File Number:
HR10-D-H

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,

Electronically signed

Hearing Representative

PAUL H FELSER, ESQ.
QUEENSBORO BANK BLDG
7393 HODGSON MEMORIAL DR
SUITE 102
SAVANNAH, GA 31406

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Washington DC, January 24, 2017

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 Office properly adjudicated claim for a schedule award.

born , is employed as a for the She filed Form CA-1 for a timely notice of a Traumatic Injury which occurred on On this date Ms. Newton was attacked in a parking lot behind the building where she worked. The claim is approved for concussion without loss of consciousness, unspecified hemiplegia (left), post-concussion syndrome, post-traumatic stress disorder, headache, classical migraine, and a decubitus pressure ulcer, buttock.

The claimant sought initial medical treatment at the Ocean Springs Hospital emergency department. She subsequently treated with a number of physicians including neurosurgeon M.D., physical and rehabilitation medicine specialist M.D., Clinical Psychologist , Ph.D., M.D., Psychiatrist M.D., , M.D. of Gulf State Rehabilitation Associates, neurologist M.D., , M.D., , M.D. of the SRHS Clinic, , M.D. of the Neuroscience Center for Pain Management, and , M.D.

On the Office sent a letter advising that she may be entitled to a Schedule Award. A blank CA-7 was enclosed. The Office subsequently received the CA-7 form which had been completed by the claimant on On the Office wrote to the claimant's physician Dr. advising him of the requirements necessary to establish schedule award entitlement. He was asked to supply an impairment rating using the *Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment (the Guides).*

On the Office referred for a second opinion examination to assess whether she demonstrated measurable impairment under the Sixth Edition of the Guides based upon the accepted conditions on the claim. She was seen on by , M.D. a board certified neurologist. He documented the history of her condition and performed a medical record review. Following a physical examination he opined

Washington DC, January 24, 2017

that she suffered a traumatic brain injury with neurological deficits which resulted from an attack at work. She was left with chronic left sided corticospinal tract signs and chronic cognitive difficulties. She was also diagnosed with post-traumatic stress disorder, post-concussion syndrome, low back pain[1], right hip bursitis and chronic hip pain. Dr. opined that had reached maximum medical improvement (MMI) as of . He noted that her left spastic hemiparesis had improved and was stable without change for almost three years. He stated,

> "She has chronic left-sided corticospinal tract signs i.e. left spastic hemiparesis, which is well documented and is present on my exam today. This is objective. She also has a left hemianesthesia i.e. left spinothalamic tract dysfunction, again associated with the traumatic brain injury. These neurological deficits are chronic and stable. Her complaints of left-sided weakness, numbness, stiffness, muscle spasm and contractures are consistent with left spastic hemiparesis and left hemianesthesia."

Dr. rated the claimant in terms of mental status, cognition highest integrated function. This was documented in Table 13-8 of the Guides and was rated as having Class 1 impairment which equated to 5% impairment. He noted that there was an alteration in the claimant's mental status, cognition and highest integrated function but she was still able to assume all usual roles and perform activities of daily living.

Dr. also evaluated the claimant's language difficulty, aphasia and dysphasia. Using Table 13-9 she was rated as Class 1 which equated to 2% impairment. This was based upon the fact that she had minimal disturbance in comprehension and production of language symbols for daily living.

With regard to the claimant's left spastic hemiparesis for upper extremities CNS dysfunction, Dr. stated "...I have classified this claimant as just qualifying in Class 1. She really straddles Class 1 and Class 2, but I have an impairment rating for this claimant of Class 1 describing the individual that left upper extremity is able to perform ADLs and holding but has difficulty with digital dexterity." Based upon Table 13-11 of the Guides, Dr. assigned 10% impairment. He also addressed the claimant's station and gait as it relates to the left spastic hemiparesis. This is addressed in Table 13-12 of the Guides. He assigned 10% for Class 1 impairment based upon the fact that the claimant could rise to a standing positon and walk but had difficulty with elevation, grades, stairs, deep chairs and long distances. Dr. assigned whole person impairment as 23%.

