United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 12-1574**
	)	**Issued: April 12, 2013**
U.S. POSTAL SERVICE, POST OFFICE, Lorain, OH, Employer	)	

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

Case submitted the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 17, 2012 appellant, through his attorney, filed a timely appeal from a 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 has more than 15 percent permanent impairment of the right upper extremity; (2) whether OWCP properly made a retroactive determination on the date of maximum medical improvement; (3) whether an overpayment in the amount of $28,495.81 was created; and (4) whether a waiver of the overpayment should be granted.

FACTUAL HISTORY

On October 18, 2005 appellant, then a 41-year-old letter carrier, injured his right elbow while working.[2] OWCP accepted a right elbow contusion and an ulnar nerve lesion of the right

[1] 5 U.S.C. §§ 8101-8193.

[2] Appellant had a right elbow fracture in the mid-1980s with five subsequent surgeries to his right elbow.

elbow. Appellant returned to work with restrictions. He stopped work on August 1, 2006 and did not return.[3] OWCP approved an October 30, 2006 arthroscopic nerve decompression at the right elbow, but appellant declined the surgery after it was scheduled. Appellant retired on disability retirement in October 2006.

On July 26, 2007 appellant filed a claim for a schedule award. In a November 21, 2006 report, Dr. Kathleen Fagan, Board-certified in occupational medicine, opined that appellant had permanent limitations and no further treatment would improve his condition as surgery was declined. In an August 2, 2007 report, Dr. Todd Hochman, a Board-certified internist, found that appellant had 29 percent whole person impairment based on the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In an October 27, 2007 report, Dr. Anthony F. Skalak, an OWCP medical adviser, determined that appellant reached maximum medical improvement on October 29, 2005. He used Dr. Hochman's findings to find and that appellant had 38 percent right arm impairment under the fifth edition to the A.M.A., *Guides*.

In a November 30, 2009 report, Dr. William Grant, a Board-certified internist, diagnosed right elbow contusion, right ulnar nerve lesion. He opined that appellant was at maximum medical improvement. Examination revealed the right elbow ankylosed at a 130 degree angle; 0 degrees of pronation and supination, flexion to 140 degrees and extension to 120 degrees. Atrophy was noted. Under Table 15-4, page 399, Dr. Grant placed appellant in class 3. He assigned a functional history grade modifier 4 per Table 15-7, page 406; physical examination grade modifier 4 per Table 15-8, page 408. A net adjustment of two was found under the net adjustment formula. Dr. Grant found that appellant had class C, grade E or 46 percent right upper extremity impairment under the sixth edition of the A.M.A., *Guides.*

On December 23, 2009 Dr. Howard P. Hogshead, an OWCP medical adviser, opined that appellant reached maximum medical improvement on November 13, 2009 but a new evaluation with diagnostic testing was needed to determine impairment. He noted several discrepancies between Dr. Grant's evaluation and a prior medical adviser's review of October 27, 2007. Dr. Hogshead found that Dr. Grant's examination was inadequate, electrodiagnostic studies were not provided and there was no evidence of treatment from October 27, 2007 to November 13, 2009.

OWCP referred appellant to Dr. Daryl Miller, a Board-certified orthopedic surgeon, for an impairment evaluation. In a February 4, 2010 report, Dr. Miller examined appellant and reviewed the medical record and a statement of accepted facts. He recommended a functional capacity evaluation, which was completed on February 23, 2010, as well as electrodiagnostic study of the right arm. In a March 2, 2010 addendum, Dr. Miller noted that appellant did not show up for or agree to reschedule the scheduled nerve conduction examination. He found that appellant reached maximum medical improvement 12 months after the injury date or October 18, 2006. Based on a diagnosis of ulnar neuropathy, Dr. Miller opined that appellant had 2.4 percent right upper extremity impairment.

[3] OWCP denied appellant's claim for disability compensation beginning August 1, 2006.

On March 17, 2010 Dr. Hogshead opined that maximum medical improvement was reached on November 13, 2009 and referred to his December 23, 2009 report. He agreed with Dr. Miller's four percent right upper extremity impairment under Table 15-23, page 449 of the sixth edition of the A.M.A., *Guides.*

On May 14, 2010 OWCP granted appellant a schedule award for four percent right arm impairment with November 13, 2009 as the date of maximum medical improvement.

