United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 15-1520**
	)	**Issued: March 1, 2016**
DEPARTMENT OF THE NAVY, PACIFIC FLEET SHIPYARD, Pearl Harbor, HI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On July 2, 2015 appellant filed a timely appeal of April 15 and May 18, 2015 merit decisions 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 to consider the merits of the case.

ISSUES

The issues are: (1) whether appellant has more than 14 percent impairment of his right upper extremity and no permanent impairment of his left upper extremity for which he had received schedule awards; (2) whether appellant received an overpayment of compensation in the amount of $6,942.78 for the period June 30 through November 29, 2005 for an erroneous schedule award for three percent impairment of the left upper extremity; and (3) whether appellant was entitled to waiver of recovery of the overpayment.

[1] 5 U.S.C. § 8101 *et seq.*

On appeal appellant argued that he made a mistake and sent the financial information requested by OWCP to OWCP's Branch of Hearings and Review rather than to the appropriate address. He alleged that he would suffer severe financial hardship repaying the overpayment.

FACTUAL HISTORY

The case has previously been before the Board. On June 3, 1999 appellant, then a 46-year-old marine machinery mechanic, filed a traumatic injury claim (Form CA-1) alleging that he injured his right shoulder when unloading his tools in the performance of duty. OWCP accepted his claim for right shoulder strain and temporary aggravation of cervical degenerative disc disease and cervical subluxation. On April 4, 2000 appellant underwent C3-4, C5-6, and C6-7 microforaminotomy with some decompression of the lateral spinal cord as authorized by OWCP.

A May 1, 2001 magnetic resonance imaging (MRI) scan of the right shoulder showed degenerative arthritis of the glenohumeral joint and acromioclavicular (AC) joint with erosions on the humeral head and impingement of the supraspinatus and degenerative changes of the AC joint. A cervical spine MRI scan on November 26, 2001 demonstrated chronic moderate foraminal narrowing at C4 on the right and C7 on the right, with loss of cervical lordosis and mild disc bulge at C4-5, C5-6, and C6-7. OWCP authorized C3-7 cervical fusion on February 19, 2002. Appellant returned to light-duty work on March 17, 2003.

An MRI scan dated April 12, 2006 demonstrated moderate supraspinatus tendinitis with a possible small undersurface tear and significant impingement upon the tendon by AC joint hypertrophy, and mild glenohumeral joint degenerative changes. An April 21, 2008 x-ray showed mild glenohumeral and AC joint degenerative changes.

An OWCP medical adviser, Dr. Arthur S. Harris, a Board-certified orthopedic surgeon, reviewed the medical records on March 6, 2010 and found that appellant had one percent impairment of his right arm due to rotator cuff tendinitis and impingement syndrome, one percent impairment due to rotator cuff tendinitis and partial rotator cuff tear, one percent impairment of the right arm due to impaired sensation due to C6 cervical radiculopathy, and one percent impairment of the right arm due to C7 cervical radiculopathy. He further concluded that appellant had one percent impairment of the left arm due to C5 radiculopathy, one percent of the left arm due to C6 radiculopathy, and one percent impairment of the left arm due to C7 radiculopathy.

By decision dated May 28, 2010, OWCP granted appellant a schedule award for four percent impairment of the right upper extremity and three percent impairment of the left upper extremity. Appellant appealed that decision to the Board. In its September 13, 2011 decision, the Board found that the medical evidence of record had not included sufficiently reasoned medical opinion as to the degree of permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*[2] (A.M.A., *Guides*) and remanded the case for further development of the medical evidence and a detailed

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

report comporting with the sixth edition of the A.M.A., *Guides* in regard to his upper extremity impairments due to his cervical and right shoulder conditions.[3]

