File Number:
HR11-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

RECEIVED MAY 10 2010

MAY 4 2010

Date of Injury:
Employee:

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.

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,

Carol E Adams

Carol E. Adams
Hearing Representative

PAUL FELSER, ATTORNEY
FELSER LAW FIRM
PO BOX 10267
SAVANNAH, GA 31412

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 case file was completed in Washington, D.C. Based on this review, the decision of the District Office dated January 29, 2010, has been set aside and remanded for the reasons set forth below.

The issue for determination is whether the claimant is entitled to additional compensation for permanent impairments to the larynx beyond what has already been awarded.

was employed as a for the . As the result of his employment, he contracted staphylococcal bacterial endocarditis. The accepted work-related conditions are as follows:

The claimant filed a claim for additional schedule award on . The Office had already begun development for additional permanent impairment prior to the receipt of the claim.

The claimant was previously paid compensation for permanent impairment as follows:

15% bilateral lung
50% left arm
51% larynx
40% left leg
57% sexual function
21% right leg
33% right arm

In accordance with Office procedures, on May 14, 2009, the case file was referred to the District Medical Advisor (DMA) to review the records and provide his opinion as to whether the claimant had sustained additional impairment as the result of his work injuries. The DMA in his report dated May 18, 2009, reviewed the records and specifically referred to Dr. report of January 22, 2008. The DMA noted that Dr. had increased the claimant's impairment rating as follows:

FROM TO
15% -- 70% bilateral lung
50% -- 70% left arm
51% -- 75% larynx
40% -- 75% left leg
57% -- 100% sexual function
21% -- 60% right leg
33% -- 55% right arm

The DMA determined that the evidence was insufficient to support an increase in permanent impairment. The DMA noted that Dr. report did not contain any examination findings or any reference to the AMA Guides as a basis for his opinion. The DMA recommended that a second opinion be obtained with a neurologist for an impairment rating under the AMA Guides 6th edition.

On June 25, 2009, the Office referred the case file to another DMA for review of the records and determination as to whether there was any increase in permanent impairment to the lungs or larynx as the result of the work injury. The DMA recommended a second opinion with a pulmonary physician for pulmonary function tests and a recommendation for a treatment program for chronic asthma. The DMA also recommended a second opinion with an otolaryngologist for evaluation of dysphasia and determination of schedule award for the larynx.

The Office referred the medical records for review to (per case records the claimant was too ill to attend the second opinion examination). By report dated December 5, 2009, Dr. , an , reviewed the claimant's medical records and provided a whole body impairment rating of 15% for impotence, without age adjustment and 40% for cardiomyopathy, giving a combined whole body impairment rating of 49%. The doctor answered the Office's question as to whether the claimant had greater than a 57% impairment of the sexual function. The doctor stated that it did not appear that the claimant's impairment was greater than 57%.

The Office also referred the claimant's case record to Dr. , otolaryngologist, for an opinion as to whether the claimant had additional impairment of the larynx. Dr. reviewed the medical records and held a teleconference on November 16, 2009, with Dr. , an otolaryngologist who had previously evaluated the claimant's larynx and phonation. Dr. stated that she last examined the claimant on September 28, 2006. Dr. indicated that on last examination the claimant had blunting of the laryngeal ventricles and thickening of the vocal folds. Dr. felt the voice was weak and could not be projected well and that the claimant's phonation was affected by his GERD, expressive aphasia and his Parkinsonian symptoms.

Dr. in his report dated December 30, 2009, responded to the question that had been posed to him, regarding permanent impairment of the larynx. Dr found that the claimant had an 18% permanent impairment of the larynx based on the AMA Guides 6th edition. Dr stated he based his determination on the review of the evidence of record and the teleconference with Dr.

The claimant was also referred to a second opinion regarding the increase permanent impairment of the lungs. The claimant's records were sent to Dr. The doctor reviewed the pulmonary test dated October 1, 2007, and April 2006 and stated that a more recent pulmonary function test would be helpful in arriving at a current level of impairment. Based on the review of the records, the doctor determined that the claimant had a 40% whole person impairment rating based on the AMA Guides 6th edition.

Records indicate that the claimant was scheduled for a neurological evaluation; however, by letter dated October 19, 2009, the physician notified the Office that he would not perform the evaluation.

