File Number:
HR11-D-H

RECEIVED JUN 04 2018

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 Dallas 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 16 DAL
LONDON, KY 40742-8300

Sincerely,

Electronically Signed

Hearing Representative

PAUL H FELSER
FELSER LAW FIRM
7393 HODGSON MEMORIAL DRIVE
STE 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 31, 2018

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 claim was completed in Washington D.C. Based on this review, the decision of the district office dated is set aside for the reasons set forth below.

The issue for determination is whether the claimant sustained permanent partial impairment of the right upper extremity greater than the 7% awarded.

The claimant was employed as a with the in , when she filed a CA1 Notice of Traumatic Injury form claiming on , she tripped over a bucket and fell. The Office accepted the claim for sprain of right rotator cuff and sprain of neck. The claimant stopped work on to undergo right shoulder arthroscopy, subacromial decompression, and rotator cuff repair. She returned to modified work on It appears the Office paid compensation for temporary disability from until she accepted a job offer on . The Office later expanded the claim for disorder of bursae and tendons in right shoulder and other affections of shoulder region, right. The claimant retired as of

On the Office received an impairment report from M.D, addressing the claimant's cervical condition and calculating 9% for the cervical spine regional grid.

On , the Office received a CA7 Claim for Compensation form claiming a schedule award. A impairment report from the claimant's orthopedist, M.D., was provided addressing the right shoulder, using the diagnosis-based method (DBI) and utilizing the rotator cuff tear diagnosis, assigning Class 1. Dr. explained why he assigned a 2 for the functional history grade modifier, a 1 for physical examination grade modifier, and a 2 for the clinical studies grade modifier. Using the Net Adjustment Formula, he calculated +2, moving the grade to E, for a final 7% right upper extremity impairment.

The case was referred to the District Medical Advisor (DMA) for review as procedurally required. In a report, DMA M.D., noted he was a shoulder specialist and not a spine specialist so he would only be addressing the right shoulder pathology and not the spine. DMA Garelick stated that unfortunately Dr. rating completed on only addressed the cervical spine, so he advised to send the file to a DMA skilled in evaluating and computing PPI as it related to the spine. He also advised to obtain a right upper extremity rating for the shoulder for him to review as the Office had not provided him with Dr. report.

On , the Office referred the case back to the District Medical Advisor for review of Dr. impairment report. In a report, DMA noted Dr. physical examination findings, subjective complaints, and the QuickDASH score. He stated his opinion that Dr. accurately interpreted and applied the AMA *Guides*. DMA further advised that shoulder range of motion (ROM) was not measured more than one time, so the ROM method could not be used as FECA Bulletin No.17-6 advised that in order to qualify for a PPI rating using the ROM method, three independent measurements must be taken.

By decision dated , the Office awarded the claimant 7% permanent partial impairment of the right upper extremity based on the reports of Dr. and the District Medical Advisor. The claimant disagreed with this decision and by letter postmarked , through her attorney, requested an oral hearing.

Based on my preliminary review of the evidence of record, the case is not posture for hearing and the decision must be set aside for the reasons set forth below.

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* for determining the extent of permanent impairments.[2]

Per the new Federal Employees' Compensation Act (FECA) Bulletin 17-06, 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

[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).

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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). 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.

In the present case, the claimant was awarded 7% permanent partial impairment of the right upper extremity based on the calculations provided by the claimant's physician, Dr. using the diagnosis-based method, with a confirmation statement by the District Medical Advisor. However, DMA merely agreed with Dr. and did not independently apply the findings to the *Guides* criteria to confirm Dr. calculations. The DMA report should be thorough and detail an independent review of the impairment, as opposed to simple concurrence or non-concurrence with the impairment rating of record. The claims examiner must also ensure that the DMA properly considers all reported findings, gives rationale, and uses the AMA *Guides* correctly in computing the percentage.[3]

Further, DMA advised that the ROM method could not be used as Dr. did not report the range of motion measurements three times as required to meet the validity criteria. However, per Bulletin 17-06, the Office is instructed that if the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence necessary to complete the rating, and still render an impairment rating using the DBI method, if possible, given the available evidence. Upon receipt of such a report, and if the impairment evaluation was provided from the claimant's physician, the claims examiner should write to the claimant advising of the medical evidence necessary to complete the impairment assessment and provide 30 days for submission. Any evidence received in response should then be routed back to the DMA for a final determination. Should no evidence be received within 30 days of the date of the letter, the claims examiner should proceed with a referral for a second opinion medical evaluation to obtain the medical evidence necessary to complete the rating. After receipt of the second opinion physician's evaluation, the claims examiner should route that report to the DMA for a final determination.

