United States Department of Labor
Employees' Compensation Appeals Board

P.T., Appellant	)	
and	)	**Docket No. 21-0138**
	)	**Issued: June 14, 2021**
U.S. POSTAL SERVICE, FAIRFAX MAIN POST OFFICE, Fairfax, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On November 2, 2020 appellant filed a timely appeal from an August 26, 2020 merit decision, a September 21, 2020 nonmerit decision, and an October 8, 2020 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.[2]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish greater than 25 percent permanent impairment of her left upper extremity for which she previously received a

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the October 8, 2020 decision, appellant submitted additional evidence to OWCP. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

schedule award; (2) whether OWCP properly denied appellant's request for reconsideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a); (3) whether it properly determined that appellant received an overpayment of compensation in the amount of $19,076.22 for the period June 27, 2018 through July 2, 2019 for which she was without fault because she received schedule award compensation for the left upper extremity to which she was not entitled; and (4) whether OWCP properly denied waiver of recovery of the overpayment.

FACTUAL HISTORY

On April 29, 2014 appellant, then a 49-year-old general clerk, filed a traumatic injury claim (Form CA-1)[3] alleging that on April 23, 2014 she experienced left hand and wrist pain, numbness, swelling, and tingling when casing mail while in the performance of duty. She stopped work on April 23, 2014 and returned on June 16, 2014. OWCP accepted the claim for left radial styloid tenosynovitis. It later expanded the acceptance of the claim to include left carpal tunnel syndrome and primary osteoarthritis of the left hand. OWCP paid appellant wage-loss compensation on the supplemental rolls, effective June 10, 2014.

Appellant stopped work on March 29, 2017 and returned to full-duty work on December 13, 2017.

On May 9, 2018 appellant filed a claim for a schedule award (Form CA-7).

In a development letter dated May 15, 2018, OWCP informed appellant that the medical evidence of record was insufficient to establish her schedule award claim. It requested that she submit a detailed narrative medical report from her treating physician based upon a recent examination including a date of maximum medical improvement (MMI), the diagnosis upon which the impairment rating was based, a detailed description of any preexisting impairment, and a final rating of the permanent impairment and discussion of the rationale for calculation of the impairment, with references to the applicable criteria and tables of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

On June 12, 2018 OWCP referred appellant, along with a statement of accepted facts (SOAF), for a second opinion examination with Dr. Easton Manderson, a Board-certified orthopedic surgeon. In a June 26, 2018 report, Dr. Manderson reviewed the SOAF and medical record. He provided physical examination findings and diagnosed failed carpal tunnel syndrome surgery, failed de Quervain's tenderness surgery, sensory nerve injury to the cutaneous branch of the median nerve, and early de Quervain's tenosynovitis of the right wrist. Dr. Manderson opined that appellant had reached MMI on March 29, 2018. Utilizing the diagnosis-based impairment (DBI) method of the sixth edition of the A.M.A., *Guides*, he identified the class of diagnosis (CDX) as a class 2 impairment for the diagnosis of post-surgery arthroplasty of the left wrist under Table 15-3, page 397. Dr. Manderson assigned a grade modifier for functional history (GMFH) of 3, in

[3] OWCP later determined that appellant filed an occupational disease claim (Form CA-2) as her conditions were related to performing her employment duties for a prolonged period of time and not a traumatic injury event.

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

accordance with Table 15-7, page 406, a grade modifier for physical examination (GMPE) of 3, in accordance with Table 15-8, page 408, and a grade modifier for clinical studies (GMCS) of 2, in accordance with Table 15-9, page 410. Utilizing the net adjustment formula, (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX) = (3 - 2) + (3 - 2) + (2 - 2) = 2, he calculated that appellant had a net adjustment of 2, resulting in movement from the default class of C to E and corresponding to 25 percent permanent impairment of the left wrist. Dr. Manderson also identified the CDX as a class 1 impairment for the diagnosis of wrist pain related to de Quervain's tenosynovitis under Table 15-3, page 395. He noted a GMFH of 3, a GMPE of 4, and a GMCS of 0. Dr. Manderson calculated that appellant had a net adjustment of 4, resulting in movement from the default class of C to E and corresponding to 13 percent permanent impairment of the left wrist. He found that appellant had a combined 38 percent permanent impairment of the left upper extremity. Dr. Manderson found that appellant only had 12 percent permanent impairment of the left upper extremity under the range of motion (ROM) method.

