File Number: (
HR10-D-H

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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 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 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 H FELSER
FELSER LAW FIRM
QUEENSBOROUGH BANK BLDG
7393 HODGSON MEMORIAL DR
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, November 20, 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
A telephonic hearing was held on

The issue for determination is whether the district office properly adjudicated the claim for schedule award in their decision of

is employed as a with the in
She suffered a trip and fall on suffering injury to her right shoulder. The claim was allowed for right shoulder acromioclavicular (AC) strain. The claimant stopped all work on the date of injury, and underwent a shoulder surgery on

Orthopedic surgeon MD performed the arthroscopic procedure, including a rotator cuff repair of the supraspinatus and infraspinatus, subacromial decompression, labrum debridement, and distal clavicle resection.

The claimant resumed full time modified work on

On Dr. wrote that the patient had reached maximum medical improvement (MMI) and was entitled to a permanent partial impairment rating of 15% of the right arm.

filed a claim for schedule award on Section 8107 of the Federal Employees' Compensation Act[1] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., Guides. (the Guides)[2]

The report of the examination must always include a detailed report that includes history of clinical presentation, physical findings, functional history, clinical studies or objective tests, analysis of findings, and the appropriate impairment based on the most significant diagnosis, as well as a discussion of how the impairment rating was calculated.[3] Before applying the

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[1] 5 USC § 8107.
[2] 20 CFR § 10.404 (2002).
[3] Federal Employees' Compensation Act Procedure Manual 2-808-6(c)1.

A.M.A., Guides, the Office must determine whether the claimed impairment of a scheduled member is causally related to the accepted work injury.[4]

The district office developed the claim for schedule award by letter dated The claimant was to provide a medical report addressing whether the condition had reached MMI and offering an impairment rating consistent with the Guides. The evidence was to record the objective findings used in assigning a rating, as well as the corresponding citations from the Guides. Thirty days were afforded for a response.

No timely response was received. The claims examiner must utilize the District Medical Advisor (DMA) if the claims examiner is adjudicating a schedule award claim and requires a calculation of the percentage of impairment in order to establish the schedule award.[5]

The Office forwarded Dr. report to the DMA for consideration. The DMA responded on , reporting that insufficient information was in file to determine any impairment. Range of Motion (ROM) measurements were to be submitted, and the case returned to the DMA for review.

On the Office prepared a Statement of Accepted Facts (SOAF) specific to the instant claim, and arranged an exam with board certified orthopedic surgeon MD on The claimant failed to attend the exam. By decision dated the Office denied the claim for schedule award, finding insufficient evidence in file to support such an award.

On the claimant again requested a schedule award by form CA-7. The Office took no action, instructing the claimant to exercise her appellate rights.

A new report from Dr. was received dated . Exam findings, including ROM measures, were provided. No impairment rating was offered.

On attorney Paul Felser wrote the Office, suggesting that additional claim allowances were appropriate, based on the post-operative diagnoses indicated in the operative report. On the Office responded, noting that no physician had requested claim expansion or opined that the additional diagnoses were related to the work fall.

On attorney Felser asked that the second opinion exam be scheduled again. ON the Office again referred the claimant for a second opinion exam to determine impairment.

Board certified orthopedic surgeon . MD examined the claimant on He also reviewed the SOAF and the medical record. He summarized the medical record, and recorded his exam findings. He diagnosed a work related rotator cuff repair, "presumably work related long head biceps tendon rupture right shoulder with labral tear". and unrelated AC arthritis. He opined that MMI occurred at the date of Dr.

[4] *Michael S. Mina*, 57 ECAB (Docket No. 05-1 763, issued February 7, 2006).

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

exam. He found remaining pain in the shoulder girdle secondary to the work injury. He based impairment on the rotator cuff tear, biceps tendon tear, and labral tear, noting that the subacromial decompression and distal clavicle resection were unrelated to the accident but reasonable to be addressed during such surgery. Dr. I awarded 20% impairment of the right arm. Using Table 15-5 he assigned Class 1 impairment. After application of grade modifiers he achieved a final result of 7%, but noted that this diagnosis based impairment (DBI) method was inconsistent with the residual lost motion found on exam. He alternatively rated impairment using the range of motion (ROM) method. Using Table 15-7, he calculated 9% impairment for 90 degrees of forward flexion, 1% impairment for extension, 6% for abduction, 2% for internal rotation, and 2% for external rotation. The total award was 20%.

