U.S. Department of Labor

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

MEMORANDUM

DATE: February 26, 2018

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

FROM: CURTIS JOHNSON
Unit Chief, Policy, Regulations and Procedures

RE: CMC AUDIT REPORT - 2nd Quarter Calendar Year 2017

Below is the analysis of nine (9) 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]
Jacksonville District Office
Impairment Evaluation - **(Terminal Case)**
Report date: [redacted]
Condition: Accepted: ICD 9 code 185, Malignant neoplasm of prostate
Accepted: ICD 9 code 203, Multiple myeloma
Accepted: ICD 9 code 203.80, Other immunoproliferative neoplasms, without mention of having achieved remission
Accepted: ICD 9 code 285.8, Other specified anemias
Accepted: ICD 9 code 607.84, Impotence of organic origin
Accepted: ICD 9 code 733.0, Osteoporosis
Accepted: ICD 9 code 788.3, Urinary incontinence

The Medical Director determined that the CMC provided a minimal amount of clinical history in his report and did not state that the employee was at maximum medical improvement (MMI) due to the accepted conditions. The Medical Director determined that the CMC did not use the appropriate Chapters and Tables in the AMA Guides to the Evaluation of Permanent Impairment, 5th edition as it related to the employee's accepted conditions at MMI. This may have changed the final determination in this case.

I accept the Medical Director's findings regarding the errors found in this impairment evaluation as it relates to the use of the AMA Guides. The impairment rating provided by the CMC should be based solely on the accepted conditions. On the issue of establishing MMI, guidance provided under DEEOIC PM 21.4c(1) states that an exception to the MMI requirement exists for terminal cases.

In his report of [redacted] *the CMC rated the employee at 100% whole person impairment. On* [redacted] *the Final Adjudication Branch issued a final decision to accept the Part E claim for increased impairment and award the employee compensation benefits of* [redacted] *for 27% increased whole person impairment due to the accepted conditions. (The employee previously received impairment benefits for 73% total whole person impairment).*

RECOMMENDATION: Remind QTC that impairment evaluations performed by the CMC should be based solely on the accepted conditions. This needs to be communicated clearly in any submitted impairment rating report.

2. [redacted]
Denver District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 427.3, Atrial fibrillation and flutter
Accepted: ICD 9 code 508.1, Chronic and other pulmonary manifestations due to radiation

The Medical Director determined that the CMC provided an impairment rating for a condition (asthma) that was not a part of the list of accepted conditions. The CMC indicated that asthma was considered to avoid apportionment. The Medical Director also determined that the CMC incorrectly used the Combined Values Chart to combine two ratings for the same organ system (pulmonary fibrosis and asthma) to yield a final rating of 67%. This may have changed the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment rating. Asthma is not listed on the SOAF as part of the employee's accepted conditions, nor is it found in the medical evidence of record.

On [redacted] *the Final Adjudication Branch issued a final decision to accept the Part E claim for increased impairment and award the claimant* [redacted] *in compensation benefits for 9% increased whole person impairment due to the accepted conditions. (The employee previously received impairment benefits for 58% total whole person impairment).*

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.

3. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.3, Other and unspecified malignant neoplasm of skin of other and unspecified parts of face
Accepted: ICD 9 code 493.10, Intrinsic asthma, unspecified
Accepted: ICD 9 code 501, Asbestosis
Accepted: ICD 9 code V15.84, Personal history of contact with and (suspected) exposure to asbestos

The Medical Director determined that the CMC incorrectly used the Combined Values Chart to combine two ratings for the same organ system (asbestosis and asthma) with the rating for skin cancer to yield a final whole person impairment rating (WPI) of 85%. This may have changed the final determination in this case. The employee's WPI rating for the lung should be measured by **either** rating asbestosis under Table 5-12 or rating asthma under Tables 5-9 and 5-10 of the AMA Guides, but not both.

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

On [redacted] *the Final Adjudication Branch issued a final decision to accept the Part E claim for increased impairment and award the employee compensation benefits of* [redacted] *for 10% increased whole person impairment due to the accepted conditions. (The employee previously received impairment benefits for 75% total whole person impairment.)*

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: [redacted]
Condition: Accepted: ICD 9 code 173.31, Basal cell carcinoma of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.41, Basal cell carcinoma of scalp and skin of neck
Accepted: ICD 9 code 173.51, Basal cell carcinoma of skin of trunk, except scrotum
Accepted: ICD 9 code 381.81, Dysfunction of Eustachian tube
Accepted: ICD 9 code 733.0, Osteoporosis
Accepted: ICD 9 code 785.6, Enlargement of lymph nodes
Accepted: ICD 10 code C44.212, Basal cell carcinoma of skin of right ear and external auricular canal
Accepted: ICD 10 code C44.319, Basal cell carcinoma of skin of other parts of face