Appellant requested a hearing. In a January 6, 2011 decision, an OWCP hearing representative vacated the May 14, 2010 decision and remanded the case for a more detailed explanation from the medical adviser as to the method used for rating appellant's impairment.

In a January 10, 2011 report, Dr. Hogshead opined that Dr. Grant's opinion was flawed in his range of motion finding that appellant had ankylosis of 130 degrees. He stated that the findings noted in the October 27, 2007 report, noting 30 degrees extension and 115 degrees flexion were more credible. Based on the October 27, 2007 examination, Dr. Hogshead found under Table 15-33, page 474 flexion equaled 3 percent, extension equaled 2 percent; pronation equaled 3 percent and supination equaled 2 percent for 10 percent total right arm impairment. He stated that the sixth edition of the A.M.A., *Guides* did not recognize weakness of grip and there were no valid electrodiagnostic studies due to appellant's lack of cooperation. Dr. Hogshead further noted that the grip strength deficit may be due to the ulnar nerve loss, which was previously estimated to be 20 percent impairment. Using page 604, of the A.M.A., *Guides,* he combined the 10 percent impairment for range of motion elbow with 20 percent impairment for ulnar weakness to find 28 percent permanent impairment of right arm.

OWCP referred the medical adviser's January 10, 2011 report to Dr. Grant. In a February 1, 2011 addendum, Dr. Grant reiterated that appellant had 48 percent right arm impairment and that his rating was properly correlated with the A.M.A., *Guides*.

In a March 28, 2011 report, Dr. Hogshead stated that Dr. Grant's use of Table 15-4, page 399 to obtain a 46 percent impairment rating was not correct as there was no electromyogram (EMG). Dr. Grant stated that appellant's elbow was ankylosed, which means no motion, but he used Table 15-4, page 399, class 3 to indicate that the joint was dislocated and could not be reduced. Dr. Hogshead stated that this was not true as the joint was not dislocated and the February 4, 2010 x-ray description mentioned mild arthritis and a cerclage wire. Based on the documented range of motion, there was 10 percent impairment under Table 15-33, page 474, as noted in his reports of March 17, 2010 and January 10, 2011. Dr. Hogshead explained that Table 15-23 could not be used as there were no electrodiagnostic studies and appellant refused further testing. He advised that subjective weakness or grip strength was not in the sixth edition of A.M.A., *Guides.* Dr. Hogshead noted that under Table 15-4, page 400 an alternative diagnosis of post-traumatic arthritis, class 1, C, would yield five percent impairment.

By decision dated April 5, 2011, OWCP granted a schedule award for 24 percent permanent right upper extremity impairment or a total impairment of 28 percent. The date of maximum medical improvement was November 13, 2009.

Appellant requested a telephonic hearing, which was held on August 11, 2011. In a September 30, 2011 decision, an OWCP hearing representative set aside the April 5, 2011 decision and remanded the case for further medical development. The hearing representative noted that it was unclear why OWCP used the medical adviser's January 2011 report rather than the March 2011 report. She found that the medical adviser miscalculated the total impairment as 10 percent when the correct impairment was 11 percent. The medical adviser was asked to explain why the January 2011 report should be used as the basis for the schedule award. It also requested him to clarify how he arrived at the date of maximum medical improvement.

In an October 3, 2011 report, Dr. Hogshead opined that the date of maximum medical improvement was October 29, 2005, noting that there did not appear to be credible evidence of any material change in appellant's condition after that date. The controversy subsequent to that date related to the manner in which the impairment was evaluated. He stated rating that muscle weakness or loss of grip strength was no longer allowed under the sixth edition of the A.M.A., *Guides* and could not be used or considered in the March 28, 2011 report. Dr. Hogshead discussed how the 10 percent right arm impairment was calculated based on loss of range of motion by comparing the reported findings to specific tables and pages in the A.M.A., *Guides*.

