U.S. Department of Labor

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

MEMORANDUM

DATE: October 5, 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: CMC AUDIT REPORT – 1st Quarter 2018

Below is the analysis of ten (10) 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]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 10 code E11.42, Type 2 diabetes mellitus with diabetic polyneuropathy
Accepted: ICD 10 code E11.65, Type 2 diabetes mellitus with hyperglycemia
Accepted: ICD 10 code I25.10, Atherosclerotic heart disease of native coronary artery without angina pectoris
Accepted: ICD 10 code J45.901, Unspecified asthma with (acute) exacerbation

The Medical Director's findings are as follows: When rating the claimant's asthma, the CMC mistakenly applied Table 5-2a on Page 95 in the "AMA Guides™ to the Evaluation of Permanent Impairment, Fifth Edition" to determine the claimant's predicted normal forced expiratory volume in the first second (FEV1); he should have used Table 5-4a on Page 97. This would have yielded a post-bronchodilator FEV1 of 105% of predicted, a score of 0 for post-bronchodilator FEV1 on Table 5-9 on Page 104, and a total asthma score of 5 (10%-25% WPI) on Table 5-10 on Page 104. In addition, the CMC inappropriately applied Table 13-16 on Page 338 when rating the claimant's diabetic polyneuropathy; Table 13-16 is used to rate upper extremity dysfunction from

any lesion in the brain.). Section 13.6 is germane. This may change the final determination in this case.

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

FAB issued a final decision on [redacted] *to accept the employee's Part E claim for 29% whole person impairment* [redacted]. *The CMC report of* [redacted] *provided a whole person impairment rating of 59%. FAB issued a final decision on* [redacted] *to accept the employee's Part E claim for 59% whole person impairment (30% increase). The employee received 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 a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

2. [redacted]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 141.0, Malignant neoplasm of base of tongue
Accepted: ICD 9 code 162.3, Malignant neoplasm of upper lobe, bronchus or lung
Accepted: ICD 9 code 244.1, Other post-ablative hypothyroidism
Accepted: ICD 9 code 302.72, Psycho-sexual dysfunction with inhibited sexual excitement
Accepted: ICD 9 code 357.7, Polyneuropathy due to other toxic agents
Accepted: ICD 9 code 427.31, Atrial fibrillation
Accepted: ICD 9 code 478.30, Paralysis of vocal cords or larynx, unspecified
Accepted: ICD 9 code 494.0, Bronchiectasis without acute exacerbation
Accepted: ICD 9 code 528.9, Other and unspecified diseases of the oral soft tissues
Accepted: ICD 9 code 782.0, Disturbance of skin sensation
Accepted: ICD 9 code 787.20, Dysphagia, unspecified
Accepted: ICD 9 code 998.31, Disruption of internal operation (surgical) wound

The Medical Director's findings are as follows: The CMC inappropriately used Table 13-16 on Page 338 to rate the claimant's "left brachial plexopathy" (ICD 9 codes 357.7, 782.0, and 998.31). These diagnoses are consequences of the surgery and radiation therapy employed to treat the claimant's lung cancer. In accordance with Section 13-6, "Tables 13-16 and 13-17 are used to rate upper extremity dysfunction from any lesion in the brain." To evaluate distal nerve traumatic injury, the CMC should have referred to Chapter 16, The Upper Extremities. Section 13.1 is germane. While the CMC appropriately rated the claimant's tongue cancer and consequential vocal cord paralysis, dysphagia, and velo-pharyngeal incompetence using Chapter 11, Tables 11-7

(Dietary Restrictions), 11-8, (Voice/Speech) and 11-9 (Voice Speech Related to WPI), he inappropriately used Chapter 6, Table 6-6 to rate the claimant's stoma. Chapter 6 is used to rate impairment of the digestive system, which the claimant does not have. The use of both Table 11-7 and Table 6-6 effectively gives the claimant two ratings for the same conditions. 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 employee has received compensation benefits for 32% whole person impairment [redacted]. The CMC report dated [redacted] provided a whole person impairment rating of 86%. On [redacted] FAB issued a final decision to accept the employee's Part E claim for 86% whole person impairment (54% increase for [redacted]).

RECOMMENDATION: Recommend 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.