The Medical Director determined that the CMC mistakenly attributed the employee's hearing loss to the accepted condition of Eustachian tube dysfunction. The employee's audiogram results demonstrate normal middle ear function, meaning that the accepted condition of Eustachian tube dysfunction is not the cause of the employee's hearing loss. Therefore, the use of Tables 11-1 and 11-2 to calculate hearing loss is not applicable to this case. The Medical Director also determined that the CMC used the incorrect Class in rating the employee's skin cancer impairment (CMC used Class 2 instead of Class 1). The employee's skin disorder signs and symptoms are only intermittently present, have no or few limitation in his performance of activities of daily living, and require only intermittent treatment. Such findings are consistent with Class 1 level impairment. The rating is 47% whole person impairment. This may have changed the final determination in this case.

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

On [redacted] the Final Adjudication Branch issued a final decision to accept the Part E claim for increased whole person impairment and award the employee compensation benefits of [redacted] for 25% increased whole person impairment due to the accepted conditions. (The employee previously received impairment benefits for 22% total whole person impairment.)

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]
Denver District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.2, Other and unspec malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.3, Other and unspec malignant neoplasm of skin of other and unspec parts of face
Accepted: ICD 9 code 173.4, Other and unspec malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.5, Other and unspec malignant neoplasm of skin of trunk, except scrotum
Accepted: ICD 9 code 173.6, Other and unspec malignant neoplasm of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.9, Other and unspec malignant neoplasm of skin, site unspec
Accepted: ICD 9 code 202.0, Nodular lymphoma
Accepted: ICD 10 code C44.211, Basal cell carcinoma of skin of unspecified ear and external auricular canal

Accepted: ICD 10 code C44.320, Squamous cell carcinoma of skin of unspecified parts of face
Accepted: ICD 10 code C44.42, Squamous cell carcinoma of skin of scalp and neck
Accepted: ICD 10 code C44.611, Basal cell carcinoma of skin of unspecified upper limb, including shoulder
Accepted: ICD 10 code C44.621, Squamous cell carcinoma of skin of unspecified upper limb, including shoulder
Accepted: ICD 10 code C49.5, Malignant neoplasm of connective and soft tissue of pelvis
Accepted: ICD 10 code D04.60, Carcinoma in situ of skin of unspecified upper limb, including shoulder

The Medical Director determined that the CMC used the incorrect Class in rating the employee's skin cancer impairment (CMC used Class 2 instead of Class 1). The employee's skin disorder signs and symptoms are only intermittently present, with no or few limitation in his performance of activities of daily living, and he requires only intermittent treatment. Such findings are consistent with Class 1 level impairment. The rating is 47% whole person impairment. This may change the final determination in this case.

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

On [redacted], the Final Adjudication Branch issued a final decision to accept the Part E claim for increased impairment and award the employee compensation benefits of [redacted] for 44% increased whole person impairment due to the accepted conditions. (The employee previously received impairment benefits for 25% total whole person impairment. While the CMC provided an initial 47% whole person impairment rating, on [redacted], the CMC provided the office with a supplemental impairment rating due to updated medical documentation for the employee's non-Hodgkin's lymphoma. The supplemental rating resulted in a new total whole person impairment of 69%). There is no further action required in this case.

RECOMMENDATION: Advise QTC of the CMC's incorrect Class usage of the AMA Guides in this case.

6. [redacted]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.4, Other and unspec malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.5, Other and unspec malignant neoplasm of skin of trunk, except scrotum

Accepted: ICD 9 code 496, Chronic airway obstruction, not elsewhere classified
Accepted: ICD 9 code 501, Asbestosis

The Medical Director determined that the CMC did not state in the report that the employee was at maximum medical improvement. This would not have changed the final determination in the case.

I accept the Medical Director's opinion regarding the error found in this impairment rating. However, since the error would not have changed the final determination in this case, there is no follow-up needed by the district office. It is noted that on/about [redacted] the district office requested a clarification report from [redacted] regarding the employee's impairment rating for his lung function. [redacted] provided a clarification report on/about [redacted]. The follow-up report also did not provide a statement regarding maximum medical improvement.

On [redacted] the Final Adjudication Branch issued a final decision to deny the Part E claim for increased impairment. The employee has previously received compensation benefits for 74% total whole person impairment. The whole body impairment rating provided by the CMC in his [redacted] report was 53%. There is no further action required for this case.

RECOMMENDATION: Remind QTC that CMC impairment evaluation reports for non-terminal cases need to include a statement regarding whether the employee has reached maximum medical improvement from the accepted medical conditions.

7. [redacted]
Jacksonville District Office
Causation Review/Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 10 code G46.3, Brain stem stroke syndrome
Accepted: ICD 10 code J12.9, Viral pneumonia, unspecified

The Medical Director's review of this case noted two primary deficiencies including that the CE referral contained unclear questions and that the CMC presented two separate reports that did not respond properly to the CE referral.