In an addendum dated Dr. reported a typographical error in the body of his report. He noted that the forward flexion measure should have been 80 degrees. He also confirmed that he used three measures in each plane of motion. Citing the corrected flexion figure, he again reiterated his prior total impairment of 20% of the arm.

The Office forwarded the impairment opinion to the DMA for review. In her reply of DMA MD agreed with the DBI rating of 7%. She reviewed and summarized the calculations for lost motion, noting an error in the report which awarded 9% impairment for the lost flexion, when only 3% was due. The DMA did confirm that the ROM method produced a greater award for the claimant in comparison to the DBI method.

On the Office approved a schedule award of 14% of the right arm. The claimant's attorney disagreed with the decision and requested a telephonic hearing.

A hearing was held on . The claimant was represented by attorney Paul Felser at the proceeding. Mr. Felser argued that an error was apparent in the final rating for the arm, as it did not appear that the DMA was aware of the addendum which corrected the earlier error in the forward flexion figure. He asked that the case be returned to the DMA for consideration of the addendum and recalculation of the award. Mr. Felser also argued that the Office had failed to properly address his request for claim expansion.

The record remained open for 30 days in order to afford the claimant opportunity to submit additional evidence. As required by Office procedures, a copy of the hearing transcript was forwarded to the employing agency to afford them the opportunity to comment on the claimant's testimony. No comments have been received and the time allotted to all parties for the submission of additional evidence has now passed. No new medical evidence has been received since the decision of

I find that the Office's decision of should be set aside, and the case remanded to the district office for further medical development.

In assessing medical evidence, the weight of such 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 the analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts which determine the weight to be given each individual report.[6] The Board has held that a medical opinion that is not fortified by rationale is of diminished probative value.[7]

In some instances, a DMA's opinion can constitute the weight of the medical evidence. This occurs in schedule award cases where an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the AMA Guides. In this instance a detailed opinion by the DMA which gives a percentage based on reported findings and the AMA Guides may constitute the weight of the medical evidence.[8] As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA Guides, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The Office must ensure, however, that the DMA properly considers all reported findings, gives rationale and uses the AMA Guides correctly in computing the percentage.[9]

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While appellant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[10] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[11]

The claimant underwent an authorized shoulder repair after a fall at work. The operative report identified additional pathology not previously accepted by the Office. While Dr. did not offer opinion that the additional diagnoses should be added to the claim allowances, this matter was considered by the second opinion examiner. Dr. opined that the rotator cuff tear, biceps tendon rupture and supraspinatus and infraspinatus tears were a result of the fall. Accordingly, the claim allowances should be updated to reflect these additional diagnoses.

It is also clear that the DMA did not review the addendum report of Dr. in reaching her conclusions.

Based on the above, the decision of s set aside and the case remanded to the district office for further development. Upon return of the record to the district, the Office should prepare a revised SOAF, which includes the additional claim allowances as identified by Dr. , and again refer the case to the District Medical Advisor for an additional opinion clarifying the final and most advantageous rating for the right arm. The DMA should consider whether any DBI rating method would produce a superior result for the claimant, as

[6] Connie Johns, 44 ECAB 560 (1993).
[7] Cecilia M. Corley, 56 ECAB 662 (2005).
[8] FECA Procedure Manual – Chapter 2-810; James Massenburg, 29 ECAB 850.
[9] FECA Procedure Manual – Chapter 2-810; Susie Hall, 34 ECAB 1311.
[10] Horace L. Fuller, 53 ECAB 775, 777 (2002).
[11] Richard F. Williams, 55 ECAB 343, 346 (2004).

well as consider the addendum which addressed the discrepancy identified by the DMA on last review.

Following review of the DMA opinion, and any additional development warranted, a decision consistent with the evidence of record should be issued. The decision of the district office dated is hereby set aside, and the case is **remanded** to the district office for actions consistent with the above.

Issued:

Washington, D.C.

Hearing Representative
for
Director, Office of Workers' Compensation Programs