[3] FECA Procedure Manual 2-0810-7

Based on my review, the Office did not issue any development letters in this case to put the claimant on notice of the evidence needed to establish impairment, or to advise her of the deficiencies found by the District Medical Advisor to give her the opportunity to provide the medical evidence (three measurements) necessary to complete the alternate rating using the ROM method. As the claimant's right shoulder condition can be rated using both methods and the Office did not follow the bulletin's action items to determine which method produced the higher rating, additional medical development is necessary.

In relation to the cervical sprain also accepted as injury-related, since the back or spine is not a body part which is provided for under the Act, there is no schedule award available for any impairment of the spine. However, consideration may be given to impairment originating in the spine which affects a member or bodily function listed under the schedule, such as the legs or arms.[4] The AMA *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology,[5] and the Office has adopted this approach for rating impairment to the upper or lower extremities caused by a spinal injury.[6] However, a schedule award can be paid only for a condition related to an employment injury.[7] Before applying the *Guides*, the Office must determine whether the claimed impairment of a scheduled member is causally related to the accepted work injury.[8]

The Office cannot ignore the impairment report submitted by Dr. providing a rating based on the claimant's cervical condition. The Office has not conducted any development to address causal relationship and whether residuals remain from the accepted cervical sprain, or to put the claimant on notice of the medical evidence needed to assess injury-related impairment for spine injuries. The Office also had DMA review Dr. report and he recommended review by another District Medical Advisor skilled in evaluating and computing PPI as it related to the spine, which was not done.

On remand, the Office should issue an appropriate development letter to the claimant advising of the medical evidence necessary to complete an impairment assessment for her right shoulder based on the ROM method, with the three measurements required to meet the validity criteria. 30 days should be given, and any response should be routed back to the District Medical Advisor to calculate impairment using both the DBI and ROM rating methods in accordance with FECA Bulletin 17-06. The Office should also conduct a full review of the medical evidence to determine if additional development is necessary to confirm residuals remain from the accepted cervical sprain, and the claimant should be put on notice of the evidence needed to assess impairment of the upper extremities as it relates to the cervical injury. The Office should then have a skilled District Medical Advisor review the medical evidence to address impairment as it relates to the cervical injury.

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[4] *See* 20 C.F.R. § 10.404(a); *Tomas Martinez*, 54 ECAB 623 (2003).
[5] Rating Spinal Nerve Extremity Impairment Using the Sixth Edition, the AMA *Guides Newsletter* (AMA *Guides* Chicago, IL), July/August 2009.
[6] FECA Procedure Manual, Part 3, Chapter 3.700 (January 2010) (Exhibit 1, 4).
[7] Permanent impairment is based on direct physiological connection between the employment injury and the part of the body for which a schedule award is claimed. *See Gregory C. Esparza*, 42 ECAB 911, 915 (1991).
[8] *Michael S. Mina*, 57 ECAB ___ (Docket No. 05-1763, issued February 7, 2006).

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If no response is received or the evidence is still found deficit for either the shoulder or cervical condition, a second opinion referral will be necessary to obtain the required medical evidence. After completion of any other development deemed necessary, a *de novo* decision should be issued addressing entitlement to a schedule award of the right upper extremity beyond the 7% awarded.

Consistent with the above, the decision is set aside and remanded for further development action as described above.

ISSUED:
WASHINGTON, D.C.

Electronically Signed

Hearing Representative
For
Director, Office of Workers' Compensation Programs

Washington DC, May 31, 2018