File Number:
HR11-D-H

RECEIVED OCT 0 1 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 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,

Division of Federal Employees' Compensation

PAUL FELSER, ESQ
FELSER LAW FIRM, PC
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, September 27, 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 the ; Case number

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

The issue for determination is whether the Office properly adjudicated Mr. for a schedule award, by decision dated .

born is employed as an with the He filed Form CA-1 for a Traumatic Injury which occurred on . On that date, he was pulling foam from "AC 284 in the 2 dry bay." He heard "stuff pop" and he experienced pain in the right upper extremity. The claim is approved for lesion of ulnar nerve (right), right rotator cuff sprain, right bicipital tenosynovitis, complete right rotator cuff tear, and lesion of right ulnar nerve. Appropriate medical and wage loss benefits have been paid.

On he claimant underwent right elbow lateral epicondylectomy with debridement of the ECRB and repair, right shoulder arthroscopic acromioplasty, right shoulder arthroscopic biceps tenotomy, and right shoulder arthroscopic extensive debridement.

On the claimant underwent right radial nerve neuroplasty.

On the claimant underwent neuroplasty of the right radial sensory nerve in the forearm.

On he underwent repair of extensor muscles in the right forearm, and anconeus neurovascular island pedicle muscle flap.

On the Office received Form CA-7 which had been filed for a scheduled award. In support of this, the claimant submitted a rating report from M.D. Referencing the *Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment (the Guides),* he assigned 17% impairment of the right upper extremity. This was based upon 5% for right radial nerve compression, 5% for right lateral epicondylitis and 7% for the right shoulder. The Office forwarded the case to the District Medical Advisor (DMA) for review. A response dated was received from M.D. He assigned 5% impairment of the right upper extremity based upon the diagnosis of right lateral epicondylitis. However, he stated that additional information was required in order to properly evaluate impairment of the right upper extremity.

The Office subsequently received a rating report from PT. This was reviewed and concurred upon by . M.D. Referencing the Sixth Edition of the Guides, he

Washington DC, September 27, 2019

assigned 2% impairment of the right upper extremity relative to radial nerve entrapment and 5% secondary to lateral epicondylitis.

On the claimant was awarded 5% impairment of the right upper extremity. The date of maximum medical improvement was reflected as

The claimant disagreed with this decision and appealed to the Branch of Hearings and Review. On appeal, the Office received three separate rating reports dated These were from Mr. and they were co-signed by M.D. In the first report, impairment of the shoulder was assessed using the range of motion method. Measurements were provided for both shoulders. Total impairment was calculated to be 19%. In the second report, impairment was assessed relative to the elbow and 5% impairment was assigned for a diagnosis of right lateral epicondylitis. In the third report, 2% impairment was assigned for right radial nerve entrapment syndrome. Range of motion measurements were provided relative to the shoulder, and impairment was calculated to be 19% of the right upper extremity.

By decision dated the case was remanded for further development. The Hearing Representative noted that the DMA had requested additional medical evidence to support a range of motion rating for the claimant's right shoulder. However, the Office proceeded in issuing a 5% award that had been calculated, using the diagnosis based rating method for epicondylitis. It was noted that new evidence had been received in to the case file therefore the Office was instructed on remand to send the case back to the DMA for review.

Upon return of the case file the Office wrote to the DMA for a supplemental opinion. A response dated was received from Dr. Using the diagnosis based rating method, he assigned 7% impairment of the right upper extremity secondary to a full thickness tear, rotator cuff injury. He assigned an additional 6% impairment based upon right lateral epicondylectomy. This resulted in combined impairment of 13% of the right upper extremity. Dr. also addressed impairment using the range of motion method. For the shoulder, he assigned 18% impairment. He noted that this was greater than the DBI rating, although he indicated that the rating was incomplete. He addressed the discrepancies between his rating and that of Dr. . First, he took issue with the assignment of Grade Modifiers. He stated, "In my opinion, functional history grade modifier is not determined on the basis of physical findings, and the QuickDASH score should be considered unreliable as it is 2 or more grades greater than what would otherwise be assigned for functional history." The DMA also pointed out that Dr. had failed to assign DBI impairment for the lateral epicondylectomy and right radial nerve. Lastly, Dr. stated that Dr. had failed to include a neurologic examination to evaluate impairment of the right radial nerve. As such, the impairment evaluation was said to be incomplete. In conclusion, the DMA suggested that Dr. be asked to provide physical exam findings relative to palpatory and range of motion evaluation of the right elbow as well as neurologic exam findings of the right upper extremity. He specifically stated that absent this information, he can not determine whether the ROM rating is greater than the DBI rating.