OWCP referred appellant for a second opinion evaluation with Dr. Stephen Scheper, an osteopath Board-certified in physical medicine and rehabilitation. In his October 28, 2011 report, Dr. Scheper reviewed appellant's diagnostic test results and x-rays. He examined appellant's bilateral shoulders and found using the range of motion method, on the right flexion 130 degrees, extension 40 degrees, abduction 130 degrees, adduction 30 degrees, external rotation 70 degrees, and internal rotation 50 degrees. On the left appellant demonstrated 140 degrees of flexion, 40 degrees of extension, 100 degrees of abduction, 30 degrees of adduction, 40 degrees of external rotation and 20 degrees of internal rotation. Dr. Scheper found empty can, Neers and Yergasons tests positive on the right and Hawkins and Speeds tests positive on the left. He reported diffuse tenderness on the right of the supraspinatus, infraspinatus, subscapularis and biceps brachial at the proximal humerus. Dr. Scheper diagnosed chronic right shoulder pain and functional impairment secondary to subacromial impingement and partial rotator cuff tear, chronic degenerative joint disease of the glenohumeral and acromioclavicular joints as well as right suprascapular neuropathy with resultant motor deficit right infraspinatus, supraspinatus, and degenerative cervical spine disease. He opined that appellant had reached maximum medical improvement on or before February 19, 2003.

Dr. Scheper applied the A.M.A., *Guides* and found that appellant had right shoulder impingement syndrome in accordance with Table 15-5 of the A.M.A., *Guides*, class 1 impairment. He determined that appellant's Functional History (GMFH) 1 due to pain with strenuous or vigorous activity and the ability to perform self-care activities independently and a *Quick*Dash score of 34. Dr. Scheper reached Physical Examination (GMPH) 2 due to positive finding with provocative testing and a 14 percent decrease in range of motion from normal based on Table 15-34. He found that appellant's Clinical Studies (GMCS) 1 was due to mild pathology and reached a Net Adjustment of plus 1, grade D, four percent impairment of the right arm.

Dr. Scheper also determined that appellant had a motor deficit of mild severity or grade 1, Table 15-14, peripheral nerve impairment of the suprascapular in accordance with Table 15-21, class 1 impairment. He found a GMCS 2 due to axon loss with abnormal spontaneous activity on electromyogram (EMG). Dr. Scheper stated, "EMG report did not distinguish between 1+ or 2+ abnormal spontaneous activity, although significant atrophy is noted on physical examination, so the more severe grade modifier was adopted." He determined GMFH 1 due to significant intermittent symptoms and that the *Quick*Dash score was 34. Applying the formula, Dr. Scheper reached a Net Adjustment of positive one, grade D, or three percent impairment of the right arm. He concluded that appellant had a combined upper extremity impairment of seven percent.

Dr. Harris, the OWCP medical adviser, reviewed this report on behalf of OWCP on December 24, 2011. He noted that appellant's accepted conditions were status post left cervical decompression/foraminotomy C3-4, C4-5, C5-6, and C6-7, on April 4, 2000; status post anterior cervical fusion C3-7 on February 19, 2002, chronic cervical radiculopathy and right rotator cuff

[3] Docket No. 11-55 (issued September 13, 2011).

tendinitis and impingement syndrome. Dr. Harris found four percent upper extremity impairment due to residual right shoulder tendinitis and impingement in accordance with Table 15-5 of the A.M.A., *Guides*. He further found one percent right upper extremity impairment due to pain and impaired sensation due to right C5 radiculopathy, one percent impairment due to right C6 radiculopathy and one percent impairment due to right C7 radiculopathy. Dr. Harris combined appellant's right arm impairments to reach seven percent.

Dr. Harris also concluded that appellant had three percent left upper extremity impairment due to cervical radiculopathy resulting in mild pain/impaired sensation at C5, C6, and C7 of one percent each.

By decision dated April 27, 2012, OWCP granted appellant an additional three percent impairment of the right arm for a total of seven percent impairment of this member. It found that he had no additional impairment of his left arm. Appellant appealed that decision to the Board. In its June 5, 2013 decision,[4] the Board found that the case was still not in posture for a decision as the medical evidence still did not contain a sufficiently reasoned medical opinion as to the degree of permanent impairment under the sixth edition of the A.M.A., *Guides*. The Board remanded the case for further medical development.

