U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programa-N00
Division of Federal Employees' Compensation
P.O. Box 8300
London, Kentucky 40742-8300

File Number:

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Dear Mr.

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.

Future correspondence should be addressed to: U.S. Department of Labor, Office of Workers' Compensation Programs, DFEC Central Mailroom, P.O. Box 8300, London, KY 40742.

Sincerely,

Hearing Representative

Enclosure

cc: Department of the Army
U.S. Army Installation Management Agency - HQ
Civilian Personnel Advisory Center
101 W. Bultman Avenue, Suite 100
Ft. Stewart, GA 31314

Paul Felser
Attorney at Law
P.O. Box 10267
Savannah, GA 31412

U.S. Department of Labor
Office of Workers' Compensation Programs

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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
Case No:

Merit consideration of the case file was completed on in Based on this review, the Decision of the District Office is vacated for the reason(s) set forth below.

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The claimant, born on (presently years old) was employed as a fire fighter on when he submitted Notice of Traumatic Injury and Claim for Compensation on Form CA-1, claiming that the pain in his left shoulder was due to an injury in the performance of duty on He stated that the injury was caused by pulling the crank rope on a chainsaw. The Office accepted that the employment incident caused left shoulder rotator cuff impingement syndrome and necessitated left shoulder surgery on consisting of arthroscopic debridement of the rotator cuff tendon and of the superior labrum anterior/posterior (SLAP) lesion, and subacromial decompression.

The claimant was paid compensation for total wage loss from through . He returned to work on with no physical restrictions.

On Dr. reported that the claimant complained of an occasional dull ache in his shoulder. On physical examination, he reported the following: minimally tender over the biceps long head, full range of motion, and intact motor and sensory. He opined that the claimant had reached maximum medical improvement. He indicated that he could return on an as needed basis. He noted that he was back to full activities.

On the claimant submitted Form CA-7, claiming compensation for a schedule award. He submitted a report dated from Dr. who opined that he had a 13% permanent impairment of the left upper extremity. Dr. cited table 16-10, 16-11 and 16-15 in the Fifth Edition of the

AMA Guides to the Evaluation of Permanent Impairment. He noted that table 16-15 (maximum upper extremity impairment due to unilateral sensory or motor deficits of the major peripheral nerves) allowed a maximum 5% upper extremity impairment rating for sensory deficit or pain involving the axillary nerve, and a maximum 35% upper extremity impairment rating for motor deficit involving the axillary nerve. He selected grade 2 in table 16-10 (determining impairment of the upper extremity due to sensory deficits or pain resulting from peripheral nerve disorders) which allows a range of 61% to 80% for the following description of sensory deficit or pain: "decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities." He then multiplied 80% times 5% to arrive at a 4% upper extremity impairment rating due to sensory deficit or pain. He selected grade 4 from table 16-11 (determining impairment of the upper extremity due to motor and loss of power deficits resulting from peripheral nerve disorders) which allows a range of 1% to 25% for the following description of muscle function: "complete active range of motion against gravity with some resistance." He then multiplied 25% times 35% to arrive at a 9% upper extremity impairment rating due to motor deficit. He then added the ratings for sensory and motor deficits to arrive at the 13% upper extremity impairment rating.

Dr. re-examined the claimant on and reported that he had occasional sharp pains in the shoulder particularly with overhead activities. On physical examination, he reported full range of motion of the left shoulder, positive crepitus with full abduction, tenderness over the left lateral rotator cuff, and intact motor and sensory examination. He opined that the claimant had a 13% impairment of the left upper extremity and explained the calculations as provided in his report dated

The file was reviewed by the District Medical Advisor who noted that Dr. failed to supply information on symptoms and findings which he based his rating on as required by the Guides. The Office requested Dr. to provide this information. In a letter dated Dr. again described the results of his physical examination on and again explained how he calculated the impairment rating of 13%. On the District Medical Advisor noted that Dr. rating was based on motor and sensory loss but when examined on Dr. had described intact motor and sensory examination. He noted that the claimant had normal range of motion of the shoulder. He opined that the claimant had a 0% impairment of the left upper extremity.