In accordance with the above, the Office wrote to Dr. on and requested the additional information cited by the DMA. No response was forthcoming. Therefore, the claimant was referred for a second opinion examination which took place on with board certified specialist M.D. Using the range of motion method, he assigned 25% impairment. This was based upon 6% impairment secondary to maximum abduction of 60 degrees, 0% for 60 degrees on extension, 6% for 65 degrees on flexion, 1% for 15 degrees on abduction, 2% for 70 degrees on internal rotation, and 2% for 45 degrees on external rotation. Using the combined values chart, impairment totaled 19% of the right shoulder. For the right elbow, Dr. assigned 8%. Upon combining shoulder and elbow impairment, Mr. was said to have 25% right upper extremity impairment.

Using the diagnosis based method, Dr. assigned impairment for a right rotator cuff tear with some residual loss. A Grade Modifier of 2 was assigned for Functional History, Physical Exam and Clinical Studies. Following application of the net adjustment formula, impairment totaled 7% of the right upper extremity relative to the shoulder. Impairment was also assessed as the claimant was status post-surgical release of the extensor tendon. This was considered Class 1 impairment. A Grade Modifier was not applicable for Functional History. However, a Modifier of 1 was assigned for Physical Exam and a Modifier of 2 was assigned for Clinical Studies. Following application of the net adjustment formula, impairment totaled 6%. For peripheral nerve impairment, there was moderate sensory deficit of the radial nerve sparing the triceps. A Grade Modifier of 1 was assigned for physical Exam and a Modifier of 1 was assigned for Clinical Studies. A Grade Modifier for Functional History was not applicable. This resulted in 4% upper extremity impairment. Using the combined value chart, the claimant had 16% impairment using the DBI method. Using the range of motion scores for the shoulder and elbow the claimant was said to have 25% upper extremity impairment. Dr. recommended 25% impairment using the ROM method as this was higher than the DBI rating.

The report of Dr. was forwarded to the DMA for review. A response dated was received from M.D. He assigned 13% impairment of the right upper extremity using the diagnosis based method for a full thickness rotator cuff tear and right lateral epicondylectomy. For the rotator cuff tear, he assigned a default value of 5%. However, he assigned Grade Modifiers of 2 for Functional History and Physical Exam and 3 for Clinical Studies. Following application of the net adjustment formula, impairment increased to 7%. For right lateral epicondylectomy, he assigned 6% impairment. This was calculated using a Grade Modifier of 1 for Physical Exam and 2 for Clinical Studies. A Modifier was not assigned for Functional History. With regard to the right radial nerve, the DMA stated that there was insufficient medical documentation in Dr. report to accurately assess this. In particular, he noted that there was no description of monofilament or 2 point discrimination testing which is required to assign the degree of sensory deficit of the nerve. Therefore, Dr. explained that a rating relative to the right radial nerve could not be provided. However, he combined 7% impairment of the shoulder with 6% to the elbow for a total of 13%.

Dr. also assessed impairment using the range of motion method. Based upon the measurements outlined for the shoulder, he calculated 20% impairment. This was based upon 9% for flexion of 70 degrees, 0% for extension of 60 degrees, 6% for abduction of 60 degrees, 1% for adduction of 10 degrees, 2% for external rotation of 50 degrees and 2% for internal rotation of 70 degrees. The DMA also stated that right elbow flexion was 80 degrees which correlated with 8% impairment. He noted that no other motion measurements were provided. Therefore, he stated that combining 20% with 8% resulted in 26% impairment of the right upper extremity using the ROM method.

