U.S. Department of Labor

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

MEMORANDUM

DATE: May 18, 2017

TO: RACHEL LEITON
Director, Division of Energy Employees
Occupational Illness Compensation

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

RE: 3RD QUARTER FY 2016 CMC AUDIT REPORT

Below is the analysis of eight cases determined to have a deficient Contract Medical Consultant report.

1. [redacted]
Cleveland District Office
Impairment Evaluation
Reviewed on April 27, 2016
Condition: Accepted: ICD 9 code 174.9, Malignant neoplasm of breast (female), unspecified
Accepted: ICD 9 code 428, Heart failure
Accepted: ICD 9 code 562.00, Diverticulosis of small intestine (without mention of hemorrhage)
Accepted: ICD 9 code 562.01, Diverticulitis of small intestine (without mention of hemorrhage)
Accepted: ICD 9 code 726, Peripheral enthesopathies and allied syndromes
Accepted: ICD 9 code 733, Other disorders of bone and cartilage

The Reviewer states that the CMC did not answer each of the claims examiner's questions. The CMC applied Table 8-2 on Page 178 of "The AMA Guides" incorrectly when considering the claimant's disability due to her history of breast cancer and the CMC failed to address the patient's adhesive capsulitis of the left shoulder when calculating whole person impairment.

The Reviewer is correct in that the CMC did not provide an impairment rating for the accepted condition of left shoulder adhesive capsulitis. Since the Reviewer is well-versed in the use of the AMA Guides, I would accept his opinion that the CMC incorrectly applied Table 8-2 of the Guides when assessing the claimant's impairment due to the accepted condition of breast cancer.

The FAB issued a final decision on January 11, 2017 awarding the employee $5,000 in compensation benefits for 2% increased impairment. However, since the impairment rating did not include a rating for the left shoulder adhesive capsulitis and the Reviewer indicates that Table 8-2 was used incorrectly in assessing breast cancer, the district office should refer this case to the CMC to provide an updated/corrected rating for those conditions. The Reviewer should be consulted to determine the correct application of the Table for breast cancer.

I would also recommend that the contractor be notified of the CMC's requirement to answer all questions posed by the claims examiner and instruct the CMC in the appropriate use of the AMA Guides.

2. [redacted]
Jacksonville District Office
Impairment Evaluation
Reviewed on May 2, 2016
Condition: Accepted: ICD 9 code C25.9, Malignant neoplasm of pancreas, unspecified

The Reviewer states that the SOAF lacks a specific question for the CMC. The CMC failed to clearly articulate how he reached his final conclusion of 90% WPI.

A review of the question posed to the CMC shows that the CE requested that the CMC advise if the employee's accepted condition is at MMI, and if so, provide the whole body impairment rating for the accepted condition in accordance with the 5th Edition of the AMA Guides, with specific page and table references and rationale and objective findings to support the conclusions. According to the CMC, the purpose of the review is to address the issues of maximum medical improvement and permanent partial impairment with respect to the accepted condition. The CMC opined that the employee is at MMI and has a 90% WPI based on Table 5-11 on page 106 of the 5th edition of the AMA Guides, due to his terminal status and inability to care for self and total confinement to a bed or chair.

The FAB issued a final decision on May 6, 2016 awarding the employee $225,000 for 90% whole person impairment benefits. I do not see that any additional action is needed at this time.

3. [redacted]
Seattle District Office
Causation Review
Reviewed on April 1, 2016
Conditions: Claimed: ICD 10 code I27.0, Primary pulmonary hypertension
Claimed: ICD 10 code J45.40, Moderate persistent asthma, uncomplicated

The Reviewer states that the CMC did not appropriately apply the "at least as likely as not" standard. [redacted] consistently fails to use the "at least as likely as not" standard in this report.