OWCP referred appellant for a reevaluation with Dr. Scheper on July 8, 2013. In a report dated July 26, 2013, Dr. Scheper addressed the question of whether the diagnosis-based impairment from subacromial impingement and rotator cuff pathology encompassed the suprascapular neuropathy. He stated:

> "A suprascapular neuropathy, although relatively uncommon, is a significant cause of functional impairment resulting from bony or ligamentous constrain at the suprascapular or spinal glenoid notches, extrinsic compression from a glenohumeral ganglion or other soft tissue mass, direct trauma, for a traction neuropathy following excessive nerve excursion during overhead activities. A suprascapular neuropathy is rarely seen with concomitant rotator cuff injury, typically through massive retracted rotator cuff tears in older patients. MRI [scan] evaluation of the shoulder in this case failed to reveal extrinsic or ligamentous compression, and he is not involved in recreational repetitive overhead activities typically seen resulting in a suprascapular neuropathy, which leaves the potential from a traction injury INDIRECTLY related to the supraspinatus rotator cuff injury and subacromial compression pertinent in this case."

Dr. Scheper concluded that appellant experienced a right rotator cuff injury with an indirectly-related suprascapular neuropathy and an aggravation of cervical spondylosis. He found that appellant had an upper extremity impairment of seven percent. Dr. Scheper stated that OWCP did not include spine ratings and that he completed the assessment based on right shoulder and nerve pathology.

[4] Docket No. 13-152 (issued June 5, 2013).

OWCP referred this new report to the medical adviser Dr. Harris on November 20, 2013. In a November 23, 2013 report, Dr. Harris stated that the following diagnoses had been established: right C3-4, C5, C6 and C7 right-sided foraminotomies, anterior cervical fusion C3-7, chronic right cervical radiculopathy, and right rotator cuff tendinitis and impingement syndrome. He found that appellant had five percent upper extremity impairment for residual problems with right rotator cuff tendinitis, impingement, and partial thickness tearing in accordance with Table 15-5.[5] Dr. Harris noted that cervical radiculopathy must be calculated under the A.M.A., *Guides* Newsletter July/August 2009 and found that appellant had four percent impairment of the right arm for residual problems with mild motor weakness from right C5 cervical radiculopathy and five percent impairment of the right arm for residual mild motor weakness or nine percent impairment for cervical radiculopathy. He combined 5 percent for the right shoulder and 9 percent for cervical radiculopathy to reach 14 percent right arm impairment. Dr. Harris stated that appellant had no impairment of his left arm. He offered no further explanation of this determination. Dr. Harris found that appellant's residual weakness appeared to be secondary to cervical radiculopathy as well as rotator cuff tendinitis and impingement resulting in 14 percent right arm impairment. He stated, "I would agree with Dr. Scheper that [appellant] does not clinically have evidence of suprascapular neuropathy."

By decision dated December 10, 2013, OWCP found that appellant had an additional 7 percent impairment of his right upper extremity for a total impairment rating of 14 percent, and no ratable impairment of his left upper extremity. It noted that he had previously received a schedule award for three percent impairment of his left arm in error. Appellant filed an appeal with the Board. In its December 19, 2014 decision,[6] the Board found that medical adviser had not properly applied the A.M.A., *Guides* to either of appellant's upper extremities. It noted regarding the left arm that the medical adviser had not provided adequate reasoning for eliminating the three percent impairment of appellant's left upper extremity which OWCP had found on December 24, 2011. The Board directed OWCP to obtain medical evidence explaining the impairment rating for both arms in accordance with the A.M.A., *Guides*. The facts and circumstances of the case as set forth in the Board's prior decisions are adopted herein by reference.

Following the Board's December 19, 2014 decision, OWCP requested an additional report from Dr. Harris, the medical adviser, on January 26, 2015 to fully explain his impairment ratings for both upper extremities. Dr. Harris responded on January 31, 2015 and listed appellant's accepted conditions including C3-4, C5-7 right sided foraminotomies, anterior cervical fusion C3-7, chronic right cervical radiculopathy, right rotator cuff tendinitis, and impingement syndrome. He determined that appellant's right shoulder injury should be evaluated as a rotator cuff injury, partial thickness tear in accordance with Table 15-5 of the A.M.A., *Guides*.[7] Dr. Harris determined that appellant had class 1 impairment. He found GMFH class 2, due to worsening symptoms with activities as well as functional limitations. Dr. Harris concluded that appellant demonstrated GMPE 2 due to limited motion and rotator cuff

[5] A.M.A., *Guides*, 402, Table 15-5.