The DMA addressed the discrepancies between his rating and the rating of Dr. He noted that Dr. had assigned a Grade Modifier of 2 for Clinical Studies for the rotator cuff however he had assigned a Modifier of 3. Additionally, he re-iterated that there were insufficient objective physical findings to accurately assign impairment for the radial nerve injury. He maintained that monofilament and 2 point discrimination testing was required. Additionally, he further explained,

> "Dr. summed the impairments by ROM and recorded a sum of 19%. By my addition, his impairment for ROM of the right shoulder sum to 17%. He assigned 6% impairment for flexion of the right shoulder. My reading of Table 15-34 provides an impairment of 9% for that motion. I thereby arrive at a sum of 20% for ROM of the right shoulder."

Dr. assigned an MMI date of .

On the Office issued a schedule award for 26% total impairment of the right upper extremity, less 5% previously paid. The MMI date was reflected as The weight of medical evidence was afforded to the District Medical Advisor who properly applied the Guides to the examination findings.

The claimant disagreed with this decision and appealed to the Branch of Hearings and Review. By decision dated the case was remanded for further development. It was noted that DMA Dr. had stated that he could not provide a rating relative to the right radial nerve because Dr. had not supplied the necessary information from a sensory examination to grade the degree of sensory deficit. Additionally, the DMA had erroneously stated that Dr. had failed to provide ROM measurements for all elbow motions. Specifically, in the addendum of Dr. did provide three measurements for flexion, extension, pronation and supination. However, this had not been considered by the DMA. Therefore, on remand, the Office was instructed to request an addendum report from Dr. He was to provide exam findings of monofilament and 2 point discrimination testing to adequately evaluate the claimant's right radial nerve injury. It was noted that if the appropriate sensory testing had not been performed, the claimant was to be referred for a re-evaluation. Upon receipt of a supplemental report, the case was to be referred back to the DMA for review.

Upon return of the case file, the Office wrote to Dr. for a supplemental opinion. The claimant was seen for a re-evaluation and a supplemental report dated was received. He assigned 27% impairment of the right upper extremity using the range of motion method. He stated that exam of the right radial nerve revealed normal motor function however there was decreased light touch to filament, decreased 2 point discrimination and no sharp dull discrimination in the right superficial radial nerve distribution. For radial nerve impairment he assigned 3%, per Table 15-18 on page 429 of the Guides. Using the combined values chart, he stated "...3% right upper extremity impairment combined with the previous 25% right upper extremity impairment yields a final right upper extremity impairment of 27%.

The supplemental report of Dr. was forwarded to the DMA for review. A response dated was received from Dr. Based upon the rating supplied for the radial nerve, he was able to fully assess diagnosis based impairment for a total of 16% of the right upper extremity. This was based upon the previously assigned 7% for the rotator cuff tear and 6% for the epicondylectomy. These were combined with 3% for the radial nerve injury. Dr. again addressed the range of motion method but maintained that this was 26% of the right upper extremity. This was based upon 20% relative to the shoulder and 8% relative to the elbow. He stated that aside from flexion, no other motion measurements were provided. Since the ROM method yielded a higher rating, he stated that the final impairment should be 26% of the right upper extremity.

Dr. stated that he had been supplied with an impairment evaluation from Dr. within which he assigned 28% impairment using the ROM method. However, this is inaccurate. In Dr. original report he assigned 25% right upper extremity impairment and in his addendum of he assigned 27% impairment.

The DMA proceeded to address the difference between his rating and the rating of Dr. and stated,

> "1. Dr. combined the determination of nerve deficit with impairment for ROM. ROM impairment is identified by the Guides as a stand alone impairment, not combined with other impairments. The 'example' in the Guides on page 479 demonstrates the combination of impairment by the DBI method with that for neurologic deficit (in this case carpal tunnel syndrome). 2. Dr. did not comment in his most recent addendum concerning discrepancies between his prior report and mine in which I assigned a 26% DBI rating for range of motion of the right shoulder and right elbow, and his assignment of 28% impairment for ROM of the RUE."

