined the claimant and provided his narrative report dated June 11, 2018. At the request of the District Office, he provided addendum reports dated October 19, 2018 and December 10, 2018 to clarify his medical opinion on the issue of permanent impairment. The case was also referred to the DMA for assessment the evidence, to provide an opinion on permanent impairment according to the *AMA Guides*. The DMA provided a narrative report dated January 17, 2019.

In a formal decision dated August 22, 2018, the District Office denied the claimant's request to expand the claim to include additional medical conditions with a formal finding that the weight of medical evidence should be afforded to the opinion of the referee physician, Dr. who negated a causal relationship between the employment injury and the additional diagnosed conditions of bilateral carpal tunnel syndrome and ankylosing spondylitis/DISH.[1]

In a formal decision dated January 31, 2019, the District Office denied the claim for schedule award with a finding that the weight of medical opinion should be afforded to the DMA, who opined there was no ratable impairment based on review of the medical evidence of file. The District Office further found the opinion of the referee physician, Dr. was of no probative value with respect to this issue. After being given two opportunities to address deficiencies in his reports, he had failed to provide a viable impairment rating based on the 6th Edition *AMA Guides*.

On appeal, the claimant's attorney argued that the opinion of the referee physician, Dr. , could not be accepted as the weight of medical evidence due to errors on the part of the District Office and due to deficiencies in his medical opinion.

Attorney Felser noted the April 18, 2018 questions posed to the referee physician by the District Office were in error, as they instructed him to review the SOAF dated September 4, 2012 and not the revised SOAF of April 18, 2018. He argued that Dr. committed error when he refused to recognize the accepted condition of permanent aggravation of lumbar disc disease was work-related, as identified in the current SOAF. He argued that, in the same memo of April 18, 2018, Dr. was given a list of nine conditions and was asked to address whether these were work-related, but he failed to do this. He only addressed the diagnosis of bilateral carpal tunnel. Attorney Felser argued that Dr. did not offer good medical reasoning to support his opinions. He did not follow the SOAF. He did not acknowledge the accepted conditions. His opinions were equivocal and incomplete. He recognized the work-related cervical injury with bilateral hand numbness diagnosed on EMG on August 20, 2008 with evidence of right C-8 radiculopathy, mild and chronic, sensory deficit related to the accepted cervical injury and surgery; but he did not follow the standards of the Office in assessing permanent impairment of the extremities due to spinal injury. Three times, he did not properly address the questions posed to him by the District Office and failed to

[1] diffuse idiopathic skeletal hyperostosis.

provide the requested information. On this basis, a new referee physician should be selected to perform an examination and provide a proper opinion on these issues.

Upon assessment of the reports of record by the referee physician Dr. I find that the claimant's attorney has made compelling arguments. The opinions expressed by Dr. are flawed in that they are insufficiently reasoned and not based on a complete and accurate factual background according to the SOAF. These opinions are therefore of lessened probative value, and are insufficient to represent the weight of medical evidence.

The weight of medical evidence is determined by its reliability, its probative value, and its convincing quality. The opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion are factors which enter into this evaluation.[2]

If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser or consultant, OWCP shall appoint a third physician to make an examination (see §10.502). This is called a referee or impartial examination. OWCP will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[3] Where opposing medical reports of virtually equal weight and rationale exist, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, is sufficiently rationalized and based upon a proper factual background, must be given special weight.[4]

The Office provides a physician with a SOAF to assure that the medical specialist's report is based upon a proper factual background.[5] The SOAF must include the date of injury, claimant's age, the job held on the date of injury, the employer, the mechanism of injury and the claimed or accepted conditions.[6] Office procedures further indicate that, when an Office medical adviser, second opinion specialist or referee physician "renders a medical opinion based on a SOAF which is incomplete or inaccurate or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether."[7]

When the report of the impartial medical specialist was not based upon a proper factual background of the case due to several deficiencies in the Statement of Accepted Facts as prepared by the Office, the Board found the report of the impartial medical specialist could not constitute the weight of medical opinion. The Board remanded the case to the Office to

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[2] 44 ECAB 560 (1993.)

[3] 20 C.F.R. § 10.321, *What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?*

[4] 44 ECAB 343 (1992.); 44 ECAB 840 (1992.)

[5] 46 ECAB 1044 (1995).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.12 (June 1995); *see also* 55 ECAB ___ (Docket No. 03-868, issued November 10, 2003).

