United States Department of Labor
Employees' Compensation Appeals Board

L.F., Appellant	)	
and	)	**Docket No. 15-489**
	)	**Issued: May 11, 2015**
U.S. POSTAL SERVICE, NEW JERSEY INTERNATIONAL BULK MAIL CENTER, Jersey City, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 5, 2015 appellant, through counsel, filed a timely appeal from the November 7, 2014 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 review the merits of this case.

ISSUES

The issues are: (1) whether appellant's 1991 employment injury caused any permanent impairment to his lower extremities; (2) whether he is entitled to waiver of recovery for any overpayment arising from the schedule award he received; and (3) whether OWCP took into account relevant factors in setting the rate of recovery from continuing compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On January 14, 1991 appellant, a 37-year-old mail handler, filed a traumatic injury claim for an injury received while bending to pick up sacks of mail in a truck. OWCP accepted his claim for aggravation of herniated nucleus pulposus at the L4-5 level.[2] Appellant underwent extensive surgery in 2009.

Appellant filed a schedule award claim. Dr. Nicholas Diamond, an osteopath, evaluated his impairment in 2010. Using Table 16-12, page 534, of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (6th ed. 2009), he found a 39 percent impairment of the right lower extremity and an 11 percent impairment of the left lower extremity due to peripheral nerve impairment.

An OWCP medical adviser found that the marked neurological deficits Dr. Diamond found on examination, affecting so many nerve roots, seemed inconsistent with the findings of appellant's other physicians. He recommended an impartial medical specialist to resolve the conflict.

OWCP found a conflict between Dr. Diamond and the medical adviser. It referred appellant to Dr. Michael H. Gordon, a Board-certified orthopedic surgeon, to resolve the conflict. Dr. Gordon examined appellant and, using Table 16-12 of the A.M.A., *Guides*, he found an 11 percent impairment of the right lower extremity due to mild motor weakness in the peroneal/ sciatic nerve. There was no evidence of sensory or motor deficit in the left lower extremity.

On June 20, 2012 OWCP issued a schedule award for an 11 percent impairment of the right lower extremity and a 0 percent impairment of the left lower extremity.

Appellant, through counsel, requested an oral hearing, which was held before an OWCP hearing representative on October 25, 2012.

By decision dated January 15, 2013, an OWCP hearing representative found that Dr. Gordon's opinion could not be accorded the weight of an impartial medical specialist because no true conflict existed. An OWCP medical adviser offered no impairment rating and, therefore, his report did not form the basis for a conflict. Noting that Dr. Gordon's examination findings were incomplete and therefore insufficient to represent the weight of the medical evidence, the hearing representative remanded the case for a second opinion evaluation of permanent impairment.

OWCP referred appellant to Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, for a second opinion evaluation. Dr. Askin evaluated appellant and found no clinical suggestion of radiculopathy: no atrophy, clinic weakness, confirmatory straight leg raising, reflex abnormality, or area of anesthesia. Applying Table 17-4, page 570, of the A.M.A., *Guides*, he found that appellant had no more than a nine percent impairment of the whole person.

[2] Appellant sustained previous work-related back injuries on May 29 and August 15, 1978 and May 26, 1980. OWCP accepted the 1980 injury, resulting from bending over to remove parcels, for lumbosacral sprain and herniated nucleus pulposus at the L4-5 level. OWCP File No. xxxxxx417.

In an addendum report, Dr. Askin applied Table 16-12 of the A.M.A., *Guides*. He found that appellant did not fall within any of the classification schemes in the peripheral nerve impairment table based on his clinical examination on March 15, 2013. Therefore, Dr. Askin concluded that appellant had no objectively determinable findings consistent with such. Appellant impairment rating was zero percent.

An OWCP medical adviser agreed, as Dr. Askin found no motor or sensory deficits, and an impairment under Table 16-12 depended on either motor or sensory deficits or both.

In a decision dated May 13, 2013, OWCP found that Dr. Askin's evaluation represented the weight of the medical opinion evidence as it was contemporaneous, while Dr. Diamond's evaluation was nearly three years old. It denied appellant's schedule award claim.