In order to resolve the conflict in medical opinion between the District Medical Advisor and Dr. , the Office referred the claimant to a referee medical specialist pursuant to the provisions of Section 8123(a) of the Act. The Office selected Dr. an orthopedic surgeon, to act as the referee medical specialist. Dr. examined the claimant on and was provided with a statement of accepted facts and the entire file. In a report of the same date, Dr. reviewed the claimant's history dating back to the injury and subsequent surgery. At the time of his examination, he noted that the claimant complained that his left shoulder "cracks and pops" and that he also complained of "hanging up" and pain occasionally, particularly with overhead activity. On physical examination he described the following: obvious biceps tendon deficit, full range of motion of the left shoulder (he provided exact measurements), no significant atrophy of the deltoid musculature, intact internal and external rotational strength and abduction strength, some crepitus in left shoulder with motion, and no sensory deficits. He noted that the claimant stated he was performing full activities with the exception of decreased upper extremity weight workout. He stated that there was no evidence of axillary nerve dysfunction noting that the claimant essentially had a fully functional shoulder based on range of motion and strength. He opined that the claimant had a 5% impairment of the left upper extremity based on pain and decreased exercise capacity.

On , another District Medical Advisor reviewed the file and noted the different ratings by Dr. and Dr. He noted that Dr. provided a rating based on injury to the axillary nerve but that Dr. stated there was no evidence of axillary nerve injury. He noted that both reports indicated full range of motion of the left shoulder. He opined that the report by Dr. seemed more credible and that, in the absence of other evidence, a final schedule award of 5% of the left upper extremity based on pain and weakness was appropriate.

By Order dated the Office awarded the claimant compensation for 5% permanent impairment of the left upper extremity. Pursuant to this award, the Office paid the claimant compensation for 15.6 weeks (5% of 312 weeks, the schedule award for loss of an arm) from to I find that this award is premature.

In order to resolve the conflict in medical opinion between the District Medical Advisor and Dr. , the Office referred the claimant to a referee medical specialist, Dr. When a referee medical specialist is requested to resolve a conflict in the medical evidence, his opinion is to be accorded special weight if it is sufficiently well rationalized and based on a

proper medical and factual background.[1] I find that Dr. opinion is not sufficiently well rationalized because he does not cite the specific tables in the Guides which he relied upon to determine that the claimant has a 5% impairment of the left upper extremity. In the case of [2] the Board held that because the referee medical specialist did not discuss the specific tables used in the Guides, he did not use the Guides appropriately and therefore his opinion on the extent of the claimant's permanent impairment was of diminished probative value and insufficient to resolve the conflict in medical evidence. Accordingly, I find that the opinion of Dr. is of insufficient probative value to constitute the weight of the medical evidence.

When the Office secures an opinion from a referee medical specialist for the purpose of resolving a conflict in the medical evidence and the opinion from such specialist requires clarification, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report.[3] Accordingly, the Order dated is hereby set aside and the case is remanded to the Office for further development of the medical evidence. Upon remand, the Office should request Dr. to provide a supplemental report explaining the basis for his opinion that the claimant has a 5% permanent impairment of the left upper extremity, citing the specific table(s) in the Guides. Following receipt of the supplemental report from Dr. and after any additional development deemed necessary, the Office should make a de novo decision concerning the claimant's entitlement to compensation under the schedule award provisions of the Act.

DATED: FEB 1 2007
WASHINGTON, D.C.

Hearing Representative
For
Director, Office of Workers' Compensation Programs

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[1] James Roberts, 31 ECAB 1010.
[2] Docket No. 00-2636, issued July 5, 2001.
[3] Harold Travis, 30 ECAB 1074.