The Office issued a decision on within which they reflected an award for 28% impairment of the right upper extremity, less 5% previously paid. This will be discussed further in this decision.

The claimant disagreed with the decision of the District Office and an oral hearing was requested. Based upon the written evidence of record, I find that the decision of the District Office should be *SET ASIDE* and the claim *REMANDED* for further development.

5 U.S.C. § 8107 provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[1] The Employees' Compensation Appeals Board has held that, for consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The Board has concluded with the Office's decision to adopt the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA Guides) for determining the extent of permanent impairments.[2]

Federal Employees' Compensation Act (FECA) Bulletin 17-06 was released addressing diagnosis based impairment ratings versus range of motion ratings as it relates to upper extremity impairment. Specifically, Chapter 2, page 20, of the AMA *Guides* states that one of the fundamental principles is if the AMA *Guides* provide more than one method to rate a particular impairment or condition, the method producing the higher rating must be used. The Bulletin noted that unfortunately, the complexities of the explanations and the language throughout Chapter 15 has sometimes led physicians who have evaluated claimants to provide inconsistent interpretations for calculating upper extremity impairments. The Employees' Compensation Appeals Board (ECAB) held that in light of the conflicting language in the Sixth Edition of the *Guides* it is incumbent upon OWCP through its implementing regulations and/or internal procedures to establish a consistent method for rating upper extremity impairment. Impairment ratings should be based upon the most recent version of the Sixth Edition *Guides*. Currently, the reprinted 2009 AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition is the most recent version. As such, this version should be consistently utilized by the DFEC (Department of Federal Employees' Compensation). Impairment ratings should be based upon the most recent version of the Sixth Edition *Guides*. Currently, the reprinted 2009 AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition is the most recent version. As such, this version should be consistently utilized by the DFEC (Department of Federal Employees' Compensation). The DMA should identify (1) the methodology used by the rating physician (i.e. DBI (diagnosis-based impairment) or ROM (range of motion) and (2) whether the applicable tables in Chapter 15 of the *Guides* identify a diagnosis that can alternatively be rated by ROM. If the *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.[3]

Additionally, the Guides caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE should provide this information (via the updated instructions noted above) to the rating physician(s).

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[1] 5 U.S.C. § 8107. This section enumerates specific members or functions of the body for which a schedule award is payable and the maximum number of weeks of compensation to be paid; additional members of the body are found at 20 C.F.R. § 10.404(a).

[2] *James E. Archie*, 43 ECAB 180 (1991).

[3] See also *Jeffrey J. Stickney*, 51 ECAB 616 (2000).

The issue on appeal is whether the Office properly adjudicated Mr. schedule award claim in their decision dated

On review, I find that the decision of the District Office must be set aside. As outlined above, the Office had issued a schedule award on for 5% impairment of the right upper extremity. This was appealed to the Branch of Hearings and Review however the case was remanded for further medical development, by decision dated The basis for this decision has been outlined above. On remand, the claimant was ultimately seen for a second opinion examination which took place on with Dr. Using the diagnosis based method, he assigned 16% impairment however the ROM method yielded 25% impairment. The DMA reviewed this report although he found the claimant to have 13% impairment using the DBI method and 26% using the ROM method. The Office afforded the weight of medical evidence to the DMA who properly applied the Guides to the examination findings and in a decision of June 27, 2018 they issued an award for 26% impairment of the right upper extremity less 5% previously paid. Therefore, the claimant received an increased award of 21%. Mr. disagreed with this decision and appealed to the Branch of Hearings and Review. By decision dated the case was remanded for further development. The basis for this decision was the fact that DMA Dr. specifically indicated that Dr. had not supplied the necessary information to properly assess impairment relative to a radial nerve injury. Additionally, the DMA had only rated the claimant's elbow using a ROM measurement for flexion however the file contained a addendum from Dr. which outlined all necessary measurements relative to the elbow. Therefore, this was to be considered. Upon return of the case file, a supplemental report was received from Dr. within which he assigned 27% impairment of the right upper extremity. This report was reviewed by the DMA at which time he continued to assign 26% impairment using the ROM method and 16% using DBI.