On July 5, 2018 OWCP referred appellant's medical record, along with a SOAF, for a schedule award impairment rating with Dr. Herbert White, Jr., a Board-certified specialist in occupational medicine serving as a district medical adviser (DMA). In a July 8, 2018 report, the DMA reviewed the SOAF and medical record. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he identified the CDX as a class 3 impairment for the diagnosis of left thumb carpometacarpal (CMC) arthroplasty under Table 15-2, page 394. The DMA assigned a GMFH of 3 and GMPE of 3 and noted that a GMCS was not applicable. He calculated that appellant had a net adjustment of 0, resulting in no movement from the default class of C and corresponding to 30 percent permanent impairment of the left upper extremity digit, which converted to 11 percent permanent impairment of the left upper extremity under Table 15-12, page 421. The DMA also identified the CDX as a class 1 impairment for the diagnosis of nonspecific wrist pain under Table 15-3, page 395. He reported a GMFH and GMPE of 3 and noted that a GMCS was not applicable. The DMA calculated that appellant had a net adjustment of 4, resulting in movement from the default class of C to E and corresponding to 1 percent permanent impairment of the left upper extremity. He further identified the CDX as a class 1 impairment for the diagnosis of de Quervain's tenosynovitis under Table 15-3, page 395. The DMA assigned a GMPE of 3 and noted that a GMFH and GMCS were not applicable. He calculated that appellant had a net adjustment of 2, resulting in movement from the default class of C to E and corresponding to 2 percent permanent impairment of the left upper extremity. The DMA noted that he could not rate appellant's impairments using the ROM method as ROM measurements were not properly taken. He found that appellant had 13 percent permanent impairment of the left upper extremity and opined that she had reached MMI on June 26, 2018.

In a July 12, 2018 supplemental report, Dr. Manderson provided ROM measurements for appellant's left wrist and thumb. He noted that appellant's ulnar deviation was markedly limited because of severe pain. Utilizing the ROM method of the sixth edition of the A.M.A., *Guides*, Dr. Manderson indicated that appellant's clinical findings coincided with a grade modifier of 3 and 12 percent permanent impairment of the left upper extremity under Table 15-32, page 473.

On July 17, 2018 OWCP referred appellant's case back to the DMA, Dr. White. In a July 17, 2018 report, the DMA reviewed appellant's ROM measurements. Utilizing the ROM method of the sixth edition of the A.M.A., *Guides*, he identified that appellant had 10 degrees of left wrist ulnar deviation under Table 15-32, page 473. The DMA assigned a ROM grade modifier

of 2, in accordance with Table 15-35, page 477, and a functional history grade modifier of 3, in accordance with Table 15-7, page 406. Applying the modifier adjustment, he found that appellant had 13 percent permanent impairment of the left upper extremity. The DMA noted that the ROM method resulted in greater impairment for appellant's left wrist and, therefore, should be used. He calculated that appellant had a combined 23 percent permanent impairment of the left upper extremity.

In a July 24, 2018 supplemental report, Dr. Manderson reviewed the DMA's July 17, 2018 report. He clarified that he rated appellant's arthroplasty as a wrist radiocarpal arthroplasty instead of a thumb CMC arthroplasty. Dr. Manderson noted that he incorrectly identified the CDX as left wrist sprain under Table 15-3, page 395 and instead should have identified the CDX as a class 2 impairment for the diagnosis of left wrist sprain with surgically-induced carpal instability under Table 15-3, page 396. He assigned a GMFH of 3, a GMPE of 4, and a GMCS of 2. Dr. Manderson calculated that appellant had a net adjustment of 3, resulting in movement from the default class of C to E and corresponding to 18 percent permanent impairment of the left upper extremity. He indicated that his other impairment ratings were accurate.

On July 25, 2018 OWCP again referred appellant's case to the DMA, Dr. White. In a July 28, 2018 report, the DMA reviewed Dr. Manderson's July 24, 2018 supplemental report. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he identified the CDX as a class 2 impairment for the diagnosis of complicated, unstable radiocarpal arthroplasty under Table 15-3, page 397. The DMA assigned a GMFH of 3, a GMPE of 3, and a GMCS of 2. He calculated that appellant had a net adjustment of 2, resulting in movement from the default class of C to E and corresponding to 25 percent permanent impairment of the left upper extremity. The DMA, therefore, concurred with Dr. Manderson's assessment. However, he noted that Dr. Manderson improperly combined appellant's impairment ratings related to her left wrist. The DMA indicated that only appellant's radiocarpal arthroplasty should be rated for her left wrist because it resulted in the highest rating. He, therefore, concluded that appellant had 25 percent permanent impairment of the left upper extremity.