[7] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

prepare a revised statement of accepted facts and to refer appellant to another appropriate specialist for examination[8].

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 of 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. However, 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, of 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[9].

Attorney Felser is correct to assert that Dr. was instructed by the District Office to review the Statement of Accepted Facts dated September 4, 2012. That version of the SOAF was found deficient and the District Office was instructed to amend it in the prior remand decision dated August 31, 2017. This was clear error on the part of the District Office, which casts doubt on whether Dr. based his opinion on the accepted factual background for the claim according to the amended SOAF of April 18, 2018. Further doubt is cast, as nowhere in his reports did Dr. document his review of the Statement of Accepted Facts. Nowhere in his report did he acknowledge the accepted, work-related conditions according to the SOAF. Nowhere in his report did he provide any description or discussion of the claimant's work duties performed as a during her career for

From his reports, it is unclear whether Dr. was aware of the accepted conditions and unclear whether he was aware of the nature of the specific repetitive work duties performed by the claimant that form the basis for the accepted claim. These reports do not establish that his opinions are based upon a completed and accurate factual background of the claim. As the referee physician has not discussed the claimant's specific work duties or described their impact of the claimed conditions, I find that his opinion is not sufficiently well-reasoned.

Lastly, the memorandum from the District Office dated April 18, 2018 instructs I to provide his opinion as to whether any of the following medical conditions are causally related to the accepted work injury:

1. 716.11 Bilateral Traumatic Arthritis of the Shoulders.
2. 726.32 Bilateral Lateral Epicondylitis of the Elbows.
3. 726.31 Bilateral Medial Epicondylitis of the Elbows.
4. 354.2 Bilateral Cubital Tunnel Syndrome with Ulnar Nerve impingement at the Elbows.
5. 354.3 Bilateral Radial Tunnel Syndrome.
6. 727.05 Bilateral Tendonitis of the Hands and Wrists.
7. 354.0 Bilateral Carpal Tunnel Syndrome with Median Nerve impingement at the Wrists.
8. 716.15 Bilateral Traumatic Arthritis of the Hips.
9. 716.16 Bilateral Traumatic Arthritis of the Knees.

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8 41 ECAB __ (Docket No. 89-1886 issued May 2, 1990.)

9 45 ECAB __ Docket No. 93-1840, issued January 31, 1994.)

As noted above, Dr. provided no discussion of the claimant's specific federal work duties in his reports of record nor did he acknowledge the accepted conditions according to the SOAF. He did not provide a reasoned medical opinion specifically addressing whether the claimant's federal work duties as a or caused or contributed to the claimed conditions, as identified in the SOAF and the April 18, 2018 memorandum of the District Office. He offered no opinion explaining whether the accepted conditions caused or contributed to any of the additional claimed medical conditions. The medical opinion provided by Dr. addressing this issue is incomplete, insufficiently reasoned and not based on a complete and accurate history of injury. It is therefore of diminished probative value, and insufficient to resolve the conflict in medical opinion.

On this basis, the decision of the District Office dated August 22, 2018, denying the request to expand the claim to include additional work-related conditions, must be set aside. Additional development of the medical evidence is warranted before a decision on the issue can be rendered.

Regarding the issue of permanent impairment and schedule award entitlement, the District Office correctly found that the opinion of Dr. was insufficient.

FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[10] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. No schedule award is payable for a member, function or organ of the body not specified in FECA or in the regulations.[11] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[12] no claimant is entitled to such an award.[13] Amendments to FECA, however, modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[14]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[15] For peripheral nerve impairments to the upper or lower extremities resulting from spinal injuries, OWCP's procedures provide that *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition

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[10] , Docket No. 10-274 (issued September 3, 2010); 27 ECAB 77 (1975).

[11] 27 ECAB 579 (1976).

[12] FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

[13] 34 ECAB 189 (1982).

[14] 37 ECAB 398 (1986).

[15] FECA Transmittal No. 10-04 (issued January 9, 2010).

(July/August 2009) is to be applied as provided in section 3.700 of its procedures.[16] Specifically, OWCP will address lower extremity impairments originating in the spine through Table 16-11[17] and upper extremity impairment originating in the spine through Table 15-14.[18] In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnosis (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).[19]

In the District Office memorandum of April 18, 2018, Dr. was advised of these provisions and asked to provide a permanent impairment evaluation based upon *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) to be applied as provided in section 3.700 of its procedures.