Dr. Diamond offered a supplemental report dated September 24, 2013. Applying the methodology presented in *Rating Spinal Nerve Extremity Impairment Using the Sixth Edition*, *The Guides Newsletter* (A.M.A., Chicago, Ill.), July/August 2009, he recalculated appellant's impairment based on his clinical findings from June 17, 2010. Dr. Diamond found that appellant had a 22 percent impairment of the right lower extremity and a 5 percent impairment of the left lower extremity.

Following a September 24, 2013 oral hearing, an OWCP hearing representative found by decision dated December 11, 2013, that Dr. Diamond's rating had little probative value as he had merely converted his June 17, 2010 findings, based on 2010 examination results. Further, he found that Dr. Askin's testing for sensory and motor deficits was vague and lacked any detail. The hearing representative had provided no specific findings or measurements for manual muscle testing, and he had failed to adequately document specific sensory testing. It was not obvious that he was examining or testing for deficits to address lower extremity impairments as a result of spinal injury. The hearing representative initially provided a whole person rating based on the spine and stated in his addendum report that he "did not specifically seek" any manifestations of neurologic impairment which would include any sensory deficit or any muscular deficit. Given progress reports documenting tingling and numbness bilaterally and weakness on the right, as well as a new lumbar imaging study due to right leg numbness and foot swelling, he found that further development was warranted to verify the degree of impairment. The hearing representative remanded the case for Dr. Askin to fully document his examination findings and sensory/motor testing for the record, and to fully assess lower extremity impairment based on *The Guides Newsletter*, July/August 2009.

Dr. Askin reexamined appellant on January 31, 2014. He explained that his earlier statement that he "did not seek" any manifestations of neurologic impairment had been a typographical error. The statement should have read that he did not specifically "see" any manifestation of neurological impairment. "Please note that I carefully examined [appellant] for neurologic impairment, and there is none." On physical examination, Dr. Askin stated: "I wish to emphasize that I did specifically, repeatedly and carefully, look for any objectively determinable change in his lower extremities indicative of nerve damage." Objectively, appellant had pitting edema, which was a different phenomenon from that which might be associated with his back complaints or back diagnosis. The skin of his feet appeared normal. There was no atrophic or dystrophic change about either foot. Appellant advised that he had diminished sensation over the dorsum of both feet and the lower legs, which did not respect

dermatomal alignment. This was entirely subjective with no objective corroboration clinically. Appellant advised that the decreased sensation was from the feet up to the upper calves and at no other location. He advised that the sensation of the soles of his feet was preserved, and the skin wear pattern of his feet was within normal limits.

Distal thigh circumference was 47 centimeters on the right and 45 on the left. The calf circumference was 45 centimeters on the right and 42 on the left. Dr. Askin found the difference could be due to additional pitting edema of the right leg. Straight leg raising, to evaluate sciatica, was negative to 90 degrees for either leg. Deep tendon reflexes, which should be bilaterally asymmetric if there were some radiculopathy, were symmetrical at the knees and ankles. Dr. Askin individually tested the muscles of the toe motors, the flexor halluces longus, extensor halluces longus, flexor digitorum longus, extensor digitorum longus, anterior tibial, posterior tibial, and peroneal tendons, hamstrings, quadriceps, hip adductors, hip abductor, hip flexors, and hip extensors. Each and every one of the muscle groups were preserved and capable of exerting normal strength for both lower extremities. "There is no neuromuscular deficit."

Dr. Askin further reported that, when he had previously prepared the supplemental report, there was no objectively determinable nerve impairment. "As emphatically as I can state it, I did specifically seek neurologic impairment, and there is no objectively determinable evidence of nerve impairment at the present time." Dr. Askin made clear that he was not stating that appellant had no symptoms, or that he had no imperfections within his spine, or that he did not have the surgical alternation of his low back. "I am merely observing that on examination there is no lower extremity impairment as a result of spinal nerve injury at this time." Dr. Askin explained that, when pain is perceived at a distance from its anatomic source, that phenomenon is termed "referred pain." Most so-called sciatica is actually on the basis of referred pain, which is due to irritability of an anatomic structure in the back interpreted by the central nervous system as causing pain into the lower extremity. "That a patient may perceive such, does not mean that there is an impairment of the lower extremity spinal nerves."