*A review of the questions shows that the CMC answered all the questions, but failed to use the "at least as likely as not" standard in his report. The CMC definitively stated that there is no evidence to support a relationship between the diagnosed condition and occupational exposure. The CMC provided responses of "no", but should have used "**not** at least as likely as not" when responding to the questions. The FAB issued a final decision on July 26, 2016 to deny the Part E claim for asthma, chronic bronchitis, scarring of the lungs, and pulmonary hypertension and has cited the CMC's report in the decision.*

Since a final decision has been issued to deny the Part E claim, I would recommend that the contractor be notified of the CMC requirement to use appropriate program language in their reports, specifically consulting with Dr. [redacted] *about the report in question.*

4. [redacted]
Denver District Office
Impairment Evaluation
Reviewed on May 19, 2016
Condition: Accepted: ICD code 156.2, Malignant neoplasm of ampulla of vater
Accepted: ICD code 157.3, Malignant neoplasm of pancreatic duct
Accepted: ICD 10 code C78.7, Secondary malignant neoplasm of liver and intrahepatic bile duct

The Reviewer states that the CMC's medical opinion was not based upon the accepted facts of the case as listed in the SOAF. The CMC included conditions which have not been accepted in his impairment rating. [redacted], DO, MPH included conditions which have not been accepted in his impairment rating.

The initial referral to the CMC indicated that the claim was accepted for pancreatic cancer, but liver cancer and hearing loss were not accepted. The CMC was to evaluate impairment for pancreatic cancer. In an initial report (April 19, 2016), the CMC requested additional medical records from the employee before an impairment rating could be performed. The office received additional medical evidence diagnosing liver cancer and accepted liver cancer as a consequential condition. The case was again referred to the CMC for impairment evaluation based on

pancreatic and liver cancer. The CMC determined a 79%WPI based on pancreatic and liver cancer.

The FAB issued a final decision on May 25, 2016 accepting the Part E impairment claim for 79% WPI for pancreatic and liver cancer and denying hearing loss. The employee was awarded $197,500. I am not sure what conditions that have not been accepted the Reviewer found in the report. I do not see any additional actions that need to be taken at this time.

5. [redacted]
Seattle District Office
Causation Review
Reviewed on May 13, 2016
Condition: Claimed: ICD 9 code 389.18, Sensorineural hearing loss, bilateral
Claimed: ICD 9 code 493.30, Asthma unspecified
Claimed: ICD 10 code L25.9, Unspecified contact dermatitis, unspecified cause

The Reviewer states that the CMC did not appropriately apply the "at least as likely as not" standard. The CMC failed to use the "as likely as not" standard in his response to the claims examiner.

*A review of the question posed to the CMC shows that the CMC answered the question, but failed to use the "at least as likely as not" standard in his report. The CMC definitively stated that there is no clear date of when asthma was diagnosed; there are no reports from the employer showing that the employee suffered asthma as a result of his employment; and there was no evidence to show that work was a factor in the employee's asthma. The CMC's responses should have used "**not** at least as likely as not" when responding to the question. It is noted that the CMC stated that the condition of asthma is accepted in this claim; however, that is incorrect.*

The district office sent the case for an IH referral. The IH's response (January 19, 2017) is on file. The case appears to be in posture for a recommended decision regarding the asthma claim.

I would recommend that the contractor be notified of the CMC's requirement to use appropriate program language in his report, specifically consulting with Dr. [redacted] *about the report in question.*

6. [redacted]
Seattle District Office
Impairment Evaluation
Reviewed on March 19, 2016
Condition: Accepted: ICD 9 code 203.0, Multiple myeloma

The Reviewer states that the combined tables were not used appropriately in this case where multiple organs or functions were rated and the CMC did not provide a whole body impairment rating for only the accepted conditions. The Reviewer stated there was no need to use the combined values table; there was no need to rate the claimant's anemia. The CMC does not understand the EEOICP's policy on apportionment.

Since the Reviewer is well-versed in the use of the AMA Guides, I would accept his opinion that the combined tables were not used appropriately in this case and that there was no need to rate the claimant's anemia. The CMC provided a 67% whole person impairment rating for the accepted myeloma (65% myeloma; 5% anemia). The CMC stated that in order to avoid apportionment, the anemia is also considered as part of the Hematopoietic System.