In an October 6, 2011 report, Dr. James W. Dyer, a Board-certified orthopedic surgeon acting as an OWCP medical adviser, found that appellant reached maximum medical improvement on March 2, 2010, as OWCP was using the sixth edition of the A.M.A., *Guides* to determine the degree of impairment and appellant underwent a functional capacity evaluation on February 23, 2010. Based on the range of motion from the functional capacity evaluation and Dr. Miller's February 4, 2010 second opinion report, Dr. Dyer concluded that appellant had 15 percent right arm impairment. Under Table 15-33, page 474. Dr. Dyer found flexion of 81 degrees equaled 8 percent impairment; extension of 19 degrees equaled 2 percent impairment; pronation of 30 degrees equaled 3 percent impairment; and supination of 19 degrees equaled 2 percent impairment, for a total right arm impairment of 15 percent. He stated that Table 15-23, page 449 could not be used as there were no electrodiagnostic studies available to objectively evaluate appellant's ulnar never deficit. Dr. Dyer stated that Dr. Grant did not properly follow the sixth edition of the A.M.A., *Guides* and that he incorrectly used a diagnosis of elbow dislocation.

OWCP requested that Dr. Dyer review the June 7, 2006 EMG report and address impairment for any preexisting injuries. In a November 10, 2011 report, Dr. Dyer listed the date of maximum medical improvement as March 2, 2010. He opined that the EMG supported that appellant had a chronic ulnar nerve lesion from his childhood fracture and surgery. Dr. Dyer concluded that loss of range of motion was the most accurate objective measure of appellant's impairment. Using the February 23, 2010 functional capacity evaluation and Dr. Miller's March 2, 2010 findings, he reiterated that appellant had 15 percent right arm impairment. Since OWCP had issued a 28 percent scheduled award, no additional impairment was payable. In response to OWCP's questions, he stated in a December 8, 2011 report that 15 percent impairment for lost motion was the most advantageous and appropriate for appellant and took into account the accepted work-related condition as well as his preexisting condition. Dr. Dyer stated that Dr. Grant incorrectly used the diagnosis for persistent right elbow subluxation or dislocation which was not accurate. He also stated that appellant had preexisting fracture, not a dislocation so Dr. Grant's conclusion that appellant had 46 percent impairment as a result of this

preexisting condition was not valid. Dr. Dyer discussed the specific tables in the A.M.A., *Guides* that allowed a maximum of five percent for elbow fracture, three percent for elbow contusion, nine percent for ulnar nerve entrapment/compression neuropathy and seven percent for ulnar nerve neuropathy with sensory impairment. He advised, however, that impairments could not be combined for multiple diagnoses.

In a December 30, 2011 decision, OWCP advised appellant that the medical evidence supported 15 percent right arm impairment based on the medical adviser Dr. Dyer. Since an award for 28 percent impairment had previously been paid, no additional impairment was payable. It advised that March 2, 2010 was the date of maximum medical improvement.

On February 2, 2012 OWCP issued a preliminary finding that appellant received a $28,495.81 overpayment from October 7, 2010 to July 18, 2011 because he was paid a schedule award for 28 percent impairment of his right arm, but had only 15 percent impairment. It found that he was without fault in creating the overpayment and requested that he submit an overpayment recovery questionnaire within 30 days. An attached memorandum noted that, as of October 18, 2005, the date of injury, appellant's effective pay rate was $47,396.00. This divided by 52 weeks equals $946.46 per week multiplied by 2/3 compensation rate equaled $630.97 per week. The date of maximum improvement was listed as November 13, 2009 with a weekly pay of $673.75 due to Consumer Price Index (CPI) increase and weekly pay as of March 1, 2010 of $696.75 due to CPI. It stated that the correct schedule award entitlement of 15 percent ran for 327.6 days for a total of $32,253.04. For the 108-day period November 13, 2009 to February 28, 2010, OWCP found the $673.75 weekly rate divided by 7 days equaled $96.250 a day multiplied by 180 days equaled $10,395.50. For the 219.6 day period from March 1, 2010 to October 5, 2010, it found the $696.75 weekly rate divided by 7 days equaled $99.5357 multiplied by 219.6 days equaled $21,858.04. OWCP added the $10,395.50 to $21,858.04 to find a total of $32,253.04 for the 15 percent right arm impairment appellant was entitled. It noted that he received a total of $60,748.85 for the period from November 13, 2009 to July 18, 2011 for the 28 percent schedule award compensation. OWCP found that the $60,748.85 received minus the $32,253.04 to which appellant was entitled represented a $28,495.81 overpayment of schedule award compensation.

