United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 12-1878**
	)	**Issued: March 18, 2013**
U.S. POSTAL SERVICE, CARRIER ANNEX, Lorain, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 13, 2012 appellant, through his attorney, filed a timely appeal from the June 25, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant received an overpayment of compensation; and (2) whether OWCP properly denied waiver of recovery.

FACTUAL HISTORY

On October 18, 2005 appellant, a 41-year-old letter carrier, sustained a traumatic injury in the performance of duty. As he attempted to deliver mail to a residence, a dog jumped on the metal screen door. The door swung open, but appellant blocked it with his right arm, injuring his

[1] 5 U.S.C. § 8101 *et seq.*

elbow.[2] OWCP accepted that appellant sustained a right elbow contusion. It later accepted a lesion of the right ulnar nerve. A nerve conduction study and electromyogram in 2006 was found to be consistent with right ulnar neuropathy across the elbow.

Dr. Daryl L. Miller, a Board-certified orthopedic surgeon and OWCP second opinion physician, evaluated appellant for permanent impairment in 2010. Active range of right elbow motion was 81 degrees flexion, 19 degrees extension, 30 degrees pronation and 19 degrees supination. There was some question regarding volitional limitation of motion.

Dr. Miller noted that it would have been more appropriate to quantify objective findings with a nerve conduction study, but appellant refused to be tested. The right upper extremity showed no significant visible atrophy. Appellant appeared to have intact sensation in all digits, though there were subjective complaints, so it was difficult for Dr. Miller to determine whether this was in fact an impairment or simply subjective. He also reported persistent pain that was difficult to control.

Using Table 15-23, page 449 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009), Dr. Miller found that appellant had a four percent impairment of the right upper extremity due to entrapment/compression neuropathy. There were no current test findings, but appellant reported persistent pain, and physical findings were between normal and decreased sensation. Appellant's functional scale was moderate. An OWCP medical adviser agreed with Dr. Miller's rating.

On May 14, 2010 OWCP issued a schedule award for a four percent impairment of appellant's right upper extremity.

An OWCP hearing representative found on January 6, 2011 that further development of the medical evidence was warranted.

On January 10, 2011 Dr. H.P. Hogshead, a medical adviser, reviewed the record and determined that appellant had a 10 percent upper extremity impairment due to loss of elbow motion, based on measurements obtained in 2007. He explained that the sixth edition of the A.M.A., *Guides* no longer recognized weakness in grip strength, as it was too subjective. As it was estimated under the previous edition of the A.M.A., *Guides* to be a 20 percent impairment, this was acceptable "in the interest of resolving the matter." Combining appellant's 10 percent motion loss impairment with a 20 percent weakness impairment, Dr. Hogshead concluded that appellant had a 28 percent total impairment of the right upper extremity.

On April 5, 2011 OWCP issued a schedule award for an additional 24 percent impairment of the right upper extremity, or a total of 28 percent. A hearing representative again found, by a September 30, 2011 decision, that further medical development was warranted.

On October 6, 2011 Dr. James W. Dyer, a medical adviser, explained that entrapment neuropathy could not be used to evaluate impairment because the neuropathy found in the 2006

[2] Appellant previously had an open reduction and internal fixation of the right elbow and five prior elbow surgeries, including ulnar nerve transpositions.

electrodiagnostic study reflected a chronic preexisting ulnar nerve lesion and was not related to the accepted contusion in 2005. He advised that range of motion was the most accurate, objective method for rating appellant's upper extremity impairment. Using the measurements reported by Dr. Miller, Dr. Dyer found that appellant had a 15 percent impairment of the right upper extremity under Table 15-33, page 474 of the A.M.A., *Guides*. As a stand-alone approach, this was considered more favorable to appellant than a five percent impairment due to his previous olecranon fracture,[3] a three percent impairment due to contusion,[4] a nine percent impairment due to ulnar nerve entrapment or compression neuropathy,[5] or a seven percent impairment due to ulnar nerve neuropathy with sensory impairment above the mid-forearm,[6] all of which were the maximum possible ratings for those conditions.

On December 30, 2011 OWCP issued a decision finding that appellant had a 15 percent impairment of his right upper extremity. As appellant was previously awarded 28 percent, OWCP found no entitlement to an additional schedule award.

OWCP made a preliminary determination on February 2, 2012 that appellant received a $28,495.81 overpayment because he was granted schedule awards for a 28 percent impairment but only had 15 percent. It explained its calculation and found that he was without fault in the matter.

At a prerecoupment hearing, appellant testified that he had a monthly net income of $6,222.00 and expenses of $2,805.65 to $2,845.64. He later submitted a statement advising that his monthly income was $6,216.00 and his expenses were $3,585.63 to $3,720.63.

In a June 25, 2012 decision, OWCP found that appellant had no more than a 15 percent right upper extremity impairment. It finalized the overpayment determination. OWCP found that appellant received a $28,495.81 overpayment because he received schedule awards for a 28 percent impairment, but the weight of the medical evidence established that his impairment was only 15 percent. It denied waiver of recovery on the grounds that he was financially capable of repaying the debt from excess monthly income and he did not relinquish a valuable right or change his position for the worse as a result of the overpayment. Noting that appellant was not receiving continuing compensation benefits, OWCP determined that he should repay the debt by monthly payments of $400.00.

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[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* 399 (6th ed. 2009) (Table 15-4).

[4] *Id.* at 398 (Table 15-4).

[5] *Id.* at 449 (Table 15-23).

[6] *Id.* at 443 (Table 15-21).