By decision dated August 6, 2018, OWCP granted appellant a schedule award for 25 percent permanent impairment of the left upper extremity based on the opinions of Dr. White, the DMA, and Dr. Manderson, the second opinion physician. The award ran for 78 weeks for the period June 27, 2018 to December 24, 2019.

On January 24, 2020 appellant filed a claim for an additional schedule award (Form CA-7).

In support of her claim, appellant submitted a January 22, 2020 work excuse note from Dr. Subir Jossan, a Board-certified orthopedic surgeon, who noted that appellant was at MMI for left hand surgery.

On July 16, 2020 OWCP referred appellant, along with a SOAF, for a second opinion examination with Dr. John C. Barry, a Board-certified orthopedic surgeon. In an August 3, 2020 report, Dr. Barry reviewed the SOAF and medical record. He provided physical examination findings and ROM measurements for appellant's left hand, wrist, and thumb. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, Dr. Barry identified the CDX as a class 3 impairment for the diagnosis of left thumb CMC arthroplasty under Table 15-2, page 394. He

assigned a GMFH of 2 and a GMPE of 3 and noted that a GMCS was not applicable. Dr. Barry found that appellant had 10 percent permanent impairment of the left upper extremity. He also identified the CDX as a class 1 impairment for the diagnosis of de Quervain's syndrome under Table 15-3, page 395. Dr. Barry reported a GMFH of 2 and a GMPE of 3 and noted that a GMCS was not applicable. He found that appellant had one percent permanent impairment of the left upper extremity. Dr. Barry further rated appellant's carpal tunnel syndrome using electrodiagnostic studies, dated July 11, 2019. He applied a test findings grade modifier of 1, a history grade modifier of 3, and a physical findings grade modifier of 2. Dr. Barry found that appellant had five percent permanent impairment of the left upper extremity. He combined appellant's impairment ratings and determined that she had a total of 16 percent permanent impairment of the left upper extremity. Dr. Barry noted that a ROM impairment rating was not appropriate as appellant had normal ROM measurements.

On August 10, 2020 OWCP referred appellant's case to the DMA, Dr. White. In an August 20, 2020 report, the DMA reviewed the SOAF and medical record. Utilizing the DBI method of the sixth edition of the A.M.A., *Guides*, he identified the CDX as a class 3 impairment for the diagnosis of thumb CMC arthroplasty under Table 15-2, page 394. The DMA assigned a GMFH of 2 and a GMPE of 3 and noted that a GMCS was not applicable. He calculated that appellant had a net adjustment of -1, resulting in movement from the default class of C to B and corresponding to 28 percent permanent impairment of the left upper extremity digit, which converted to 10 percent permanent impairment of the left upper extremity under Table 15-12, page 421. The DMA also identified the CDX as a class 1 impairment for the diagnosis of wrist sprain/strain under Table 15-3, page 395. He assigned a GMPE of 3 and noted that a GMFH and GMCS were not applicable. The DMA calculated that appellant had a net adjustment of 2, resulting in movement from the default class of C to E and corresponding to two percent permanent impairment of the left upper extremity. He rated appellant's left carpal tunnel syndrome using the Entrapment/Compression Neuropathy Impairment method under Table 15-23, page 449. The DMA applied a test finding grade modifier of 1, a history grade modifier of 2, and a physical findings grade modifier of 2, resulting in five percent permanent impairment of the left upper extremity impairment. He noted that a ROM impairment rating was not appropriate as appellant had normal ROM measurements. The DMA combined appellant's impairment ratings and determined that she had a total of 17 percent permanent impairment of the left upper extremity. He opined that appellant had reached MMI on August 3, 2020.

By decision dated August 26, 2020, OWCP denied appellant's claim for an additional schedule award, finding that she had not met her burden of proof to establish greater than 25 percent permanent impairment of the left upper extremity for which she previously received a schedule award.