On January 9, 2012 appellant requested a telephonic hearing on the schedule award decision. On February 18, 2012 he requested a prerecoupment hearing. A telephonic hearing was held April 17, 2012 in which appellant discussed his impairment, the proposed overpayment and his income and expenses. Appellant stated that he did not disagree with the degree of impairment (15 percent impairment), but that he disagreed with the date the award began. He argued that his social security benefit, which began in January 2008, would be offset by the monies paid for an impairment rating and there were economic reasons why the schedule award should be paid starting in January 2008. Appellant argued that OWCP had no jurisdiction to render a new decision on the degree of impairment. He also provided information regarding his finances.

In a June 25, 2012 decision, a hearing representative affirmed the December 30, 2011 decision insofar as it found 15 percent impairment of the right upper extremity but modified the decision to reflect the date of maximum medical improvement as November 21, 2006. Thus, the period of the schedule award ran from November 21, 2006 through October 14, 2007. The

hearing representative finalized the February 2, 2012 preliminary overpayment determination and denied waiver as the evidence did not support that recovery was against equity and good conscious or that it would it defeat the purpose of FECA.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA and its implementing regulations[4] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from 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.[5] 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. The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

In determining entitlement to a schedule award, preexisting impairment to the scheduled member should be included.[8] Any previous impairment to the member under consideration is included in calculating the percentage of loss except when the prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment.[9]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides,* with the medical adviser providing rationale for the percentage of impairment specified.[10]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision as to the extent of appellant's right arm impairment. The accepted conditions are right elbow contusion and ulnar nerve lesion of the right elbow. Appellant received a total of 28 percent permanent impairment of the right

[4] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

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

[6] *Ronald R. Kraynak*, 53 ECAB 130 (2001).

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

[8] *Carol A. Smart*, 57 ECAB 340 (2006); *Michael C. Milner*, 53 ECAB 446 (2002).

[9] *Supra* note 7 at Chapter 2.808.7(a)(2) (January 2010).

[10] *Supra* note 7 at Chapter 2.808.6(d) (August 2002).

arm, with 4 percent impairment granted on May 14, 2010 and an additional 24 percent impairment granted on April 5, 2011. On December 30, 2011 OWCP found that the evidence supported 15 percent right arm impairment with March 2, 2010 as the date of maximum improvement, based on the opinion of the medical adviser, Dr. Dyer. An OWCP hearing representative affirmed OWCP's decision on impairment and modified it regarding the date of maximum medical improvement.

The Board notes that OWCP erroneously awarded 28 percent right arm impairment. In January 10 and March 28, 2011 reports, Dr. Hogshead, clearly explained why the range of motion impairment of 10 percent was appropriate and beneficial to appellant. However, in his January 10, 2011 report, he erroneously combined 10 percent range of motion deficit under the sixth edition of the A.M.A., *Guides* with 20 percent ulnar weakness from the fifth edition of the A.M.A., *Guides* to find 28 percent right arm impairment.[11] The sixth edition of the A.M.A., *Guides* does not allow a rating for this type of muscle weakness.[12] The sixth edition of the A.M.A., *Guides* also provides that, if a range of motion rating is appropriate, it is to be used as a stand-alone rating.[13] Therefore, the finding of 28 percent impairment was incorrect based on the current medical evidence of record.

OWCP found that appellant had 15 percent right arm impairment based on the opinion of Dr. Dyer, an OWCP medical adviser, who utilized range of motion findings from the February 23, 2010 functional capacity evaluation and Dr. Miller's second opinion examination findings. Dr. Dyer found the range of motion method yielded the highest rating of 15 percent under the sixth edition of the A.M.A., *Guides.* He provided an impairment assessment, citing impairment values for elbow fracture, elbow contusion, ulnar nerve entrapment/compression neuropathy and ulnar nerve neuropathy with sensory impairment above mid-forearm citing to appropriate tables within the A.M.A., *Guides*, which yielded upper extremity impairment greater than 15 percent. Regarding nerve injuries, section 15-4 of the A.M.A., *Guides*, provides that peripheral nerve impairment may be combined with diagnosis-based impairments at the upper extremity level as long as the diagnosis-based impairment does not encompass the nerve impairment.[14]

Dr. Dyer did not specifically address whether the peripheral nerve impairment rating may be combined with the diagnosis-based impairment rating or whether the A.M.A., *Guides* preclude such combination. Under section 2.7 of the A.M.A., *Guides*, an explanation of how the impairment rating was calculated is a crucial part of the sixth edition.[15] It is unclear whether appellant's sensory and motor impairment resulting from the ulnar nerve impairment would be fully compensated applying the range of motion rating. Discussion of how the A.M.A., *Guides*

[11] In his March 28 and October 11, 2011 reports, Dr. Hogshead did not combine any impairment with the range of motion impairment.