At first, Dr. gave his opinion based upon whole person impairment, which is not acceptable under the FECA. He provided an impairment rating reflecting 4% permanent impairment of the upper extremities without sufficient explanation as to how he arrived at these figures based on the applicable criteria. The DMA correctly acknowledged this deficiency in a report dated January 17, 2019 and recommended that Dr. be afforded the opportunity to provide an amended report.

Rather than pursue additional medical development of the issue of permanent impairment as recommended by the DMA, the District Office denied the claim for schedule award in a decision dated January 31, 2019 with a finding that the opinion of Dr. was of no probative value with regard to the issue and he had been unable to provide a suitable opinion after two requests for clarification. This was a correct finding. The schedule award was denied based on a finding that the DMA was the weight of medical evidence and found no ratable impairment related to the accepted injury. This was not a correct finding. The DMA did not offer an opinion of that nature. The DMA correctly opined that further development of the medical evidence was necessary to determine the degree of impairment.

An Office medical adviser may review a report to verify the correct application of the *AMA Guides* and confirm the percentage of permanent impairment,[20] but it is the impartial medical specialist who must resolve a conflict in medical opinion.[21] It is well established that when a referee examination is arranged to resolve a conflict in medical opinion, the medical adviser is not to attempt clarification or expansion of the impartial medical specialist's opinion.[22]

In this case, it was improper to deny the claim for schedule award when the opinion of the referee was insufficient to resolve the conflict in medical opinion regarding permanent impairment; and additional development of the medical evidence was warranted to obtain a proper opinion on this issue. Once the Office starts to procure medical opinion, it must do a

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1, 4 (January 2010).
[17] A.M.A., *Guides*, 533, Table 16-11.
[18] *Id.* at 425, Table 15-14.
[19] *Id.* at 521, Table 15-14. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).
[20] *I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).
[21] See 56 ECAB 341 (2005);
[22] *I.H.*, 60 ECAB ___ (Docket No. 08-1352, issued December 24, 2008).

complete job.[23] The Office has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case.[24]

On this basis, the decisions of the District Office dated August 22, 2018 and January 31, 2019 must be set aside. The opinion of the referee physician was deficient, and therefore of lessened probative value. It was insufficient to carry the weight of medical evidence or properly resolve the outstanding conflicts in medical opinion. The Office is obligated to obtain a referee opinion sufficient to resolve the conflict. As the referee physician Dr. has been unable or unwilling to offer a sufficient medical opinion after two attempts by the District Office to clarify his opinions, referral of the claimant to a new referee physician is warranted.

Upon return of the case file record to the District Office, the claimant should be referred to a new referee physician in the appropriate medical specialty, who is familiar with the application of the 6th Edition *AMA Guides to the Evaluation of Permanent Impairment*. The District Office should be sure to refer the referee physician to review the current Statement of Accepted Facts dated April 18, 2018. The referee physician should discuss the claimant's federal work duties and acknowledge the accepted work-related conditions, according to the SOAF. The referee physician should discuss the relevant medical records and provide his or her own current examination findings.

The referee physician should explain whether any of the following additional diagnoses are established:

716.11 Bilateral Traumatic Arthritis of the Shoulders.
726.32 Bilateral Lateral Epicondylitis of the Elbows.
726.31 Bilateral Medial Epicondylitis of the Elbows.
354.2 Bilateral Cubital Tunnel Syndrome with Ulnar Nerve impingement at the Elbows.
354.3 Bilateral Radial Tunnel Syndrome.
727.05 Bilateral Tendonitis of the Hands and Wrists.
354.0 Bilateral Carpal Tunnel Syndrome with Median Nerve impingement at the Wrists.
716.15 Bilateral Traumatic Arthritis of the Hips.
716.16 Bilateral Traumatic Arthritis of the Knees.

For the established diagnoses, the referee physician should explain whether the claimant's federal work duties as identified in the SOAF caused or contributed to this condition. The referee physician should explain whether the accepted work-related conditions or surgery identified by the SOAF caused or contributed to any of these medical conditions.

The referee physician should be reminded that, under the FECA, there is no apportionment. It is not necessary for the employment injury, by itself, to have caused the condition, in order for it to be compensable. It needs only to have contributed to it. Where a person has a preexisting condition which is not disabling but which becomes disabling because of aggravation causally related to the employment, then regardless of the degree of such

[23] 8 ECAB 769 (1956).