Finally, on the matter of impairment under the A.M.A., *Guides*, Dr. Askin advised: "Respecting the fact that on careful clinical examination with careful attention looking for any neurologic deficit or other consequence of a spinal injury affecting the lower extremities and there being none, I continue to consider that [appellant] has [zero] impairment of the lower extremities secondary to the spinal disorder."

In a decision dated March 24, 2014, OWCP denied appellant's schedule award claim.

On that same date, OWCP issued a preliminary determination that appellant had received a $27,965.52 overpayment of compensation because he was incorrectly paid a schedule award for an 11 percent impairment of his right lower extremity "when in fact you had no such impairment referable to your accepted condition." It found him without fault in creating the overpayment and explained how it calculated the amount.

In a decision dated November 7, 2014, an OWCP hearing representative affirmed OWCP's March 24, 2014 denial of a schedule award. He found that Dr. Askin's most recent evaluation represented the weight of the medical opinion evidence and established that appellant was not entitled to a schedule award.

In a second decision dated November 7, 2014, the same OWCP hearing representative found that OWCP correctly determined that appellant had received a $27,965.52 overpayment of compensation from June 22, 2011 through January 29, 2012 and that appellant was not at fault in creating the overpayment. Appellant did not challenge the calculation of the overpayment. As he indicated on his overpayment recovery questionnaire that he and his wife had over $17,000.00 in their savings account, the hearing representative determined that appellant's assets exceeded the specified resource base; therefore, he was not entitled to waiver of recovery. The hearing representative considered appellant's financial information, which showed $584.00 in monthly discretionary income available for debt repayment. Accordingly, he found that appellant should begin monthly repayments of $500.00 beginning November 1, 2014.

On appeal, appellant argues that Dr. Askin's January 31, 2014 addendum cannot carry the weight of the medical opinion evidence, as he failed to document how he conducted manual muscle testing or neurosensory testing. He did not review Dr. Diamond's September 24, 2013 supplemental report or the most recent imaging study. Dr. Askin's simple conclusion that he finds no neurologic deficit is not well reasoned. At a minimum, appellant argues, OWCP's November 7, 2014 decisions should be vacated and the matter remanded for further medical development.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA[3] provide compensation to employees sustaining permanent impairment from loss or loss of use of specified members 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 making such determination is a matter which rests in the sound 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. The A.M.A., *Guides* has been adopted by OWCP as the standard for evaluating schedule losses, and the Board has concurred in such adoption.[4] For schedule awards issued after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*.[5]

ANALYSIS -- ISSUE 1

In 2010 Dr. Diamond, the osteopath, used Table 16-12, page 534 of the A.M.A., *Guides*, which was meant for impairment due to peripheral nerve injuries. OWCP accepted appellant's claim for aggravation of herniated nucleus pulposus at the L4-5 level. Dr. Diamond therefore should have evaluated lower extremity impairment due to spinal nerve injury. Moreover, an OWCP medical adviser observed that the marked neurological deficits that Dr. Diamond had found on examination seemed inconsistent with the findings of appellant's other physicians. This rendered Dr. Diamond's findings unreliable.

[3] 5 U.S.C. § 8107.

[4] *Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5.a (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

In 2013 Dr. Diamond evaluated appellant's impairment using *The Guides Newsletter* from July/August 2009. This newsletter described how to rate extremity impairment due to spine nerve injury under the sixth edition of the A.M.A., *Guides*. Although this was the proper methodology for rating appellant's impairment, Dr. Diamond did not reexamine appellant to obtain current findings. Instead, he simply applied the methodology to the clinical findings he had obtained in 2010, which were considered inconsistent and unreliable and had become somewhat stale with respect to appellant's current condition. Accordingly, the Board finds that Dr. Diamond's evaluation of impairment has little or no probative value.

Dr. Gordon, the second opinion orthopedic surgeon, also used Table 16-12, page 534 of the A.M.A., *Guides*, which again was meant for peripheral nerve injuries. Further, an OWCP hearing representative found that Dr. Gordon's examination findings were incomplete and therefore insufficient to represent the weight of the medical evidence. The Board therefore finds that his evaluation of impairment has little or no probative value.