Upon receipt of the report from Dr. , the Office referred the case to the District Medical Advisor (DMA) for review. A response dated was received from , M.D. He performed a record review and addressed the impairment rating of the second opinion examiner. He stated that Dr. had assigned impairment based upon Tables 13-8, 13-9 13-11 and 13-12 of the Guides for a total schedule award of 23% for CNS impairment. However, he stated that the FECA does not provide schedule awards for CNS impairment.

[1] Part 2-0803-3 of the FECA states.., a medical condition, however minor or seemingly incongruous, must be stated. Findings of pain or discomfort alone do not satisfy the medical aspect of the fact of injury determination.

Only left upper extremity impairment could be considered. He noted that the claimant's lumbar degenerative disc disease was treated with epidural steroid shots with no motor or sensory deficit. He also explained that whole person impairment is not permitted under the FECA. Dr. noted that the claimant's neurological condition was stable. The only ratable orthopedic condition she had was right greater trochanteric bursitis due to an abnormal gait. Based upon Table 16-4 on page 512 of the Guides, he assigned 5% right lower extremity impairment. Dr. opined that the claimant had reached MMI on

The Office wrote back to Dr. on and advised that whole person impairment cannot be considered under the FECA. Therefore, he was asked to review the findings of the DMA and advise whether he concurred with the rating supplied by Dr.

An addendum report dated was received from Dr. . He stated that he agreed with the assignment of 5% permanent partial impairment of the right lower extremity. He also agreed with an MMI date of

By decision dated the Office issued a Schedule Award for 5% permanent partial impairment of the right lower extremity. This was based upon the report and addendum from Dr. . Dr. concurred with this rating.

The claimant disagreed with this decision and a hearing was requested by his legal representative, Paul Felser, Esq. A telephone hearing took place on . By decision dated the decision of the District Office was affirmed in part and remanded in part. Specifically, it was affirmed with regard to the 5% right lower extremity impairment. However, it was remanded for further development to determine whether had measureable impairment of either the left upper or left lower extremities, attributable to her left sided hemiplegia condition.

In accordance with the instruction of the Hearing Representative, the Office forwarded the case to the District Medical Advisor on A response dated was received from M.D. He reviewed the medical records as well as the reports of Dr. and Dr. However he disagreed with the opinion of Dr. as he stated that provisions are made for rating the claimant's CNS dysfunction under the Sixth Edition of the Guides. He explained,

> "The various options are possible to provide the rating would include neurologic deficit for this closed head injury and hemiparesis and hemiplegia of the left upper and left lower extremities. This was a spinal cord injury and therefore, one could not utilize the July-August Newsletter of 2009 of The AMA Guides 6th Edition for calculation because this relates to nerve root injuries and this claimant did not have nerve root injuries; the claimant had spinal cord injury and therefore cannot be rated based upon the nerve roots.
>
> In addition, she could not be rated on the basis of range of motion because number one, range of motion should only be utilized when no diagnostic-based calculations

are possible and that was not the case here since calculations are available with reasonable options and secondly, range of motion cannot be utilized because in the case of hemiplegia, the claimant does not have neurologic control to move the extremity through range of motion and because of the neurologic impairment and lack of control of the extremity, inconsistent measurements would be obtained when examined. Neurologic impairment precludes use of range of motion because it would be inconsistent and inaccurate."

Therefore, Dr. proceeded to rate using Table 13-11, *Criteria for Rating Impairments of the Upper Extremities Due to CNS Dysfunction* on page 235 of the Guides. She was rated as Class 2 for left side non-dominant where the claimant can use the involved extremity for activities of daily living, she can grasp and hold objects with difficulty but has no digital dexterity. This equated to 10% left upper extremity impairment. For the lower extremity, Dr. used Table 13-12 *Criteria for Rating Impairments Due to Station and Gait Disorders*. She was rated as Class 1 as she could rise to a standing position and walk but had difficulty with elevations, grades, stairs, deep chairs and long distances. This equated to 10% left lower extremity impairment.