The FAB has issued a final decision on September 1, 2016 awarding the survivor (wife) $125,000 in compensation benefits under Part E for myeloma and denying the Part B claim for multiple myeloma and bladder cancer and Part E claim for bladder cancer as maximum benefits have been paid under those parts.

The analysis of this case shows that the employee died before the CMC impairment rating occurred. Thereafter, the survivor filed a separate claim, which DEEOIC accepted and paid under Part E. DEEOIC denied the Part B claim survivor claim on the grounds that the employee had received the maximum allotment of compensation. As such, there is no corrective action specifically needed in the case because the impairment is no longer applicable to any payment of compensation. The only remaining action recommended in this situation is notifying the contractor of the need from the CMC to apply the AMA Guides/Tables appropriately.

7. [redacted]
Seattle District Office
Causation Review
Reviewed on April 13, 2016
Condition: Accepted: ICD 9 code 202.0, Nodular lymphoma
Accepted: ICD 9 code 279.3, Unspecified immunity deficiency
Accepted: ICD 9 code 346.80, Other forms of migraine, without mention of intractable migraine without mention of status migrainosus
Accepted: ICD 9 code 381.1, Chronic serous otitis media
Accepted: ICD 9 code 388.70, Otalgia, unspecified
Accepted: ICD 9 code 733.9, Other and unspecified disorders of bone and cartilage

Claimed: ICD 10 code M81, Osteoporosis without current pathological fracture
Claimed: ICD 10 code M85, Other disorders of bone density and structure

The Reviewer states that the CMC did not answer each of the claims examiner's questions. The CMC answered questions 1-4, but did not answer question 5.

This is actually a dual Causation and Impairment Review. The CE asks questions regarding impairment (1, 3 and 4) and causation (2 and 5). A review of the case file in OIS shows that there are three CMC reports dated April 13, 2016 – one for the impairment review [redacted] *and two for the causation review* [redacted]*. Apparently the Reviewer was not provided with the CMC's causation review reports where the CMC answers "yes" to question 2 regarding whether it is at least as likely as not that the newly claimed conditions were caused, contributed to, or aggravated by the accepted conditions and "yes" to question 5 regarding whether the accepted conditions caused or contributed to the employee's wage loss for 2014-2015. The documentation in this case is rather confusing in that there appears to be two sets of questions from the CE (one referral has 4 questions and one referral has 5 questions) and the three CMC reports.*

The FAB has issued a final decision on June 1, 2016 to accept the consequential conditions of bone and cartilage disorder under Parts B and E; 17% impairment under Part E; and wage loss for 2014 and 2015. The employee has received compensation of $65,000 ($35,000 impairment; $30,000 wage loss).

I do not see that any additional action needs to be taken at this time. However, I would advise the CE to be consistent when preparing the questions to the CMC.

8. [redacted]
Seattle District Office
Causation Review
Reviewed on April 15, 2016
Condition: Accepted: ICD 9 code 186.9, Malignant neoplasm of other and unspecified testis
Claimed: ICD 9 code 197.0, Secondary malignant neoplasm of lung

The Reviewer states that the CMC did not answer each of the claims examiner's questions and the CMC did not appropriately apply the "at least as likely as not" standard. [redacted] MD did not provide the first date of diagnosis or an appropriate ICD 9 code for the diagnosis claimed by [redacted]. The SOAF was unusually brief. It did not include all the information usually included in a SOAF.

A review of the question posed to the CMC shows that the claims examiner asked whether the evidence supported a diagnosis of metastatic lung cancer from a prior testicular cancer or other primary cancer and if so, provide a first date of diagnosis and the ICD-9 code. A review of the

CMC's report shows that while he affirmed the diagnosis of metastatic lung cancer, he did not provide the date of diagnosis or ICD-9 code.

It is noted that the SOAF is very brief and could use more information regarding the employee's claim.

The FAB issued a final decision on June 9, 2016 to accept the Part B and E claim for metatstatic lung cancer and deny the Part B claim for testicular cancer. I do not see that any additional action needs to be taken at this time.

I would recommend that the contractor be notified of the CMC's requirement to answer all of the questions posed by the claims examiner.