3. [redacted]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 337.00, Idiopathic peripheral autonomic neuropathy, unspecified
Accepted: ICD 9 code 511.0, Pleurisy without mention of effusion or current tuberculosis
Accepted: ICD 10 code C34.90, Malignant neoplasm of unspecified part of unspecified bronchus or lung

The Medical Director's findings are as follows: The CMC was asked to review the claimant's medical records and independently determine a WPI rating, which takes into consideration each of the claimant's accepted conditions (lung cancer, peripheral neuropathy, and asbestos-related pleural disease). Instead, the CMC took the WPI rating for the claimant's peripheral neuropathy determined by another physician more than three years earlier and combined it with his own rating of the claimant's other conditions (lung cancer and asbestos-related pleural disease) to determine a WPI rating-which may or may not accurately reflect the claimant's level of impairment. Finally, the CMC incorrectly used the Combined Values Chart to combine two ratings for the same organ system (the respiratory system). In accordance with Section 5.9 on Page 106, the CMC correctly placed the claimant in Class 4 on Table 5-12 on Page 107 and assigned him a WPI of 51% for his lung cancer. Then, using the results of a pulmonary function test (PFT) administered on [redacted] the CMC correctly placed the claimant in Class 3 on Table 5-12 on Page 107 and assigned him a WPI of 46% for his asbestos-

related pleural disease (ICD 9 code 511.0). The employee's respiratory impairment can be based on either the accepted illness of lung cancer or the accepted illness of asbestos related pleural disease, but not both illnesses. 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 employee has received compensation benefits for 80% whole person impairment [redacted] *The CMC report dated* [redacted] *provided a whole person impairment rating of 92%. The district office requested a clarification report from the CMC, which he provided (report dated* [redacted]*. On* [redacted] *FAB issued a final decision to accept the employee's Part E claim for 92% increased whole person impairment (12% increase for* [redacted]*.*

RECOMMENDATION: Recommend 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.

4. [redacted]
Denver District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 401.9, Unspecified essential hypertension
Accepted: ICD 9 code 416.9, Chronic pulmonary heart disease, unspecified
Accepted: ICD 9 code 427.31, Atrial fibrillation
Accepted: ICD 9 code 502, Pneumoconiosis due to other silica or silicates
Accepted: ICD 9 code 505, Pneumoconiosis, unspecified
Accepted: ICD 9 code 508.1, Chronic and other pulmonary manifestations due to radiation
Accepted: ICD 9 code 515, Post-inflammatory pulmonary fibrosis

The Medical Director's findings are as follows: The claimant is 79 years old, in hospice, and suffering from dementia, severe congestive heart failure (ejection fraction of only 25%), and a variety of other ailments that are neither accepted nor consequential accepted conditions. The CMC did not rate the claimant's accepted conditions of silicosis (ICD 9-CM 502), pneumoconiosis (ICD 9-CM 505), and pulmonary fibrosis (ICD 9-CM 515) at MMI using the most recent, valid PFT data available [redacted] and Table 5-12 on Page 107 in the "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition". Instead, he seemed to have arbitrarily chose a WPI rating of 85% based on a reference to Table 1-2 on Page 4. The most recent PFT data show "Normal spirometry, normal lung volumes, mild reduction in diffusion capacity adjusted to hemoglobin." In addition, the claimant's hemoglobin oxygen saturation was

91% while he was breathing room air when he was discharged from hospital on [redacted]. In addition, the CMC inappropriately rated the claimant for valvular heart disease (aortic stenosis) using Table 3-5 on Page 30, but aortic stenosis is not one of the claimant's accepted conditions. Finally, the CMC did not rate the claimant's accepted atrial fibrillation (ICD 9-CM 427.31) using Section 3.7 and Table 3-11 on Page 56, and pulmonary hypertension (ICD 9-CM 401.9) and cor pulmonale (ICD 9-CM 416.9) using Section 4.4 and Table 4-6 on Page 79. 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 employee has received compensation benefits for 56% whole person impairment [redacted]. The CMC report dated [redacted] provided a whole person impairment rating of 96%. On [redacted] FAB issued a final decision to accept the employee's Part E claim for 96% increased whole person impairment (40% increase). The employee was awarded compensation benefits of [redacted].

RECOMMENDATION: This is a terminal case. Recommend 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.

5. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 172.4, Malignant melanoma of skin of scalp and neck
Accepted: ICD 9 code 172.5, Malignant melanoma of skin of trunk, except scrotum
Accepted: ICD 9 code 173.21, Basal cell carcinoma 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 173.31, Basal cell carcinoma 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 173.42, Squamous cell carcinoma of scalp and skin of neck
Accepted: ICD 9 code 173.5, Other and unspecified malignant neoplasm of skin of trunk, except scrotum
Accepted: ICD 9 code 173.51, Basal cell carcinoma of skin of trunk, except scrotum
Accepted: ICD 9 code 173.6, Other and unspecified malignant neoplasm of skin of upper limb, including shoulder

Accepted: ICD 9 code 173.61, Basal cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.62, Squamous cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.71, Basal cell carcinoma of skin of lower limb, including hip
Accepted: ICD 9 code 197.0, Secondary malignant neoplasm of lung
Accepted: ICD 9 code 232.3, Carcinoma in situ of skin of other and unspecified parts of face
Accepted: ICD 9 code 232.4, Carcinoma in situ of scalp and skin of neck
Accepted: ICD 9 code 232.5, Carcinoma in situ of skin of trunk, except scrotum
Accepted: ICD 9 code 232.6, Carcinoma in situ of skin of upper limb, including shoulder
Accepted: ICD 9 code 238.2, Neoplasm of uncertain behavior of skin
Accepted: ICD 9 code 249.0, Secondary diabetes mellitus without mention of complication
Accepted: ICD 9 code 365.11, Primary open angle glaucoma
Accepted: ICD 9 code 426.7, Anomalous atrioventricular excitation
Accepted: ICD 9 code 428.0, Congestive heart failure, unspecified
Accepted: ICD 9 code 715.11, Osteoarthrosis, localized, primary, shoulder region
Accepted: ICD 9 code 721.0, Cervical spondylosis without myelopathy
Accepted: ICD 9 code 722.83, Post-laminectomy syndrome, lumbar region
Accepted: ICD 9 code 957.1, Injury to other specified nerve(s)
Accepted: ICD 9 code V02.62, Hepatitis C carrier

The Medical Director's findings are as follows: The CMC was asked to review the claimant's medical records and independently determine a WPI rating, which takes into consideration each of the claimant's accepted conditions (multiple skin cancers, diabetes mellitus, glaucoma, cardiac arrhythmia, osteoarthrosis, post-laminectomy syndrome, cervical spondylosis, nerve damage, hepatitis C, and lung cancer). Instead, the CMC merely accepted the WPI rating determined by another physician more than two years earlier, which may or may not accurately reflect the claimant's current level of impairment. 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 employee has received compensation benefits for 95% whole person impairment [redacted]
The CMC report dated [redacted] *provided a 95% whole person impairment rating.*
On [redacted] *FAB issued a final decision to deny the employee's Part E claim for increased impairment.*

RECOMMENDATION: Recommend 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.

6. [redacted]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 493.90, Asthma, unspecified type, unspecified
Accepted: ICD 9 code 496, Chronic airway obstruction, not elsewhere classified

The Medical Director's findings are as follows: The CMC did not provide a meaningful clinical summary--only a recitation of the claimant's [redacted] PFT data. While the CMC did accurately determine the claimant's WPI rating for COPD using Table 5-12 on Page 107 of the "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition", he did not accurately determine the claimant's WPI rating for asthma using Tables 5-9 and 5-10 on Page 104. When applying Table 5-9, the CMC appears to have appropriately assigned a score of 3 for post-bronchodilator FEV1, neglected to assign any score for either reversibility or degree of airway hyper-responsiveness, and serendipitously assigned an appropriate score of 2 for medications despite his mistaken belief that the claimant is using an inhaled corticosteroid (The claimant uses tiotropium bromide and albuterol sulfate--neither of which is a corticosteroid.). Thus, when the CMC applied Table 5-10 to determine the claimant's WPI rating for asthma, he assigned a score of 5; the correct score is 7 (Class 3). Finally, the CMC inappropriately used the Combined Values Chart on Pages 604-606 to combine two ratings for the same organ system (COPD and asthma) to yield a final WPI rating of 58%. The employee's respiratory impairment can be based on either the accepted illness of asthma or the accepted illness of COPD, but not both illnesses. 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 CMC report dated [redacted] provided a 58% whole person impairment rating. FAB issued a final decision on [redacted] to accept the employee's Part E claim for 58% whole person impairment. The employee received 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 a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

7. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 151.9, Malignant neoplasm of stomach, unspecified site
Accepted: ICD 10 code J44.9, Chronic obstructive pulmonary disease, unspecified

The Medical Director's findings are as follows: The CMC did not state that the claimant had achieved MMI. This would not have changed the final determination in this case.

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

The employee has received compensation benefits for 5% whole person impairment [redacted]. *The CMC report dated* [redacted] *provided a 5% whole person impairment rating. FAB issued a final decision on* [redacted] *to deny the employee's Part E claim for increased impairment. Since the Medical Director's findings would not have changed the final determination in this case and FAB has issued a final decision to deny the claim for increased impairment, there is no further action required for this case.*

RECOMMENDATION: Discuss the errors in this report with QTC so the CMC can be advised of the deficiencies.

8. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.5, Other and unspecified malignant neoplasm of skin of trunk, except scrotum
Accepted: ICD 9 code 173.6, Other and unspecified malignant neoplasm of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.62, Squamous cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 501, Asbestosis
Accepted: ICD 10 code C44.622, Squamous cell carcinoma of skin of right upper limb, including shoulder
Accepted: ICD 10 code C44.629, Squamous cell carcinoma of skin of left upper limb, including shoulder

The Medical Director's findings are as follows: The CMC was asked to review the claimant's medical records and independently determine a WPI rating, which takes into consideration each of the claimant's accepted conditions (multiple skin cancers and asbestosis). Instead, the CMC merely accepted the WPI rating previously determined

by another physician, which may or may not accurately reflect the claimant's current level of impairment. The appropriate approach would have been to note the absence of current PFT data in the record and request it so that a current WPI rating can be determined. 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 employee has received compensation benefits for 22% whole person impairment [redacted]. The CMC report of [redacted] provided a whole person impairment rating of 22%. On [redacted], FAB issued a final decision to deny the Part E claim for increased impairment.

RECOMMENDATION: Recommend 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.

9. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 172.5, Malignant melanoma of skin of trunk, except scrotum
Accepted: ICD 10 code C85.89, Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
Accepted: ICD 10 code G62.0, Drug-induced polyneuropathy

The Medical Director's findings are as follows: When determining a WPI rating for the claimant's upper extremity peripheral polyneuropathy, the CMC inappropriately applied Table 13-17 on Page 340 of the "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition." In accordance with Section 13.6 on Page 338, "Table 13-17 is used to rate upper extremity dysfunction from any lesion in the brain." Tables 13-23 and 13-24 are used to rate peripheral nerve impairments. Section 13.9c on Page 347 is germane. When rating the claimant's skin cancer, the CMC inappropriately placed her in Class 4 (55%-84% impairment) on Table 8-2 on Page 178. The claimant's melanoma was completely removed on [redacted]--leaving her with a scar from the treatment and the need for regular screening, but her history of skin cancer has no impact on her activities of daily living. Therefore, she falls into Class 1 (0%-9% impairment) because her skin disorder signs and symptoms are only intermittently present and she has no or few limitations in the performance of ADL and she requires only intermittent 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 employee has received compensation benefits for 48% whole person impairment [redacted] *The CMC report of* [redacted] *provided a whole person impairment rating of 86%. On* [redacted] *FAB issued a final decision to accept the Part E claim for 86% whole person impairment (38% increase) and award the employee compensation benefits of* [redacted]

The employee died on [redacted] *Since the employee received the award for increased impairment and she has now passed away, no further action is required.*

RECOMMENDATION: Discuss the errors in this report with QTC so the CMC can be advised of the deficiencies.

10. [redacted]
Cleveland District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 153.1, Malignant neoplasm of transverse colon
Accepted: ICD 9 code 357.3, Polyneuropathy in malignant disease
Accepted: ICD 10 code C44.129, Squamous cell carcinoma of skin of left eyelid, including canthus
Accepted: ICD 10 code H90.3, Sensorineural hearing loss, bilateral

The Medical Director's findings are as follows: The CMC was asked to review the claimant's medical records and independently determine a WPI rating, which takes into consideration each of the claimant's accepted conditions (colon cancer, neuropathy, hearing loss, and skin cancer). Instead, he misapplied Table 11-2 on Pages 248-249 of the "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition" to conclude that the employee was entitled to impairment benefits for hearing loss based on 3.4% binaural impairment. However, because the employee's decibel sum hearing loss in the right ear was calculated at less than 100, the employee's binaural impairment is calculated at 0%. The CMC also did not provide an impairment rating for the employee's colon cancer, and simply noted in his report that there was no basis for a higher rating than the previously calculated 55% WPI for colon cancer. 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 employee has received compensation benefits for 55% whole person impairment [redacted]. *The CMC report of* [redacted] *provided a whole person impairment of 55%. Following a recommended decision to deny the Part E claim for increased impairment and the employee's objection to the recommended decision, a remand order was issued on* [redacted] *due to receipt of new medical documentation. The CMC then provided a supplemental report dated* [redacted] *which provided a whole person impairment rating of 60%. On* [redacted]

FAB issued a final decision to accept the employee's Part E claim for 5% increased whole person impairment. The employee 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 a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.