U.S. Department of Labor

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

MEMORANDUM

DATE: February 6, 2020

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: Contract Medical Consultant (CMC) AUDIT REPORT
2nd Quarter 2019

Below is the analysis of five (5) cases determined to have a deficient CMC report based on a review by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) Medical Director.

1. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 170.1, Malignant neoplasm of bone and articular cartilage, Mandible
Accepted: ICD 9 code 172.3, Malignant melanoma of skin, Other and unspecified parts of face
Accepted: ICD 9 code 173.2, Other and unspecified malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.3, Other and unspecified malignant neoplasm of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.32, Squamous cell carcinoma of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.4, Other and unspecified malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.42, Squamous cell carcinoma of scalp and skin of neck
Accepted: ICD 9 code 232.3, Carcinoma in situ of skin, Skin of other and unspecified parts of face
Accepted: ICD 9 code 501, Asbestosis

Accepted: ICD 10 code C44.112, Basal cell carcinoma of skin of right eyelid, including canthus
Accepted: ICD 10 code C44.311, Basal cell carcinoma of skin of nose
Accepted: ICD 10 code D48.5, Neoplasm of uncertain behavior of skin

The Medical Director's findings are as follows: The CMC's report of the claimant's clinical history and his summary of the facts in the claimant's case are overly brief and not entirely accurate. The most recent PFT in the claimant's record is [redacted]016--not [redacted] as stated by the CMC. Also, the CMC overstates the degree of the claimant's pulmonary impairment. The claimant's [redacted] PFT demonstrates that his FVC, FEV1, and FEV1/FVC are all within normal limits. According to his physician's progress notes, the claimant "loves doing his yard work. He does not really complain much about shortness of breath...([redacted])," is "Still quite active, out in the yard almost daily. Minimal dyspnea. ([redacted])," and "He feels good, remains active. No worsening in shortness of breath. ([redacted]). Thus, the claimant's pulmonary impairment falls into Class 1 (0% Impairment of the Whole Person) in Table 5-12 on Page 107 of "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition." This may change the final determination in this case.

While the Director found that the CMC offered only a brief factual history, the CMC indicated that he reviewed the Statement of Accepted Facts and the series of medical records (which included ADL and PFT reports) that were included with the referral. It is also noted that this specific deficiency regarding the factual history will not impact the overall outcome of the case. As such, this deficiency is being removed.

I accept the Medical Director's opinion regarding the error as it relates to incorrect Class placement found in this impairment evaluation. The CMC indicated that the claimant falls in Class II (10% to 24% impairment of whole person), whereas the Medical Director indicated that the claimant should be in Class 1 (0% impairment of the whole person).

The claimant has previously received compensation benefits for 28% WPI (Whole Person Impairment) ([redacted]). The CMC's [redacted] report provided a WPI rating of 36%. The Final Adjudication Branch (FAB) issued a final decision on [redacted], to accept the claimant's Part E claim for 36% WPI (8% increase for [redacted]).

RECOMMENDATION: It is unlikely that a new rating would exceed the 36% rating that has already been determined, therefore, a new rating is not appropriate and there is no further action required for this case. Discuss the errors in this report with the contractor for improvements to future submissions.

2. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 244.9, Unspecified hypothyroidism
Accepted: ICD 9 code 389.11, Sensory hearing loss, bilateral

The Medical Director's findings are as follows: The CMC appropriately applied Table 11-1 on Page 247, Table 11-2 on Pages 284-249, and Table 11-3 on Page 250 of "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition" when determining the claimant's WPI due to hearing loss, but his final determination was inaccurate. The employee's binaural hearing impairment was erroneously calculated at 42.8%, when it should have been calculated at 41.6%. Accordingly, the claimant's final WPI rating should be 14%--not 15%.

I accept the Medical Director's opinion regarding the error found in this impairment evaluation.

The claimant has previously received compensation benefits for 26% WPI ([redacted]). The CMC's [redacted] report provided a 15% WPI rating. FAB issued a final decision on [redacted] to deny the claimant's Part E claim for increased impairment.

RECOMMENDATION: The Medical Director's determination is that the claimant's final impairment rating should be 14%, not 15%. However, since the correct 14% rating remains less than the previous 26% WPI rating, there is no further action required for this case. Discuss the error in this report with the contractor for improvements to future submissions.