Dr. Askin, the next second opinion orthopedic surgeon, rated appellant's impairment under the chapter for impairments to the spine. In an addendum report, like Dr. Diamond and Dr. Gordon before him, he applied Table 16-12 of the A.M.A., *Guides*, relating to peripheral nerve injuries. Further, an OWCP hearing representative explained that it was not obvious that Dr. Askin was examining or testing for neurologic deficits, as he initially offered a whole-person rating and then stated that he "did not specifically seek" any manifestations of neurologic impairment.

Dr. Askin's January 31, 2014 report sufficiently clarified that appellant had no neurological deficits. He explained that his earlier statement should have read that he "did not see" any manifestations of neurologic impairment. Dr. Askin made clear that he carefully examined appellant for neurologic impairment, and there was none, and with his current physical examination of appellant, he emphasized that he did specifically, repeatedly, and carefully look for any objectively determinable change in his lower extremities indicative of nerve damage. He explained that appellant objectively had pitting edema, but this was not a phenomenon that might be associated with his back complaints or back diagnosis. There was no atrophic or dystrophic change about either foot. Appellant reported diminished sensation over the dorsum of both feet and the lower legs, but this did not follow any dermatomal pattern. It was also entirely subjective with no objective clinical corroboration. Straight leg raising was not associated with any discomfort to 90 degrees for either leg. Deep tendon reflexes were symmetric at the knees and ankles. Dr. Askin individually tested the muscles of the toe motors, the flexor halluces longus, extensor halluces longus, flexor digitorum longus, extensor digitorum longus, anterior tibial posterior tibial, and peroneal tendons, hamstrings, quadriceps, hip adductors, hip abductor, hip flexors, and hip extensors. Each and every one of the muscle groups were preserved and capable of exerting normal strength for both lower extremities. The Board finds that Dr. Askin's January 31, 2014 report was based on an appropriate factual and medical history and was sufficiently well rationalized to constitute the weight of the medical opinion evidence on the issue of appellant's lower extremity impairment.

Appellant objects that Dr. Askin did not specifically describe how he conducted sensory or motor testing, but he provided sufficient medical reasoning to establish that appellant's complaints of diminished sensation were unreliable, while other, more objective findings such as the lack of atrophic or dystrophic change about either foot, negative straight leg raising, and

symmetric deep tendon reflexes confirmed the absence of neurologic involvement. As for manual muscle testing, Dr. Askin individually tested a number of muscle groups, and each and every one was preserved and capable of exerting normally. That he did not specifically state that these muscles were able to move a joint through the range of motion with full resistance does not diminish the probative value of his opinion. Dr. Askin is a Board-certified orthopedic surgeon, and he made clear that he did specifically, repeatedly, and carefully look for any objectively determinable change in appellant's lower extremities indicative of nerve damage. He found none.

Accordingly, the Board finds that appellant's 1991 employment injury caused no permanent impairment to his lower extremities. The Board will therefore affirm OWCP's November 7, 2014 decision on appellant's claim for a schedule award.

LEGAL PRECEDENT -- ISSUE 2

If a claimant received a schedule award and the medical evidence does not support the degree of permanent impairment awarded, an overpayment of compensation may be created.[6]

Section 8129(a) of FECA provides that when an overpayment of compensation has been made because of an error of fact or law, adjustment shall be made under regulations prescribed by the Secretary of Labor by decreasing later payments to which an individual is entitled.[7] OWCP may consider waiving an overpayment only if the individual to whom it was made was not at fault in accepting or creating the overpayment.[8] If OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless: (1) adjustment or recovery of the overpayment would defeat the purpose of FECA; or (2) adjustment or recovery of the overpayment would be against equity and good conscience.[9]

Recovery of an overpayment will defeat the purpose of FECA if such recovery would cause hardship to a currently or formerly entitled beneficiary because: (a) the beneficiary from whom OWCP seeks recovery needs substantially all of his current income (including compensation benefits) to meet current ordinary and necessary living expenses; and (b) the beneficiary's assets do not exceed the resource base of $4,800.00 for an individual or $8,000.00 for an individual with a spouse or one dependent, plus $960.00 for each additional dependent.[10]

Recovery of an overpayment is considered to be against equity and good conscience when any individual, in reliance on such payments or on notice that such payments would be

[6] *W.M.*, Docket No. 13-291 (issued June 12, 2013). *See Richard Saldibar*, 51 ECAB 585 (2000); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.9.e (February 2013).