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[7] and the implementing regulations[8] set forth the number of weeks of compensation payable to employees who sustain permanent impairment from the loss or loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[9]

For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP has adopted by regulation the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[10] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[11]

ANALYSIS -- ISSUE 1

OWCP paid schedule awards for a 28 percent impairment of appellant's right arm. It subsequently found that he had only a 15 percent impairment and was therefore overpaid by $28,495.81. The Board is not persuaded that OWCP properly determined appellant's impairment, which it based on range of motion.

Under the sixth edition of the A.M.A., *Guides*, diagnosis-based impairment is the method for evaluating impairment. Range of motion, by contrast, is used primarily as an adjustment factor. It is used to determine actual impairment values only when a diagnosis-based impairment grid permits its use as a stand-alone option or when no other diagnosis-based impairment sections are applicable.[12]

OWCP accepted appellant's claim for right elbow contusion and a right ulnar nerve lesion. In addition, the record indicates that he had a previous right olecranon fracture. Thus, several diagnosis-based impairment sections may apply.

The first step in evaluating impairment is to choose the diagnosis that is most applicable for the region being assessed. If more than one diagnosis can be used, the highest causally-related impairment rating should be used; this will generally be the more specific diagnosis.

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[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[10] 20 C.F.R. § 10.404; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[12] A.M.A., *Guides* 387, 461.

Typically, one diagnosis will adequately characterize the impairment and its impact on activities of daily living.[13]

Dr. Miller, the second-opinion orthopedic surgeon, chose the diagnosis of ulnar nerve lesion. He evaluated impairment due to entrapment neuropathy, applying section 15.4f, page 432, and Table 15-23, page 449. Dr. Dyer incorrectly advised that entrapment neuropathy could not be used because the findings of the 2006 electrodiagnostic study reflected a chronic preexisting ulnar nerve lesion and was not related to the accepted contusion in 2005.

It is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[14] Moreover, OWCP had expanded its acceptance of appellant's claim to include the diagnosis of right ulnar nerve lesion. Accordingly, it appears that Dr. Dyer erred by discounting any diagnosis-based impairment due to the accepted nerve lesion.

The A.M.A., *Guides* offers two methods for evaluating peripheral nerve impairment. Depending on its nature, such impairment may be evaluated using the method for isolated traumatic nerve injury under section 15.4e, page 429, or entrapment neuropathy under section 15.4f, page 432.

For peripheral nerve impairment from a traumatic event, as opposed to an entrapment neuropathy, the evaluator defines the sensory and motor deficits from the descriptions in Table 15-14, page 425. The evaluator then uses Table 15-21, page 436 to identify the potential impairment on the basis of the severity of the deficit. Impairments due to ulnar nerve injury are found on pages 443 and 444. The A.M.A., *Guides* indicate that the impairment for peripheral nerve injury may be significantly greater than appellant's 28 percent rating, depending on the severity of any motor deficit. Range of motion is not authorized as an alternative method of evaluation.

The method used to calculate impairment in entrapment neuropathies, as opposed to traumatic injury to a peripheral nerve, deviates slightly from the usual diagnosis-based impairment method. The diagnosis of entrapment neuropathy is already established; therefore, only grade modifiers need be determined. The diagnosis of a focal neuropathy syndrome must be documented by sensory and motor nerve conduction studies or needle electromyogram in order to be ratable as impairment under section 15.4f.[15] If test results exclude the condition from rating using this method, a rating may be performed using the appropriate regional diagnosis-based impairment class for nonspecific elbow pain. Additional impairment values are not permitted for decreased grip strength, loss of motion or pain.[16]

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[13] A.M.A., *Guides* 387, 389 (6th ed. 2009).

[14] *E.g., E.B.*, Docket No. 12-1270 (issued January 10, 2013).

[15] *Id.* at 445.

[16] *Id*. at 433.

Neurological impairment may be combined with a diagnosis-based impairment, such as contusion, so long as the latter does not encompass the nerve impairment.[17]

OWCP's December 30, 2011 determination that appellant had only a 15 percent range of motion impairment failed to consider any diagnosis-based impairment due to the accepted ulnar nerve lesion. It does not appear that the first step in evaluating appellant's impairment -- choosing the diagnosis that is most applicable for the region being assessed -- was accomplished. This selection is critical because not all diagnosis-based impairments allow range of motion as a stand-alone option. The Elbow Regional Grid (Table 15-4, page 398) authorizes range of motion as an alternative for impairment due to fracture and contusion, but as noted, range of motion may not be used as an alternative for traumatic nerve injury or entrapment neuropathy.

Whether OWCP may base appellant's schedule award on range of motion depends on which diagnosis best characterizes his impairment and its impact on his activities of daily living. Dr. Miller found that the accepted right ulnar nerve lesion best characterized the impairment, although he did not explain why he evaluated the impairment as an entrapment neuropathy and not a traumatic nerve injury. Dr. Dyer found that range of motion was the most accurate, objective method for rating appellant's impairment, but this appears inconsistent with the protocols of the A.M.A., *Guides*, which gives priority to diagnosis-based impairment and allows stand-alone range of motion impairment only under limited circumstances, which are not established in this case.

As the extent of permanent impairment to appellant's right arm was not properly rated, the Board finds that fact of overpayment is not established. Accordingly, the Board will set aside the June 25, 2012 decision, on the issue of appellant's schedule award entitlement and the issue of overpayment. The issue of waiver is moot.

CONCLUSION

The Board finds that fact of overpayment is not established. OWCP did not properly established that appellant has less than a 28 percent impairment of his right upper extremity.

[17] *Id*. at 419.

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2012 decision of the Office of Workers' Compensation Programs is reversed.

Issued: March 18, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board