Dr. also rated the claimant for chronic trochanteric bursitis with documented chronically abnormal gait. Using Table 16-4 on page 512 of the Guides, was documented as having Class 1 impairment for a default value Grade C. However, following the assignment of applicable Grade Modifiers on page 516 of the Guides, the impairment was reduced from Grade C to Grade A for a total of 5% impairment.

Conclusively, Dr opined that the claimant had 10% left upper extremity impairment, 10% left lower extremity impairment and 5% right lower extremity impairment. The date of maximum medical improvement was listed as as this was the date of Dr. examination.

By decision dated the Office issued an award for 10% impairment of the left lower extremity and 10% impairment of the left arm. The decision noted that 5% of the right lower extremity had already been paid.

The claimant disagreed with this decision and an oral hearing was requested by her attorney Mr. Felser. A telephone hearing was held on The claimant was not present however she was represented by Mr. Felser. was also present on behalf of the employing agency.

Mr. Felser pointed to the prior hearing decision of which had been issued on this case. In that determination, the case was remanded to assess whether sustained permanent partial impairment to either the left upper or left lower extremity as a result of her left-sided hemiplegia condition. He argued that this directive had not been followed and that the focus was primarily on the claimant's right sided impairment. He also took issue with the content of Dr. report in that he had assigned whole person

impairment.[2] He stated that the claimant should have the benefit of a proper second opinion exam. He also argued that the DMA did not examine the claimant and did not provide sufficient rationale to support his impairment rating. He also argued that the DMA did not review the report from the claimant's physician, Dr. However, Mr. Felser was advised that this report was not even received in to the case file until *after* it had been referred to the DMA. He argued that this was relevant information that should have been considered prior to the issuance of the schedule award decision.

Mr. Felser also argued that the accepted conditions on the claim should be expanded to include additional diagnoses. He was advised that it is the claimant's responsibility to supply medical evidence to establish expansion of the claim. For example, Mr. Felser made multiple references to a back condition including spondylosis, degenerative conditions and radiculopathy. He was asked whether there was a report from the claimant's physician which addresses causation as it relates to those conditions however he was unable to provide this information at the hearing.

However, Mr. Felser pointed to the second opinion report from board certified neurologist , M.D. which diagnosed with a claw deformity of the last two fingers of the left hand as well as the varus equinus of the left foot. It was her opinion that these conditions were work related. Mr. Felser was advised that this report would be reviewed and taken into consideration prior to the issuance of a final decision.

The record remained open for 30 days in order to afford the claimant the 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.

Based upon the hearing testimony, together with the written evidence of record, I find that the decision of should be *SET ASIDE and REMANDED.*

Section 8107 of the Federal Employees' Compensation Act[3] 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.[4] The OWCP adopted the Third Edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised Third Edition of the Guides effective September 1, 1991; the Fourth Edition effective November 1, 1993; the Fifth Edition effective February 1, 2001; and the Sixth Edition effective May 1, 2009.[5]

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[2] The Office subsequently wrote to Dr. for an addendum report. He was advised that whole person impairment was not considered under the FECA. In a report of he confirmed that Ms. Newton had 5% right lower extremity impairment.

[3] 5 USC § 8107.

[4] 20 CFR § 10.404 (2002).

[5] Federal Employees' Compensation Act Procedure Manual 2-1601-8(c).

In the instant case, filed Form CA-7 for a Schedule Award. The Office referred her for a second opinion examination which took place on with Dr. , a board certified neurologist. He assigned 5% impairment for alteration in mental status, cognition and highest integrated function, 2% for language difficulties, 10% for the left upper extremity due to left spastic hemiparesis CNS dysfunction and 10% of the left lower extremity based upon station and gait, also related to left spastic hemiparisis. Upon receipt, this report was forwarded to the District Medical Advisor. In a response dated Dr. did not concur with Dr. assessment. In particular, he stated that the FECA does not allow for schedule awards based upon CNS impairment. He also noted that whole person impairment is not considered by the FECA. It was his opinion that the only ratable orthopaedic condition was right greater trochanteric bursitis due to an abnormal gait. He rated Ms. Newton at 5% impairment using Table 16-4 on page 512 of the Guides. By decision dated the claimant was awarded 5% permanent partial impairment of the right lower extremity. The claimant disagreed with this and an oral hearing was requested by her attorney Mr. Felser.

