File Number:
HR11-D-H

RECEIVED OCT 06 2017

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,

Electronically Signed

Hearing Representative

PAUL H FELSER
FELSER LAW FIRM P.C.
7393 HODGSON MEMORIAL DRIVE STE 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, October 03, 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

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

The issue is whether the Office properly determined the degree of upper extremity permanent partial impairment based on the weight of medical evidence, according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Sixth Edition.

The claimant was employed as a maintenance mechanic with the when he filed a CA1 Notice of Traumatic Injury form claiming that on while he was mowing very rough terrain the handlebars of the mower jerked his right arm and shoulder. The Office initially accepted the claim for right shoulder sprain and right shoulder traumatic arthropathy. On , the claimant underwent right shoulder arthroscopic rotator cuff repair, subacromial decompression, and mini open biceps tenodesis. The Office expanded the claim for partial tear of right rotator cuff and right biceps tendon rupture. On the claimant underwent right shoulder scope and repair of massive cuff tear.

Under case the claimant filed a CA1 Notice of Traumatic Injury form claiming that on , he was sitting at his desk eating a cheese stick while working on a CA7a form when he dropped the cheese stick from his right hand. He went to catch it with his left hand and felt a sharp pain in his left shoulder. The Office accepted this claim for acromioclavicular sprain, left shoulder. On the Office doubled this case into master claim On the claimant underwent left shoulder scope with extensive debridement for the diagnosis of left shoulder rotator cuff tear, irreparable cuff tear.

On the Office received a CA7 Claim for Compensation form claiming a schedule award. On the Office issued a development letter to the claimant advising of the evidence needed to assess impairment, which required a medical report according to the Sixth Edition of the AMA *Guides*.

Washington DC, October 03, 2017

The Office determined that a second opinion examination was warranted and referred the claimant to Board-certified , M.D., on Additional diagnostic testing was done on . In a report, Dr. opined the claimant was at maximum medical improvement for his right shoulder and fell into the category of DBI-unilateral shoulder instability Class 1. Dr. advised the default value was 11%, and assigned grade modifiers of 2 (functional history), 1 (physical examination), and 2 (clinical studies), for +2. Dr. concluded 11% + 2% equaled 13% right upper extremity impairment.

The Office requested that Dr. also provide an impairment assessment for the left shoulder. Additional diagnostic testing of the left shoulder was completed on In a report, Dr. provided the same impairment calculations for the left shoulder, with a final 13% impairment rating.

On the Office's District Medical Advisor (DMA) reviewed the record and questioned why Dr. used shoulder instability as the classification as it was not included in the Statement of Accepted Facts and the physical exam did not support instability. The DMA recommended an independent medical examination by an orthopedic surgeon.

On , the Office requested that Dr. review the District Medical Advisor's report. In a supplemental report, Dr. maintained his impairment assessment with explanation. On the DMA reviewed Dr. rebuttal and still questioned his rationale. Therefore, the Office determined that there was a conflict in medical opinions between Dr. and the District Medical Advisor.

On , the claimant was seen for an independent medical evaluation with Board-certified orthopedic surgeon, , M.D. This Office received his report on Dr. opined that the injury resulted in permanent impairment based on the right and left rotator cuff tears in his shoulders. He stated the pertinent objective findings were some weakness and intermittent pain. Dr. noted page 403 of the AMA *Guides*, Sixth Edition, and stated that "permanent impairment would be 12% of his left shoulder and 12% of his right shoulder".

By decision dated the Office awarded the claimant 12% permanent partial impairment of the right upper extremity and 12% impairment of the left upper extremity based on the referee report of Dr. [1] The claimant disagreed with this decision and by letter postmarked through his attorney, requested an oral hearing.

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

[1] In a memo, the Office noted no schedule awards had been paid out in other claims

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.[2]

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.[3]

Per 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 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. 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.

Section 8123(a) of the Act provides that when there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist to resolve the conflict of medical opinion.[4] When a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical opinion evidence, the opinion of such specialist, if sufficiently well-rationalized and based on a proper medical background, must be given special weight.[5]

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[2] 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).
[3] *James E. Archie*, 43 ECAB 180 (1991).
[4] *William C. Bush*, 40 ECAB___(Docket No. 89-0449, issued July 10, 1989)
[5] *Annabelle Shank*, 39 ECAB___(1987)

In the instant case, the claimant was referred for an independent medical evaluation with Dr. to address a conflict in medical opinions between the District Medical Advisor and Dr. , a second opinion physician, concerning the appropriate diagnosis to be used for rating the injury-related shoulder conditions. Although Dr. stated that the claimant had 12% right upper extremity and 12% left upper extremity impairment, noting page 403 of the AMA *Guides*, Sixth Edition, he did not assign a class or grade modifiers and gave no explanation or calculations to establish how he arrived at 12% of each upper extremity. Further, the Office has only formally accepted an acromioclavicular sprain on the left side and it was not documented if Dr. was rating this diagnosis or another left shoulder condition. Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[6]

The claimant's diagnosed conditions can also be alternatively rated using the ROM rating method per the Sixth Edition of the AMA *Guides*, which Dr. did not address, and is required for compliance with FECA Bulletin 17-06. For the reasons above, further development is necessary.

In a situation where the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification or 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.[7]

On remand, the Office should correct the Statement of Accepted Facts (SOAF) to reflect that the injury under involved the left shoulder, not re-injury of the right shoulder. The claimant should be referred back to Dr. to obtain a supplemental report in accordance with established procedures for resolving a conflict in medical evidence (Part 2-0810-3c of the FECA Procedure Manual). Dr. should calculate the claimant's impairment using the reprinted 2009 version of the Sixth Edition of the AMA *Guides*, using both the DBI and the ROM rating method in accordance with FECA Bulletin 17-06. The Office should ask Dr. to cite the applicable sections of the *Guides* and to provide medical rationale with a discussion of the evidence that supports all opinions given. Specifically, Dr. needs to identify the injury-related diagnosis selected for rating purposes for each upper extremity and explain the class and grade modifier assignments for the DBI method, and verify that valid range of motion measurements were taken as required by the *Guides* for the ratings using the ROM method. Dr. should also show full calculations for each method to document how he arrives at the final percentages. Following careful review of Dr. referee report and completion of any further development deemed necessary per its procedures, the Office should issue a *de novo* decision on the claim.

[6] *R.V.*, Docket No. 10-1827 (issued April 1, 2011).
[7] *Annabelle Shank*, 39 ECAB___(1988)

Washington DC, October 03, 2017

Consistent with the above findings, the decision dated is set aside and REMANDED, and the case file is returned for further action as described above.

ISSUED:

WASHINGTON, D.C.

Electronically Signed

Hearing Representative
For
Director, Office of Workers'
Compensation Programs

Washington DC, October 03, 2017