The Office proceeded to issue a somewhat confusing decision on within which they stated that the total right upper extremity award was for 28% less 5% previously paid. First and foremost, this is erroneous as the claimant had previously received right upper extremity awards totaling 26%. Specifically, he received an award for 5% on and award for an additional 21% on Therefore, if impairment was truly determined to be 28%, then the Office should have indicated that this was less *26% previously paid* and an award for the difference (2%) should have been issued. However, I find that further development must be initiated as it is unclear whether the rating reflected in the Office's decision was appropriate.

In the decision the Office stated that the *DMA* had been afforded the weight of medical evidence however the information contained within the actual decision is inconsistent with the information supplied by Dr. . Specifically, in the DMA's most recent report of he continued to assign 26% impairment using the ROM method. Yet the Office reflected a 28% rating in their decision. In Dr. most recent report he indicated that Dr. had assigned 28% impairment in his report using the ROM method. However, this is not entirely accurate. He had actually assigned 25% impairment in the report. Then, in an addendum of the rating was changed to 28%. However, in Dr. most recent addendum of he assigned 27% right upper extremity impairment. Given this, clarification is required.

In addition to the above, I find that deficiencies remain as it relates to the ROM rating offered in Dr. report. In the prior remand decision of the Hearing Representative pointed to the fact that the DMA had only assessed ROM impairment relative to the elbow using measurements for flexion. However, the file contained an addendum from Dr. dated within which he also provided measurements for extension. pronation and supination. Therefore, this was to be reviewed by the DMA. However, in Dr. report he continued to state that the only measurement provided relative to the elbow was 80 degrees for flexion. Therefore, there is no indication

that he reviewed the measurements outlined in the addendum of Dr. This must be addressed and impairment assessed using the ROM measurements provided by the second opinion examiner.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.[4] 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.[5]

Upon return of the case file, the District Office is instructed to update the Statement of Accepted Facts and request a supplemental opinion from the District Medical Advisor. Frist and foremost, he must be directed to the ROM measurements outlined in Dr. addendum as it relates to the elbow. Based upon this, the DMA must reassess impairment using the reprinted version of the Sixth Edition of the AMA Guides. Per FECA Bulletin 17-06, impairment should be assessed, if applicable, using both the DBI and ROM rating methods. In prior reports of and the DMA indicated that only measurements for flexion were provided. However, the addendum contains measurements relative to extension, pronation and supination. Therefore, this must be considered and it is important to note that this had been directed by the prior hearing representative as well in the decision of . Additionally, in the DMA's report of he indicated that Dr. had provided a ROM rating of 28% however this is not entirely accurate. The DMA must be supplied with copies of Dr. original report of and addendums dated and . In the report he had assigned 25% impairment. In the first addendum of , he assigned 28% however in the most recent addendum of he assigned a rating of 27%. The DMA should review all three reports and address any/all points of disagreement. The DMA must be sure to cite the applicable sections of the Guides and provide medical rationale with a discussion of the evidence that supports all opinions given. Reference should be made to assignment of Class and Grade Modifiers as well as application of the net adjustment formula. Once the proper impairment rating is established, the DMA should provide the date of maximum medical improvement along with an explanation to support its selection. Upon completion of any further development action deemed necessary the Office is instructed to issue a *de novo* decision on entitlement to a schedule award. The Office is reminded that Mr. has already received awards totaling 26% impairment of the right upper extremity. If, on remand, impairment is determined to be greater than this, the Office must be sure to deduct the amount previously paid from any future award. Conversely, if the award if found to be lower than prior awards, the Office should assess any potential overpayment.

Consistent with the above findings, the decision of the District Office dated is hereby set aside and ***remanded*** for further development. The case file is returned for further processing as noted.

ISSUED:

WASHINGTON, D.C.

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

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