[24] 34 ECAB 1421, 1426 (1983); 32 ECAB 863, 866 (1981) (noting that the report of the Office referral physician did not resolve the issue in the case).

aggravation, the resulting disability is compensable. It is not necessary to prove a significant contribution of factors of employment to a condition for the purpose of establishing causal relation. If the medical evidence reveals that an employment factor contributes in any way to the employee's condition, such condition would be considered employment related for purposes of compensation under the Act.[25]

If the referee physician finds that work duties or the accepted work injury in any way aggravated an underlying condition, the rationalized medical opinion must include a discussion of the nature of the underlying conditions; their natural or traditional course; how the underlying conditions may have been affected by appellant's employment as determined by medical records covering the period of employment; whether such affects, if any, caused material changes in the underlying conditions; or, if no material changes occurred, would the symptoms or changes indicative of a temporary aggravation have subsided or resolved immediately upon appellant's removal from the employment environment and, if not, at what point would such symptoms or changes have resolved; and whether any aggravation of appellant's underlying conditions caused by factors of his or her employment caused disability during or subsequent to appellant's employment.[26]

The referee physician should provide an impairment rating based on the accepted work-related conditions identified in the SOAF according to the 6th Edition *AMA Guides*. As these are spinal injuries, referee physician should be advised that whole person or spinal impairment is not acceptable under the FECA. If nerve injuries caused impairment to the extremities, impairment should be calculated based upon *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment using the sixth edition (July/August 2009) to be applied as provided in section 3.700 of its procedures.

The referee physician should be reminded that, according to the FECA *Procedure Manual*, Chapter 2-808.5(d), rated impairment should reflect the total loss as evaluated for the scheduled member (i.e. arm, leg, etc.) at the time of the rating examination. There are no provisions for apportionment under the FECA.[27] As such, schedule awards include permanent impairment resulting from conditions accepted by OWCP as job-related as well as and any non-industrial permanent impairment present in the same scheduled member at the time of the rating examination.

FECA Bulletin 17-06 makes note of one of the fundamental principles of the *AMA Guides:* if there is more than one method to rate a particular impairment or condition, the method producing the higher rating must be used."[28] The referee physician should therefore explain whether impairment of the upper extremities can be assessed according to the 6th Edition *AMA Guides* alternative ROM (range of motion) method in addition to the DBI (diagnosis based impairment) method. If so, the referee physician should provide impairment ratings based on ROM and DBI. If ROM is used to assess impairment, the physician should be reminded that

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[25] 41 ECAB ___ (Docket No. 89-0438 issued October 30, 1989).
[26] 39 ECAB ___ (1988).
[27] See 35 ECAB 247, 253 (1983).
[28] Chapter 2, page 20.

the *AMA Guides* require three independent measurements and the greatest ROM should be used for the determination of impairment.

The referee physician should explain how the 6th Edition *AMA Guides* were utilized to determine the provided permanent impairment ratings, citing tables and pages used, with sufficiently detailed calculations explaining how the impairment ratings were determined. The referee physician should explain how adjustment modifiers for functional history, clinical studies and/or physical examination were utilized to determine the final impairment rating, with reference to supportive medical findings, if applicable. The referee physician should address whether the claimant has reached a state of maximum medical improvement (MMI) and if so explain when this occurred, citing any supportive medical evidence.

If the referee physician finds that additional medical testing is needed to render an opinion on causal relationship, MMI or permanent impairment, this should be authorized by the District Office and arranged for by the referee physician. If the referee physician finds that any other additional information is necessary to render a proper opinion on causal relationship, MMI or permanent impairment, the District Office should undertake appropriate steps to obtain such evidence and provide it.

The referee physician should offer medical reasoning and cite any relevant medical findings to support his or her medical opinions. Once the new referee report is obtained, the District Office should undertake any additional development of the medical evidence such as it finds warranted, and issue a *de novo* decision on the following issues: (1) whether the claim should be expanded to include additional work-related medical conditions; (2) whether the claimant has reached maximum medical improvement, and if so, on what date this occurred; and (3) the claimant's schedule award entitlement, if any.

On this basis, the decisions of the District Office dated August 22, 2018 and January 31, 2019 are hereby set aside, and the case is remanded to the District Office for actions consistent with this decision.

Issued:
Washington, D.C.

Electronically Signed

Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs

Washington DC, May 01, 2019