3. [redacted]
Denver District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 175.0, Malignant neoplasm of male breast, Nipple and areola
Accepted: ICD 9 code 185, Malignant neoplasm of prostate
Accepted: ICD 9 code 356.4, Idiopathic progressive polyneuropathy
Accepted: ICD 9 code 501, Asbestosis

The Medical Director's findings are as follows: The claimant has difficulty with station and gait due to polyneuropathy caused by chemotherapy. The CMC should have applied Table 13-15 on Page 336 of "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition" to assign the claimant a WPI rating for polyneuropathy. Instead, the CMC applied Table 17-37 on Page 552. Table 17-37 is intended for rating

individual nerve injuries due to trauma. See Example 17-17 on Page 552. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The claimant has previously received compensation benefits for 51% WPI [redacted]. The CMC's [redacted] report provided a 29% WPI. FAB issued a final decision on [redacted] to deny the claimant's Part E claim for increased impairment.

RECOMMENDATION: In order to determine if a reopening of the case is appropriate, it is recommended that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment. Discuss the errors in this report with the contractor for improvements to future submissions. I note that the CMC indicated that the WPI he provided was based on prostate cancer and polyneuropathy. He needed additional information to provide a WPI which included asbestosis and breast cancer. However, the claimant did not provide current medical evidence, so an impairment rating was provided based on the evidence of record. (Pulmonary evidence was from 2018). Prior to the redo of the impairment rating, the assigned Claims Examiner should provide the claimant another opportunity to provide the necessary evidence to allow for a full rating for all accepted conditions in his case.

4. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 202.81, Other malignant lymphomas of lymph nodes of head, face, and neck
Accepted: ICD 10 code C34.12, Malignant neoplasm of upper lobe, left bronchus or lung
Accepted: ICD 10 code C34.32, Malignant neoplasm of lower lobe, left bronchus or lung
Accepted: ICD 10 code C43.21, Malignant melanoma of right ear and external auricular canal
Accepted: ICD 10 code C83.13, Mantle cell lymphoma, intra-abdominal lymph nodes
Accepted: ICD 10 code C83.14, Mantle cell lymphoma, lymph nodes of axilla and upper limb

The Medical Director's findings are as follows: When rating the claimant's Mantle cell lymphoma, the CMC noted that the claimant is able to perform all ADL independently without reminder or assistance--but the CMC placed the claimant in Class 3 (31%-55% Impairment of the Whole Person) of Table 9-3 on Page 200. The claimant's lymphoma does not result in "interference with the ability to perform daily activities [or require]

occasional assistance from others." The CMC should have placed the claimant in Class 2; the claimant "performs most daily activities, although [he] requires continuous treatment." This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The [redacted] report provided a 66% WPI. FAB issued a final decision on [redacted] to accept the claimant's Part E claim for 66% WPI. The claimant received [redacted] in compensation.

RECOMMENDATION: It is unlikely that a new rating would exceed the 66% rating that has already been determined, therefore a new rating is not appropriate and there is no further action required for this case. Discuss the errors in this report with the contractor for improvements to future submissions.

5. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 174.4, Malignant neoplasm of female breast, Upper-outer quadrant
Accepted: ICD 9 code 296.22, Major depressive disorder, single episode, moderate
Accepted: ICD 9 code 785.6, Enlargement of lymph nodes
Accepted: ICD 9 code V50.41, Prophylactic organ removal, Breast

The Medical Director's findings are as follows: The CMC inappropriately used Table 13-16 on Page 338 of "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition" to determine the claimant's degree of impairment in her left shoulder. "Tables 13-16 and 13-17 are used to rate upper extremity dysfunction from any lesion in the brain." The CMC should have used Section 16.4i and Table 16-3 on Page 433 of "AMA Guides" to determine the claimant's degree of impairment in her left shoulder. Given that the employee's upper extremity impairment was calculated incorrectly, the application of the Combined Values Chart on Pages 604-606 is also flawed. These errors may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The claimant has previously received compensation benefits for 66% WPI ([redacted]. The CMC's [redacted] report provided a 28% WPI. FAB issued a final decision on [redacted] to deny the claimant's Part E claim for increased impairment.

RECOMMENDATION: In order to determine if a reopening of the case is appropriate, it is recommended that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment. Discuss the errors in this report with the contractor for improvements to future submissions.