On September 2, 2020 OWCP issued a preliminary overpayment determination, finding that an overpayment of compensation in the amount of $19,076.22 had been created for the period June 27, 2018 through July 2, 2019 because appellant had previously received a schedule award for 25 percent permanent left upper extremity impairment when she only had 17 percent left upper extremity impairment. It found appellant without fault in the creation of the overpayment and provided her with an overpayment action request form and an overpayment recovery questionnaire (Form OWCP-20) for her completion. OWCP requested that she provide supporting financial documentation including income tax returns, bank account statements, bills and cancelled checks,

pay slips, and any other records to support her reported income and expenses. It notified appellant that, within 30 days of the date of the letter, she could request a telephone conference, a final decision based on the written evidence, or a prerecoupment hearing.

On September 17, 2020 appellant requested reconsideration of the August 26, 2020 decision denying her claim for an additional schedule award.

By decision dated September 21, 2020, OWCP denied appellant's request for reconsideration of the merits of her claim pursuant to 5 U.S.C. § 8128(a).

OWCP subsequently received an overpayment action request form, dated September 8, 2020, in which appellant disagreed that the overpayment occurred, disagreed with the amount of the overpayment, and requested waiver of recovery of the overpayment because she was found to be without fault in the creation of the overpayment. In an accompanying letter, appellant asserted that she would suffer financial loss as a result of repayment of the debt and would be unable to support her daughter who lived with her. She challenged the fact and amount of overpayment, noting that she was not involved in the impairment ratings and suffered permanent impairment to her left hand.

By decision dated October 8, 2020, OWCP finalized its preliminary determination that appellant had received an overpayment of compensation in the amount of $19,076.22 for the period June 27, 2018 through July 2, 2019, because she received schedule award compensation for the left upper extremity to which she was not entitled. It further found that she was without fault in the creation of the overpayment, but denied waiver of recovery of the overpayment because the evidence of record was insufficient to establish that recovery of an overpayment would defeat the purpose of FECA or would be against equity and good conscience. OWCP required recovery of the overpayment bimonthly payments in the amount of $320.00.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA,[5] and its implementing federal regulations,[6] 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. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id.* at § 10.404(a).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Chapter 3.700.2 and Exhibit 1 (January 2010).

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[9] In Table 15-23, grade modifiers levels (ranging from 0 to 4) are described for the categories Test Findings, History, and Physical Findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities.[10]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning Disability and Health (ICF).[11] Under the sixth edition, the evaluator identifies the CDX, which is then adjusted by the GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Evaluators are directed to provide reasons for their impairment rating, including the choice of diagnoses from regional grids and the calculation of the modifier score.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of permanent impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[15]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides, in part:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,]*

[9] A.M.A., *Guides* at 449.

[10] A survey completed by a given claimant, known by the name *Quick*DASH, may be used to determine the functional scale score. *Id*. at 448-49; *see also J.H.*, Docket No. 19-0395 (issued August 10, 2020).

[11] A.M.A., *Guides*, page 3, section 1.3, The International Classification of Functioning, Disability, and Health (ICF): A Contemporary Model of Disablement.

[12] *Id.* at 493-556.

[13] *Id.* at 521.

[14] *E.W.*, Docket No. 19-1720 (issued November 25, 2020); *R.R.*, Docket No. 17-1947 (issued December 19, 2018); *R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[15] *See supra* note 8 at Chapter 2.808.6(f) (March 2017).

Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used." (Emphasis in the original.)[16]

The Bulletin further advises:

"If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.[17]

"It is well established that benefits payable under 5 U.S.C. § 8107(c) are reduced by the period of compensation paid under the schedule for an earlier injury if: (1) compensation in both cases is for impairment of the same member or function or different part of the same member or function or different parts of the same member or function; and (2) the latter impairment in whole or in part would duplicate the compensation payable for the preexisting impairment."[18]

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision.

On July 16, 2020 OWCP referred appellant, along with a SOAF, for a second-opinion examination with Dr. Barry. In an August 3, 2020 report, Dr. Barry provided an impairment rating using the sixth edition of the A.M.A., *Guides*. Utilizing the DBI method, he identified the CDX as a class 3 impairment for the diagnosis of left thumb CMC arthroplasty and assigned a GMFH of 2 and a GMPE of 3. Dr. Barry found that appellant had class B, 10 percent permanent impairment of the left upper extremity. He also identified the CDX as a class 1 impairment for the diagnosis of de Quervain's syndrome and reported a GMFH of 2 and a GMPE of 3. Dr. Barry found that appellant had class E, 1 percent permanent impairment of the left upper extremity impairment. He further rated appellant's carpal tunnel syndrome and applied a test findings grade modifier of 1, a history grade modifier of 3, and a physical findings grade modifier of 2. Dr. Barry found that appellant had five percent permanent impairment of the left upper extremity impairment. He combined appellant's impairment ratings and determined that she had 16 percent permanent of the left upper extremity impairment. Dr. Barry noted that a ROM impairment rating was not appropriate as appellant had normal ROM measurements.