[6] Docket No. 14-0661 (issued December 19, 2014).

[7] *Supra* note 5.

weakness. He further found GMCS 1 due to partial thickness rotator cuff tear and tendinitis and normal electrodiagnostic studies. In applying the upper extremity formula, Dr. Harris concluded that appellant had five percent impairment of the upper extremity due to his right shoulder condition.

Dr. Harris then evaluated appellant's cervical impairments under the A.M.A., *Guides*. He found that appellant had mild motor deficit on the right as a result of right C5 cervical radiculopathy resulting in class 1 impairment. Dr. Harris noted GMFH 1 due to residual function consistent with his diagnosed cervical radiculopathy. He further determined that appellant's GMPE 1 due to weakness in his C5 innervated muscles. Dr. Harris applied the formula and determined that appellant had no adjustment for class 1 grade C or four percent arm impairment due to C5 radiculopathy. In regard to appellant's C6 radiculopathy, he found a mild motor deficit of class 1. Dr. Harris reported that appellant's residual function was consistent with his cervical radiculopathy and that his GMFH class 1. He also determined that appellant had weakness in his C6 innervated muscles consistent with cervical radiculopathy such that his GMPE class 1. Dr. Harris reported that appellant's 2005 electrodiagnostic studies did not show obvious problems with cervical radiculopathy so that his GMCS was consistent with class 1. He found that appellant had five percent right arm impairment due to right C6 radiculopathy. This resulted in nine percent impairment for right cervical radiculopathy. Dr. Harris noted that combining appellant's cervical and right shoulder impairments resulted in 14 percent right arm impairment. He did not address appellant's left arm impairment.

In a decision dated April 15, 2015, OWCP found that appellant had 14 percent impairment of the right arm for which he previously received schedule awards and no impairment of the left arm.

OWCP issued a preliminary overpayment determination on April 16, 2015 finding that appellant received a $6,942.78 overpayment of compensation as he had improperly received a schedule award for three percent impairment of the left arm. It found that he was without fault in creating the overpayment and allowed him 30 days to submit his disagreement with the determination.

By decision dated May 18, 2015, OWCP found that appellant had received a $6,942.72 overpayment for the period June 30 to November 29, 2005. It further found that he was not entitled to waiver. OWCP requested that appellant either repay the full amount of the overpayment within 30 days or contact it to make appropriate repayment arrangements.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[8] and its implementing regulations[9] set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss of use of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in

[8] 5 U.S.C. §§ 8101-8193, 8107.

[9] 20 C.F.R. § 10.404.

making such determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[10] FECA does not authorize the payment of schedule awards for the permanent impairment of the whole person.[11] Payment is authorized only for the permanent impairment of specified members, organs or functions of the body.

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[12] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back or spine,[13] no claimant is entitled to such an award.[14]

Amendments to FECA, however, modified the schedule award provisions to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provisions of FECA include the extremities, a claimant may be entitled to a schedule award for permanent impairment to a limb even though the cause of the impairment originated in the spine.[15]

The sixth edition of the A.M.A., *Guides* does not provide a separate mechanism for rating spinal nerve injuries as extremity impairment. Recognizing that certain jurisdictions, such as federal claims under FECA, mandate ratings for extremities and preclude ratings for the spine, the A.M.A., *Guides* has offered an approach to rating spinal nerve impairments consistent with sixth edition methodology.[16] OWCP has adopted this approach for rating impairment of the upper or lower extremities caused by a spinal injury, as provided in section 3.700 of its procedures.[17] Specifically, OWCP will address lower extremity impairments originating in the

[10] For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

[11] *W.D.*, Docket No. 10-274 (issued September 3, 2010); *Ernest P. Govednick*, 27 ECAB 77 (1975).

[12] *W.D., id.*; *William Edwin Muir*, 27 ECAB 579 (1976).