Following the hearing, the decision of the District Office was affirmed in part and remanded in part. Specifically, by decision dated the Hearing Representative affirmed impairment as it related to the 5% awarded for the right lower extremity. However, it was determined that further medical development was required as it related to the impairment for the left upper and left lower extremities. In accordance with the instruction of the Hearing Representative, the Office wrote to the District Medical Advisor for clarification. In a response dated Dr. opined that while a prior opinion had been given that the claimant's CNS condition could not be rated based upon the overall presentation, this was incorrect. He stated that it can and should be rated because provisions are made for a rating of such a condition in both the AMA Guides as well as OWCP regulations. He determined that the claimant had 10% left lower extremity impairment and 10% left upper extremity impairment. A more detailed explanation of Dr. calculations has been outlined earlier in this decision. Therefore, by decision dated the Office awarded 10% impairment for both the left upper extremity and left lower extremity.

The claimant disagreed with this decision and once again appealed to the Branch of Hearings and Review. At the hearing held on , Mr. Felser took issue with the second opinion report of Dr. and argued that the claimant was entitled to a valid second opinion examination. He also stated that the claimant had additional diagnoses that must be taken into consideration as it relates to her back as well as a claw deformity of the left hand and varus equinus of the left foot. He further took issue with the DMA's impairment rating of 10% for both the left upper and lower extremities. Specifically, he stated that Dr. failed to explain why he chose this percentage as opposed to a higher rating. Additionally, he argued that the DMA failed to consider the report from Dr. which documented more severe findings on exam.

On review, I find that the decision of the District Office must be set aside and the case remanded for further medical development for the reasons outlined below.

The Office had previously referred the claimant for a second opinion examination which took place on with neurologist M.D. She documented a history of the claimant's injury and the current status of her condition. Following a record review and physical examination, she found that Ms. Newton had residual cognitive impairment, mild receptive and expressive aphasia and spastic left hemiparesis. She was also suffering from post-traumatic vascular headaches. When asked to address objective findings to support residuals from the compensable injury, she noted that the claimant's physical exam revealed persistent neurological deficits including moderate spastic left hemiparesis, claw deformity of the two last fingers of the last hand and moderately severe varus equinus of the left foot. This impaired her stance and gait. Specifically, on exam the claimant had weakness in her left hand grip. While walking, she showed circumduction of the left leg. Her motor exam also revealed increased muscle tone of both left extremities with a claw deformity of the last two fingers of the left hand. She also had moderate and poorly reducible varus equinus of the left foot. Dr. noted that coordination was impaired on the left and that rapid alternating movements were slow and labored. She was also unable to walk in tandem due to the deformity of the left foot.

While the opinion of Dr. is insufficient to support an outright expansion of the claim for conditions of claw deformity of the left hand (last two fingers), varus equinus of the left foot and post-traumatic vascular headaches, it does support an uncontroverted inference between these conditions and the work related injury. Therefore, I find that this evidence is *prima facie*[6] sufficient to warrant further development.

The Employees' Compensation Appeals Board has consistently found that once an employee has established a *prima facie* case, i.e. when he or she has submitted evidence supporting the essential elements of his or her claim, including evidence of causal relationship, the Office has the responsibility to take the next step, either of notifying the employee what additional evidence is needed to fully establish the claim, or of developing evidence in order to reach a decision on the employee's entitlement to compensation.[7]

At the hearing, Mr. Felser also argued that the claimant had back problems such as spondylosis, degeneration and radiculopathy however the evidence of record is insufficient to establish that these conditions were caused, aggravated, accelerated or precipitated by the work injury. This was discussed at the hearing however no further information was forthcoming in this regard.