[16] FECA Bulletin No. 17-06 (issued May 8, 2017). *See also L.G.*, Docket No. 18-0519 (issued March 8, 2019); *D.F.*, Docket No. 17-1474 (issued January 23, 2018).

[17] *Id.*

[18] 20 C.F.R. § 10.404(d); *see J.D. (J.D.)*, Docket No. 19-1168 (issued March 29, 2021); *T.S.*, Docket No. 16-1406 (issued August 9, 2017).

Consistent with its procedures, OWCP properly referred the matter to a DMA for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[19]

In an August 20, 2020 report, the DMA, Dr. White, provided an impairment rating. using the sixth edition of the A.M.A., *Guides*. Utilizing the DBI method, he identified the CDX as a class 3 impairment for the diagnosis of thumb CMC arthroplasty and assigned a GMFH of 2 and a GMPE of 3. The DMA calculated that appellant had a net adjustment of -1, resulting in movement from the default class of C to B and corresponding to 28 percent left upper extremity digit impairment, which converted to 10 percent permanent impairment of the left upper extremity. He also identified the CDX as a class 1 impairment for the diagnosis of wrist sprain/strain and reported a GMPE of 3. The DMA calculated that appellant had a net adjustment of 2, resulting in movement from the default class of C to E and corresponding to two percent permanent impairment of the left upper extremity. He rated appellant's left carpal tunnel syndrome using the Entrapment/Compression Neuropathy Impairment method and applied a test findings grade modifier of 1, a history grade modifier of 2, and a physical findings grade modifier of 2, resulting in five percent permanent impairment of the left upper extremity. The DMA noted that a ROM impairment rating was not appropriate as appellant had normal ROM measurements. He combined appellant's impairment ratings and determined that she had 17 percent permanent impairment of the left upper extremity. The DMA opined that appellant had reached MMI on August 3, 2020.

The Board finds that the DMA failed to adequately explain his opinion in accordance with the relevant standards. Although he identified the CDX as a class 3 impairment for the diagnosis of thumb CMC arthroplasty and a class 1 impairment for the diagnosis of wrist sprain/strain, the DMA did not explain why he classified appellant's arthroplasty as a thumb CMC arthroplasty when he previously identified the CDX as a class 2 impairment for the diagnosis of complicated, unstable radiocarpal arthroplasty under Table 15-3, page 397, in his July 28, 2018 report. Furthermore, as noted, grade modifiers should be considered under the Entrapment/Compression Neuropathy Impairment procedures and the DBI method of the A.M.A., *Guides*.[20] While the DMA cited to Tables 15-7, 15-8, 15-9, and 15-23, he did not provide medical rationale for his choice of grade modifiers or reference any objective findings.[21] Consequently, the Board finds that the DMA's report requires clarification.

It is well established that proceedings under FECA are not adversarial in nature and, while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[22] Once OWCP undertook development of the

[19] *See S.C.*, Docket No. 20-0769 (issued January 12, 2021).

[20] *Supra* notes 10 and 12.

[21] *Id.*

[22] *See W.W.*, Docket No. 18-0093 (issued October 9, 2018); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

evidence by referring appellant's case file to an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[23]

The case is, therefore, remanded to OWCP for referral of the case record and a SOAF to the DMA for a proper analysis under the A.M.A., *Guides*, applying FECA Bulletin No. 17-06, in order to determine the extent of appellant's permanent impairment of the left upper extremity. After this and such other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.[24]

ORDER

IT IS HEREBY ORDERED THAT the August 26, September 21, and October 8, 2020 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: June 14, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[23] *See G.M.*, Docket No. 19-1931 (issued May 28, 2020); *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

[24] In light of the Board's disposition of Issue 1, Issues 2, 3 and 4 are rendered moot. As the fact of overpayment, if any, is not in posture until resolution of the increased schedule award, the Board finds that the determination of an overpayment and any recoupment thereof is premature.