U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation
Washington, DC 20210

MEMORANDUM

DATE: January 18, 2018

TO: JOHN VANCE
Branch Chief, Branch of Policy, Regulations and Procedures

FROM: CURTIS JOHNSON Curtis Johnson
Unit Chief, Branch of Policy, Regulations and Procedures

RE: 1st QUARTER CALENDAR YEAR 2017 CMC AUDIT REPORT

Below is the analysis of five cases determined to have a deficient Contract Medical Consultant (CMC) report based on a review by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) Medical Director.

1. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: September [redacted] 2016 [redacted]
Condition: Accepted: ICD 9 code 403.0, Hypertensive chronic kidney disease

The Medical Director states that the rating was not consistent with the evidence in the file. The Medical Director found that the September [redacted] 2016 report contained a reference to an incorrect date of a 2010 impairment. The Medical Director also found that [redacted] seemed to ignore the most recent 7% rating from 2013 and instead relied on a rating from 2011. The Medical Director found that [redacted] did not explain how he determined the claimant's creatinine clearance for purposes of the rating. This may have changed the final determination in this case.

I accept the opinion of the Medical Director regarding the errors found in this impairment rating. The usage of the incorrect prior impairment date of 9/[redacted]/2000 appears to be a typo.

The program has previously awarded the claimant a total of [redacted] for 9% whole person impairment. The CMC's rating on September [redacted] 2016 was 5% whole person impairment. On November [redacted] 2016, FAB issued a final decision to deny the Part E claim for increased whole person impairment due to chronic renal disease.

RECOMMENDATION: Recommend that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

2. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: February [redacted] 2017 [redacted]
Condition: Accepted: ICD 9 code 238.4, Polycythemia vera
Accepted: ICD 9 code 289.83, Myelofibrosis

The Medical Director states that the appropriate Chapters and Tables of the AMA Guides were not utilized. He indicated that the CMC should not have applied Table 9-4 on Page 203 because the claimant's platelet abnormality (thrombocythemia) is a function of his accepted condition (polycythemia vera) and is neither a consequential condition nor the cause of his symptoms (e.g., shortness of breath). The Medical Director referenced the correct Pages and Tables to use from the guides as Paragraph 9.3a on Page 196, Example 9-8 on Page 197, and Table 9-2 on Page 193. This may have changed the final determination in this case.

I accept the opinion of the Medical Director regarding the errors found in this impairment rating.

On [redacted] *the district office issued a recommended decision to accept the Part E claim for increased impairment benefits of 67% and award the claimant compensation of* [redacted] *While the claim was at FAB pending issuance of a final decision, FAB was notified that the claimant died on* [redacted]. *A copy of the claimant's obituary is on file. A copy of the claimant's death certificate is not available. The Part E claim for impairment was closed administratively on* [redacted]

RECOMMENDATION: In this case, the employee passed away prior to the award of compensation. As of this date, no eligible survivor has filed a claim for compensation. A redo of the impairment rating is appropriate only if (1) an eligible survivor files a claim and (2) the cause of the employee's death is unrelated to the accepted condition, thereby making an election of benefits possible. Until these two requirements are met, it is not necessary to redo the impairment rating. However, the program should advise QTC of the error so it is aware of the issue and that it takes steps to mitigate similar mistakes in the future.

3. [redacted]
Seattle District Office
Impairment Evaluation
Report date: January [redacted] 2017 [redacted]
Condition: Accepted: ICD 10 code C05.1, Malignant neoplasm of soft palate
Accepted: ICD 10 code C77.3, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes

The Medical Director states that the appropriate Chapters and Tables of the AMA Guides were not utilized and that [redacted] used criteria which are applicable to lung cancer. The Medical Director indicated that the CMC should have used the following criteria: Chapter 11, which apply to permanent impairment due to the ear, nose, throat, and related structures; Section 11.4b since the claimant requires a feeding tube (See Table 11-7) and Section 11.4c since the claimant has an inability to taste. This may have changed the final determination in this case.

I accept the opinion of the Medical Director regarding the errors found in this impairment rating.

On [redacted] FAB issued a final decision to accept the Part E claim for 79% whole person impairment due to soft palate cancer with metastasis to the lymph nodes. The claimant was awarded compensation benefits of [redacted] The claimant is currently in hospice.

RECOMMENDATION: Recommend that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

4. [redacted]
Seattle District Office
Impairment Evaluation
Report date: March [redacted] 2017 [redacted]
Condition: Approved: ICD 10 code C64.1, Malignant neoplasm of kidney, except renal pelvis

The claimant is status post right radical nephrectomy. The Medical Director states that the rating was not consistent with the evidence of file and erroneously combined the results of Table 7-1, Page 146 and Paragraph 7.3a, Page 145 of the AMA Guides. Table 7-1 serves as the sole basis for impairment rating criteria for the employee's kidney cancer. Paragraph 7.3a serves as a ***recommended*** impairment rating based on the rating criteria identified under Table 7-1. The use of either Table 7-1 or Paragraph 7.3a would justify the employee's rating, but the rating cannot be based on both. This may change the final determination in this case.

I accept the opinion of the Medical Director regarding the errors found in this impairment rating.

On [redacted] FAB issued a final decision to accept the Part E claim for 23% whole person impairment due to kidney cancer. The claimant was awarded compensation benefits of [redacted]

RECOMMENDATION: Recommend that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

5. [redacted]
Jacksonville District Office
Second Medical Opinion – Home Health Care Necessity
Report date: July [redacted] 2016 [redacted]
Condition: Approved: ICD 9 code 173.6, Other and unspec malignant neoplasm of skin of upper limb, including shoulder
Approved: ICD 9 code 232.2, Carcinoma in situ of skin of ear and external auditory canal
Approved: ICD 9 code 496, Chronic airway obstruction, not elsewhere classified
Approved: ICD 9 code 501, Asbestosis
Approved: ICD 9 code 508.8, Respiratory conditions due to other specified external agents
Approved: ICD 9 code 511.0, Pleurisy without mention of effusion or current tuberculosis
Approved: ICD 9 code 518.89, Other diseases of lung, not elsewhere classified
Approved: ICD 9 code V15.84, Personal history of contact with and (suspected) exposure to asbestos

The Medical Director found the following deficiencies in the CMC's report: 1) there is no indication of [redacted] specialty except for a reference in the body of the report to his having interviewed and examined the claimant on July 11th; 2) the report is undated; 3) the report is brief; 4) there is no summary of the facts in the case; and 5) there is no documentation of a complete review of systems and physical examination. The Medical Director indicated that given the nature of the case, the deficiencies in [redacted] report probably would not have changed the final determination.

I agree with the Medical Director's findings regarding the deficiencies found in the CMC's [redacted] medical report. I also agree with the Medical Director that the deficiencies in the medical report probably would not have changed the final determination.

The CMC's report provided a response to the claims examiner's question regarding the medical necessity of the claimant's current level of home health care. Based on the CMC's determination,

the district office approved the claimant's current level of home health care, which consisted of a home health aide/certified nursing assistant care at a rate of 24 hours per day/7 days per week and 16 hours per month of targeted case management for a six-month period.

It is noted that an occupational medicine specialist was requested at the time of the referral. The referral was ultimately made with [redacted] *whose specialty is internal medicine (see appointment letter of* [redacted]*.*

RECOMMENDATION: Recommend that QTC remind the CMC of the need to provide thorough medical reports which include the physician's specialty, claimant's clinical and medical history, and subjective complaints.