Review of this claim demonstrates a complex situation involving development for a survivor's election of benefit. In this case, the CE asked for a CMC opinion on whether there was a nexus between the employee's death and his accepted work-related illnesses. This was necessary to determine the applicability of an election of benefit. In addition, the CE requested that the CMC opine on impairment, if there was no nexus. In two separate reports, the CMC opined that there was a nexus between the accepted conditions in the case. With that opinion, there was no basis for allowing an election between normal survivor lump sum compensation and any impairment award that the employee would have received. However, the CMC went on in another report to offer an impairment rating. Completing an impairment report was in conflict with the request of the CE.

In this claim scenario, the CMC should not have completed an impairment rating. For the purposes of this review, the Medical Director indicated that the overall causation analysis offered by the CMC was well-rationalized, although lacking the reference to the "at least as likely as not" language usually included in causation opinions. The completed impairment rating performed was unnecessary, because the CMC had opined that the death of the employee was linked to the accepted conditions in the claim thereby eliminating an election between survivor and impairment benefits payable to the survivor. The Medical Director suggested that the CE should have posed her questions to the CMC in a more clear fashion to avoid confusion. I agree with the findings of the Medical Director.

On [redacted] FAB issued a final decision to accept the Part E survivor's claim and award the survivor the balance of compensation benefits available in the claim which was [redacted] (The employee previously received [redacted] in compensation benefits for Part E.) There is no further action required for this case.

RECOMMENDATION: Program policy should be reviewed to determine whether CEs are permitted to consolidate different referral types (causation and impairment) into a single referral and, if necessary, clarify this in published procedure. CEs must be provided guidance with regard to how to better communicate questions to the CMC to avoid confusing, sequential questions in their referrals. A discussion should be held with program management in the Jacksonville District Office about this claim and for it to work towards process improvements. QTC should contact the CMC and advise the CMC of the error found regarding the unnecessary impairment. It is important that the CMC properly respond to questions presented by the CE and for the CMC to seek clarification when referral questions are difficult to decipher.

8. [redacted]
Jacksonville District Office
Causation Review
Report date: [redacted]
Condition: Claimed: ICD 9 code 173.52, Squamous cell carcinoma of skin of trunk, except scrotum

The Medical Director determined that the CMC failed to apply the "at least as likely as not" standard.

I accept the Medical Director's opinion regarding the error found in this causation review. The CMC did not use the correct causation standard language "at least as likely as not" when providing his medical opinion. However, the CMC analysis provided sufficient medical rationale to support its negative causation opinion. On the issue of toxic exposure, the CMC noted that the employee's "duration of exposure of 4 years, 10 months as a maintenance mechanic is less than the 6-50 years usually associated with skin cancer causation noted in the medical literature. The nature, frequency, duration, and intensity of exposures is not adequate for causation of his skin cancer."

On July 18, 2017, FAB issued a final decision to deny the Part E claim for anal carcinoma. There is no further action required on this case.

RECOMMENDATION: Remind QTC that CMC medical reports for causation reviews should include the appropriate causation standard language "at least as likely as not."

9. [redacted]
Cleveland District Office
Supplemental Review (Impairment Evaluation)
Report date: [redacted]
Condition: Accepted: ICD 9 code 493, Asthma
Accepted: ICD 9 code 496, Chronic airway obstruction, not elsewhere classified

The Medical Director determined that the CMC's explanation of how he applied Table 5-12 on Page 107 is hard to follow. The CMC stated that Class 1 level impairment carries whole person impairment (WPI) of 0%-9%. However, a review of Table 5-12 notes that an individual with Class 1 level impairment carries WPI of 0%. Furthermore, the CMC determined that based on Class 1 level impairment, the employee is entitled to 10% WPI. The CMC also incorrectly applied the Combined Values Chart to combine two ratings for the same organ system (asthma and COPD) to yield a 33% rating. The impairment rating can be based on **either** the WPI rating for the condition of COPD or the WPI rating for the condition of asthma, but not both.

I accept the Medical Director's opinion regarding the errors found in this supplemental impairment review. The CMC provided a medical report on [redacted]*, where he stated that he needed additional medical documentation before an impairment rating could be performed. The district office forwarded the additional records to the CMC, who then provided a supplemental report on* [redacted]*, which yielded a 33% whole person impairment rating.*

The employee disagreed the CMC's impairment evaluation and obtained an evaluation from her personal physician. The employee's personal physician provided an impairment rating of 39%, which represents 6% increase from the CMC impairment evaluation. FAB issued a final decision to accept the Part E claim for 6% impairment. Since the employee's impairment rating was based on her personal physician's rating, there is no further action needed for this case.

RECOMMENDATION: QTC should contact the CMC and advise of errors found in impairment evaluation and ensure that future impairment evaluations of this kind are determined correctly.