An orthopedic report was received from Dr. Joseph P. Tobin, orthopedist, dated February 1, 2010. It appeared the doctor was asked to review the medical evidence and provide an opinion, regarding additional impairment to the upper and lower extremities. The doctor based his opinion on evidence in the record. He noted that he could not find any medical evidence to warrant a change in impairment ratings of the upper and lower extremities.

Proceedings under the FECA are not adversary in nature; nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. Once OWCP undertakes to develop the medical evidence, it has the responsibility to do so in a proper manner.[1]

Since the issue for determination is whether the claimant has additional permanent impairment of the larynx, the discussion and findings will be limited mainly to that issue. After review of the evidence, I find that the case is not in posture for a hearing. Therefore, the decision of the Office must be set aside, and the case remanded for further development.

According to the evidence on record, the claimant was too ill to attend the second opinion evaluations; therefore, the second opinion examiners reviewed the medical evidence and attempted to provide permanent impairment ratings based on a review of the medical evidence of record. Dr. obtained some information from Dr. over the telephone; however, since Dr. had not examined the claimant since 2006, the information was more than three years old. In addition, the Office procedures state, and the Board has held that medical evidence cannot be obtained over the telephone. In addition, the DMAs had already determined there was insufficient evidence on record to support additional impairment. Therefore, without new examination of the claimant, Dr. opinion provided no new probative evidence that could be used to determine the permanent impairment of the larynx. In

[1] *Phillip C. Garr*, ECAB Docket No. 04-1568, issued November 29, 2004.

addition, the information provided by Dr. in the teleconference was similar to what was already on record in her report of December 28, 2006, and as stated previously was inappropriately obtained by telephone. I also note that the Office failed to send the second opinion report to the DMA for review and calculation of permanent impairment based on the AMA Guides 6th edition as required by Office procedures.

After review of the records, I also found that the claimant's attorney requested that the case be expanded to accept loss of vision of the right eye from ischemic optic atrophy, which was due to the claimant's fall and resulting subdural hematoma. A medical report dated December 2, 2008, from Dr. was provided to support the attorney's contention that the loss of vision in the right eye was related to the work injury. Dr. stated that she had been following the claimant since 1997 and last examined the claimant on September 24, 2008. She stated that the claimant's diagnosis was ischemic optic atrophy in the right eye, which resulted in blindness. She noted that this was subsequent to the claimant's fall and subdural hematoma. Dr. determined there was a direct link and connection from the claimant's subdural hematoma to his legal blindness. Visual tests were also provided to support the finding of blindness. I find that the claimant has provided prima facie evidence that his blindness in his right eye was work-related sufficient to require the Office to undertake additional development.

In conclusion, since the claimant's is too ill to attend a second opinion examination, the attending physicians are the best source to obtain additional current evidence. Upon remand the case record should be referred to the DMA, and the DMA should be asked to provide specific details of what evidence is needed to determine the degree of permanent impairment, using the AMA Guides 6th edition. The Office should prepare a new Statement of Accepted Facts (SOAF), combining all the *addenda*. The Office then should send the SOAF along with a letter to the most appropriate attending physician to obtain current findings needed to evaluate the claimant's impairment of the larynx. Once the evidence is obtained, the DMA should be asked to determine the degree of permanent impairment to the larynx based on the AMA Guides 6th edition. In accordance with Office policy, when a medical report is received from the attending physician, the examining physician is not responsible for calculation of the percentage of impairment.[2] The District Medical Advisor (DMA) is responsible for taking the calculations provided by the examining physician and arriving at an overall impairment percentage rating.

In regards to the blindness of the right eye, the Office should refer the case file to the DMA and ask whether the blindness was related to the subdural hematoma. If the DMA determines additional information is needed, the Office should send the Statement of Accepted Facts to Dr. and ask her to provide a reasoned medical report, explaining how the subdural hematoma caused or contributed to the claimant's blindness in the right eye.

The Office should also complete their development for the other claimed conditions for increase in permanent impairments and render a decision.

[2] FECA Bulletin Number 96-17.

After completion of the aforementioned development and any other development the Office deems necessary, a new decision should be issued, regarding the permanent impairment of the larynx.

In accordance with the above findings, the decision of January 29, 2010, is set aside and the case **remanded** for additional development.

MAY 4 2010

Date:

Washington, D.C.

Carol E. Adams

Carol E. Adams
Hearing Representative
For
Director, Office of Workers'
Compensation Programs