Additionally, Mr. Felser argued the Class of impairment assigned by the DMA. He pointed to a report from Dr. which documented more severe findings on exam than those documented by Dr. during his exam. Dr. noted that the claimant had been admitted to the hospital three weeks earlier with an adverse reaction to baclofen. This was a drug used for spasticity in individuals who had suffered strokes, head injuries or spinal cord injuries. had previously failed to

[6] A prima facie claim is one that on first appearance demonstrates entitlement to compensation and which always requires further development if it is not accepted. (Robert P. Bourgeois, 45 ECAB (Docket No. 93-1155, issued July 1, 1994)).

[7] Linda L. Mendenhal, 41 ECAB 1408, (1990).

respond to this drug therefore Dr. recommended Botox. However, this was denied by workers' compensation. Due to increased spasticity, it was recommended that she try baclofen again however she had an adverse reaction. Following her discharge from this hospital she was unsteady and unable to walk unassisted. She used a walker. She had increased cognitive difficulty and speech problems. With regard to her sensory exam, Dr. stated,

> "Marked decrease to pin touch and temperature in the left compared to the right absent position sense absent sterognosis absent graphesthesia on the left and actually absent touch she has no idea which finger on touching when trying to do position sense testing. Also absent vibratory sensibility with her eyes closed she does not fell sensory modalities in the left at all."

Dr. also addressed motor function. Strength testing in the left arm was 2/5. It was also 2/5 proximally and with hip flexion on the left leg. It was 1/5 distally in the left arm and left leg and 4/5 on the right. Reflexes were +2 on the right and +3 on the left. There was marked increased tone on the left with marked spasticity, distally more than proximally, with regard to the wrists and fingers. The claimant was unable to extend her fingers and her left foot was also turned in. Dr. noted the claimant to walk with a left hemiparetic gait with no arm swing on the left and circumduction of the left leg. Her gait was described as unsteady and tremulous. She was said to have poor range of motion with essentially none in the left hand and foot.

Mr. Felser argued that the findings of Dr. establish greater schedule award entitlement. Specifically, he argued that the findings at this exam supported assignment to a higher Class of impairment as opposed to what was assigned by Dr. For example, Dr. indicated that the claimant had a mildly unsteady gait but was able to ambulate without any assistive device. However, on the more recent exam, was so unsteady that she was unable to walk unassisted and so she was using a walker. Additionally, the findings on sensory examination appear to have been more severe at the time of Dr. exam. At the time of Dr. exam, the claimant was said to be neurologically stable in that there had been no change in her condition for at least a year or so. However, according to the report of Dr. the claimant's neurologic condition had changed. The examination performed by the claimant's attending physician took place approximately a year *after* the second opinion examination therefore I find that further development should be undertaken in this regard.

It is well established that proceedings under the Federal Employees' Compensation Act are not adversarial in nature, and, while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[8]

Upon return of the case file, the Office should update the Statement of Accepted Facts and refer the claimant for a new second opinion evaluation. The examiner should first be asked to address whether claw deformity of the left hand, varus equinus of the left foot, and post-traumatic vascular headaches were caused, aggravated, accelerated or

[8] Udella Billups, 41 ECAB 260 (1989).

precipitated by the work injury or effects thereof. The Office should supply the definition of casual relationship as outlined in Chapter 2-0805 (2) of the FECA Procedure Manual. The second opinion examiner should provide a well-reasoned opinion to support his/her conclusions.[9] Following this, the examiner should be asked to calculate work related impairment under the Sixth Edition of the AMA Guides. This must be based upon the conditions which have been established as work related as well as any pre-existing impairment to the affected member. Reference should be made to the applicable page numbers and Tables from the Guides which were used to calculate the impairment. If applicable, the physician must document the Class of impairment as well as relevant Grade Modifiers for functional history, physical exam and clinical studies. Additionally, the examiner should supply the date of maximum medical improvement and an explanation to support its selection. Upon receipt and review, the Office should undertake any further action deemed necessary and issue a *de novo* decision regarding schedule award entitlement.

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.

Electronically signed

Hearing Representative
For
Director, Office of Workers'
Compensation Programs

[9] If the second opinion examiner finds that any of these conditions are attributable to the work injury, the Statement of Accepted Facts must be updated to reflect this.