U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JAN L. WALTER and U.S. POSTAL SERVICE,
POST OFFICE, Humble, Tex.

Docket No. 96-1967; Submitted on the Record;
Issued October 28, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issues are: (1) whether the Office of Workers' Compensation Programs properly determined that appellant received an overpayment of compensation benefits in the amount of $4,136.87; (2) whether the Office properly determined that appellant was at fault in the creation of the overpayment in the amount of $4,136.87; (3) whether the Office properly required repayment of the overpayment by withholding $113.00 from appellant's continuing monthly compensation benefits; and (4) whether the Office met its burden of proof in terminating appellant's compensation benefits effective April 27, 1996.

Appellant, a rural mail carrier, filed a traumatic injury claim for a back injury sustained on August 23, 1983.[1] The Office accepted appellant's claim for lumbosacral strain and lumbar radiculopathy.

By letter dated April 18, 1995, the Office advised appellant that it had made a preliminary determination that an overpayment had occurred in the amount of $4,136.87 because health benefits, and optional life and post-retirement optional life insurance premiums were not deducted from her compensation. The Office further advised appellant that she was at fault in the creation of the overpayment because she accepted and cashed payments which she knew or reasonably should have known were in error. In addition, the Office advised appellant that she could request a telephone conference, a final decision based on the written evidence only, or a hearing within 30 days of the date of this letter if she disagreed that the overpayment occurred, if she disagreed with the amount of the overpayment, if she believed that the overpayment occurred through no fault of her own, and if she believed that recovery of the overpayment should be waived. The Office requested that appellant complete an attached overpayment recovery questionnaire (Form OWCP-20) and submit financial documents in support thereof.

[1] The record reveals that on February 16, 1993 appellant retired from the employing establishment on disability.

In an accompanying memorandum, the Office calculated the amount of appellant's health and life insurance premiums that should have been deducted from her compensation during the period April 22, 1992 through September 17, 1994. The Office based its fault finding on the fact that appellant received two CA-1049 form letters dated September 15, 1992 and January 26, 1993 which indicated that no health and life insurance deductions had been made. The Office further found that it was unaware that appellant had health and life insurance coverage because two Forms CA-7 submitted by appellant did not make any reference to such coverage. The Office also found that appellant finally notified it on March 8, 1994 that she had elected health benefits. The Office then found that no mention of life insurance coverage was made until the Office of Personnel Management (OPM) submitted a master list of appellant's coverage.

On June 12, 1995 the Office finalized the overpayment decision and the finding of fault, and advised appellant of how the overpayment would be collected.

In a notice of proposed termination of compensation dated February 22, 1996, the Office advised appellant that it proposed to terminate her compensation benefits because the medical evidence of record failed to establish continued disability. The Office also advised appellant to submit additional medical evidence supportive of her continued disability within 30 days.

By decision dated April 8, 1996, the Office terminated appellant's compensation benefits effective April 27, 1996 on the grounds that the weight of the evidence of record established that appellant's work-related conditions had ceased.

The Board finds that the Office properly determined that appellant received an overpayment of compensation benefits in the amount of $4,136.87.

The record reveals that appellant had medical and life insurance coverage during the period April 22, 1992 through September 17, 1994, but that the amount of the premiums for this coverage was not deducted from appellant's compensation during this period. Accordingly, the Board finds that appellant received an overpayment of compensation in the amount of $4,136.87 based on the nondeduction of health and life insurance premiums.

The Board also finds that the Office improperly determined that appellant was at fault in the creation of the overpayment in the amount of $4,136.87.

Section 8129(a) of the Federal Employees' Compensation Act provides that when an overpayment of compensation has been made "because of an error of fact or law," adjustment shall be made by decreasing later payments to which an individual is entitled.[2] The only exception to this requirement is a situation which meets the test set forth as follows in section 8129(b): "[a]djustment or recovery by the United States may not be made when incorrect payment has been made to an individual who is without fault and when adjustment or recovery would defeat the purpose of the Act or would be against equity and good conscience."[3] Thus, the Office may not waive the overpayment of compensation in this case unless appellant was

[2] 5 U.S.C. § 8129.