[7] 5 U.S.C. § 8129(a).

[8] 20 C.F.R. § 10.433(a).

[9] *Id*. at § 10.434.

[10] *Id*. at § 10.436; Federal (FECA) Procedure Manual, Part 6 -- Debt Management, *Initial Overpayment Actions*, Chapter 6.200.6.a(1)(b) (June 2009).

made, gives up a valuable right or changes his or her position for the worse.[11] Conversion of the overpayment into a different form, such as food, consumer goods, real estate, etc., from which the claimant derived some benefit, is not to be considered a loss.[12]

ANALYSIS -- ISSUE 2

On June 20, 2012 OWCP issued a schedule award for an 11 percent impairment of the right lower extremity and no impairment of the left lower extremity. This was based on Dr. Gordon's findings and use of Table 16-12, page 534, of the sixth edition of the A.M.A., *Guides*, relating to peripheral nerve injuries, but as Dr. Askin's January 31, 2014 report would later establish, appellant had no neurological deficit and no impairment of his lower extremities. Because further development of the medical evidence showed that OWCP paid the June 20, 2012 schedule award in error, the entire amount of compensation paid under that schedule award is considered an overpayment.

Where a schedule award decision establishes a lesser impairment after a greater award has been paid, the resulting overpayment will have a finding of without fault.[13] The Board will affirm OWCP's November 7, 2014 overpayment decision on the issues of fact and amount of overpayment and the issue of fault.

Appellant was not entitled to waiver of recovery of the overpayment because his assets exceeded the resource base of $8,000.00 for an individual with a spouse. Recovery of the overpayment is therefore not considered to defeat the purpose of FECA. Appellant did not argue detrimental reliance. The record does not support that recovery of the overpayment would be against equity and good conscience. The Board will therefore affirm OWCP's November 7, 2014 overpayment decision on the issue of waiver.

LEGAL PRECEDENT -- ISSUE 3

Whenever an overpayment has been made to an individual who is entitled to further payments, the individual shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his attentions is called to same. If no refund is made, OWCP shall decrease later payments of compensation, taking into account the probable extent of future payments, the rate of compensation, the financial circumstances of the individual, and any other relevant factors, so as to minimize any resulting hardship.[14]

ANALYSIS -- ISSUE 3

Because appellant is not entitled to waiver of recovery of the overpayment, OWCP is required by law to recover the debt by decreasing subsequent payments of compensation. The hearing representative took into account appellant's financial information, understood the

[11] 20 C.F.R. § 10.437(b).

[12] Federal (FECA) Procedure Manual, *supra* note 10 at Chapter 6.200.6.b(3) (June 2009).

[13] *Supra* note 5 at Chapter 2.808.9.e(3) (February 2013).

[14] 20 C.F.R. § 10.441(a).

probable extent of future payment and the rate of compensation, and determined that recovery at the rate of $500.00 a month would minimize any resulting hardship -- not necessarily eliminate it -- while at the same time liquidating the debt in a reasonably prompt fashion. The Board will affirm OWCP's November 7, 2014 overpayment decision on the issue of recovery.

Appellant argues that his monthly expenses exceed his monthly income and that he will have to sell his house. The Board can only render a decision based on the issue presented. As currently presented, there is no justification in the record to warrant a contrary finding on waiver.

CONCLUSION

The Board finds that appellant's 1991 employment injury caused no permanent impairment to his lower extremities. The Board also finds that he is not entitled to waiver of recovery of the overpayment that arose from the schedule award he received. The Board further finds that OWCP took into account relevant factors in setting the rate of recovery from continuing compensation.

ORDER

IT IS HEREBY ORDERED THAT the November 7, 2014 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 11, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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