[12] Use of the sixth edition of the A.M.A., *Guides* was effective May 1, 2009. *See supra* note 7.

[13] A.M.A., *Guides* 461 (6th ed. 2009).

[14] *Id.* at 419.

[15] *Id*. at 28.

criteria were applied to medical information that generated the diagnostic based and peripheral nerve impairments is required for an impairment rating to be consistent with the A.M.A., *Guides.*[16] As there was no discussion by Dr. Dyer as to whether these impairment ratings may be combined, the case will be remanded for further medical development.[17]

Proceedings under FECA are not adversarial in nature nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. Once it has begun an investigation of a claim, OWCP must pursue the evidence as far as reasonably possible. OWCP has an obligation to see that justice is done.[18] The medical evidence of record does not fully comport with the A.M.A., *Guides* or provide a complete analysis of appellant's right upper extremity impairment. The case will be remanded to OWCP to refer appellant to an appropriate Board-certified specialist to further determine the extent of impairment of his right upper extremity in accordance with the sixth edition of the A.M.A., *Guides.*

Based on this, the issue of overpayment is moot.

LEGAL PRECEDENT -- ISSUE 2

It is well established that the period covered by the schedule award commences on the date that the employee reaches maximum medical improvement from the residuals of the accepted employment injury. The Board has explained that maximum medical improvement means that the physical condition of the injured member of the body has stabilized and will not improve further. The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by OWCP.[19] The Board has noted a reluctance to find a date of maximum medical improvement, which is retroactive to the award, as retroactive awards often result in payment of less compensation benefits. The Board requires persuasive proof of maximum medical improvement of the selection of a retroactive date of maximum medical improvement.[20]

ANALYSIS -- ISSUE 2

OWCP found that the date of maximum medical improvement was November 21, 2006, with the period of the schedule award running from November 21, 2006 through October 14, 2007. The Board is reluctant to find a retroactive date of maximum medical

[16] *Id.*

[17] The record should also reflect whether any preexisting impairments have been taken into account in reaching appellant's impairment rating. *See Peter C. Belkind*, 56 ECAB 580, 586 (2005) (it is well established that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included).

[18] *A.A.*, 59 ECAB 726 (2008).

[19] *Mark A. Holloway*, 55 ECAB 321 (2004).

[20] *P.C.*, 58 ECAB 529 (2007).

improvement as retroactive awards often result in payment of less compensation benefits.[21] In this case, however, the record contains persuasive evidence of maximum medical improvement reached on or about November 21, 2006. OWCP's second opinion physician, Dr. Miller, advised that maximum medical improvement was reached approximately one year following the injury, which he opined was October 18, 2006. Dr. Fagan, appellant's attending physician, indicated that appellant's condition was permanent by November 21, 2006. This was after surgery was scheduled and authorized by OWCP, but subsequently declined by appellant. While several medical advisers listed the date of maximum medical improvement as October 29, 2005, appellant had not reached maximum medical improvement as he was still undergoing treatment and surgery was being considered. Subsequent medical reports only deal with the degree of permanent impairment and thus are not relevant to the determination of maximum medical improvement.

The determination of maximum medical improvement rests with the medical evidence. As Dr. Fagen and the second opinion examiner, Dr. Miller, clearly advised that maximum medical improvement was reached in late 2006, the Board finds this evidence clear and convincing such that it was proper for OWCP to begin payment for his schedule award on November 21, 2006.[22]

CONCLUSION

The Board finds that this case is not in posture for decision as to the extent of appellant's right upper extremity impairment.[23] However, the Board affirms the retroactive date of maximum medical improvement in this case.

[21] *Id.*

[22] *L.H.*, 58 ECAB 561 (2007).

[23] Due to the disposition of the schedule award issue, the remaining issues pertaining to overpayment and waiver of such overpayment are rendered moot.

ORDER

IT IS HEREBY ORDERED THAT the June 25, 2012 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded to OWCP for further proceedings consistent with this opinion of the Board.

Issued: April 12, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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