[13] FECA itself specifically excludes the back from the definition of organ. 5 U.S.C. § 8101(19).

[14] *W.D., supra* note 11. *Timothy J. McGuire*, 34 ECAB 189 (1982).

[15] *W.D., supra* note 11. *Rozella L. Skinner*, 37 ECAB 398 (1986).

[16] FECA Transmittal No. 10-04 (issued January 9, 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (January 2010).

[17] Federal (FECA) Procedure Manual, *id*., at Chapter 3.700, Exhibits 1, 4 (January 2010).

spine through Table 16-11[18] and upper extremity impairment originating in the spine through Table 15-14.[19]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[20]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for a decision. The Board previously remanded the case for OWCP to further develop the medical evidence and determine appellant's bilateral upper extremity impairment based on the A.M.A., *Guides*.

On remand, Dr. Harris properly applied the A.M.A., *Guides* to appellant's right upper extremity diagnosing rotator cuff injury, partial thickness tear with residual loss, functional with normal motion, with a default value of three percent.[21] He determined that appellant's GMFH and GMPE were both grade 2. Dr. Harris utilized the upper extremity formula of the A.M.A., *Guides* and found that appellant had a positive net adjustment of two resulting in grade D or five percent impairment of the right upper extremity.

In regard to appellant's nerve root injuries of the right upper extremity, Dr. Harris properly applied OWCP's methodology for determining impairment of C5 and C6. He determined appellant's grade modifiers and utilized the appropriate formula resulting in impairment ratings of four percent upper extremity impairment due to C5 radiculopathy and five percent due to C6 radiculopathy. Dr. Harris then combined appellant's right upper extremity impairment ratings to reach 14 percent impairment of the right upper extremity. The Board finds that appellant has no more than 14 percent impairment of his right arm.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

The Board further finds that the case remains not in posture for a decision regarding appellant's left upper extremity impairment due to his accepted cervical injuries. Beginning on March 6, 2010, Dr. Harris opined that appellant had three percent impairment of his left arm due to his accepted cervical spine conditions. In his December 24, 2011 report, he again opined that appellant had three percent impairment of his left upper extremity due to his accepted cervical conditions. However, on November 23, 2013, Dr. Harris opined without explanation, that appellant had no impairment of his left arm due to his accepted cervical injuries.

[18] A.M.A., *Guides*, 533, Table 16-11.

[19] *Id*. at 425, Table 15-14.

[20] *Id*. at 411.

[21] *Id*. at 402, Table 15-5.

In its December 19, 2014 decision, the Board noted that Dr. Harris did not provide adequate reasoning for eliminating the three percent impairment of appellant's left upper extremity which OWCP had found on December 24, 2011. The Board directed Dr. Harris to fully explain his impairment ratings for both arms in accordance with the A.M.A., *Guides*. Dr. Harris' January 31, 2015 report did not address appellant's left upper extremity impairment or his reasons for determining that there was no cervical impairment affecting the left upper extremity. As OWCP and Dr. Harris has failed to comply with the Board's explicit directives, the Board finds that the case remains not in posture for decision with regard to the issue of appellant's left arm impairment. On remand, Dr. Harris should review the record and explain his findings on this issue. Following this and any other development that OWCP deems necessary, it should issue a *de novo* decision on this issue.

CONCLUSION

The Board finds that appellant has no more than 14 percent impairment of his right upper extremity for which he received a schedule award. The Board further finds that the case is not in posture for a decision as there is no medical explanation for the revocation of his schedule award for three percent impairment of his left arm. The second and third issues on appeal, which relate to an overpayment arising as a result of OWCP's April 15 and May 18, 2015 decisions, are moot.[22]

[22] *See Lee Z. Watson*, Docket No. 04-2176 (issued March 1, 2005) (finding that when the decision providing the basis for the overpayment is reversed or set aside, the resulting overpayment issues are moot).

ORDER

IT IS HEREBY ORDERED THAT the April 15, 2015 decision of the Office of Workers' Compensation Programs is affirmed in part and remanded in part. OWCP's May 18, 2015 overpayment decision is set aside.

Issued: March 1, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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