[3] 5 U.S.C. § 8129(b).

without fault.[4] In evaluation of whether appellant is without fault, the Office will consider whether appellant's receipt of the overpayment occurred because she relied on misinformation given by an official source within the Office or another government agency which appellant had reason to believe was connected with administration of benefits as to the interpretation of the Act or applicable regulations.[5]

In determining whether an individual is at fault, section 10.320(b) of the Code of Federal Regulations provides in relevant part:

"An individual is with fault in the creation of an overpayment who:

> (1) Made an incorrect statement as to a material fact which the individual knew or should have known to be incorrect; or
>
> (2) Failed to furnish information which the individual knew or should have known to be material; or
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> (3) With respect to the overpaid individual only, accepted a payment which the individual knew or should have been expected to know was incorrect."[6]

In this case, the Office applied the third standard -- appellant accepted payments which she knew or should have known were incorrect -- in finding appellant to be at fault in the creation of the overpayment. The record, however, does not establish such knowledge during the period April 22, 1992 through March 7, 1994, with regard to health insurance premiums or during the period April 22, 1992 through September 17, 1994, with regard to life insurance premiums.

With respect to whether an individual is without fault, section 10.320(c) of the Office's regulations provides in relevant part:

> "Whether an individual is 'without fault' depends on all the circumstances surrounding the overpayment in the particular case. The Office will consider the individual's understanding of any reporting requirements, the agreement to report events affecting payments, knowledge of the occurrence of events that should have been reported, efforts to comply with the reporting requirements, opportunities to comply with the reporting requirements, understanding of the obligation to return payments which were not due and ability to comply with any reporting requirements...."[7]

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[4] *Harold W. Steele*, 38 ECAB 245 (1986).

[5] 20 C.F.R. § 10.320(c)(1).

[6] 20 C.F.R. § 10.320(b).

[7] 20 C.F.R. § 10.320(c).

After consideration of all the circumstances surrounding the overpayment, the Board finds that the facts of this case do not establish that appellant knew or should have been expected to know that she accepted incorrect compensation payments during the periods April 22, 1992 through March 7, 1994 for the nondeduction of health premiums and April 22, 1992 through September 17, 1994 for the nondeduction of life insurance premiums.

The Board has recognized that OPM has taken the position that health benefit deductions from compensation payments must be retroactive to the date that the deductions cease and, therefore, it is OPM's policy which requires the Office to treat undereductions of health benefit premiums as overpayments of compensation and apply the Act's procedures to these overpayments.[8]

The Board has held that, where the Office advises appellant through a CA-1049 Office form letter of the gross amount of compensation to which she would be entitled every four weeks and only indicates a place for deductions for optional insurance, the CA-1049 form is not sufficient to put appellant on notice that such deductions should have been made. In *Gerald R. Brown*,[9] a CA-1049 form letter indicated that no deductions were being made for optional life insurance and the Office determined that appellant was with fault as appellant knew or should have known that deductions from his compensation payments should have been made for the optional life insurance. However, the Board found that there was nothing in the record which should have alerted appellant that he was responsible for continuing payments on optional life insurance or that such payments should be deducted from his compensation. The Board found appellant to be without fault in the creation of the overpayment and remanded the case to the Office for a determination on the issue of waiver.[10]

The Office, in the instant case, issued a CA-1049 form letter dated September 15, 1992, advising appellant that she would be paid net compensation in the amount of $3,021.15 for the period July 8 through August 22, 1992, and that her regular compensation payments every four weeks thereafter would be $1,831.00. In a January 26, 1993 CA-1049 form letter, the Office advised appellant that she would be paid compensation in the amount of $457.75 for the period January 2 through 9, 1993 and that her regular compensation payments every four weeks thereafter would be $1,831.00. In both form letters, the Office indicated that the amount of gross weekly compensation was not further reduced by any health or optional life insurance premiums.

In a March 8, 1994 letter, appellant made a request to change her physician and addressed her need for medical treatment. She also advised the Office that she had received a letter from OPM advising her to "notify the Office making compensation payments to me that there are no deductions being taken out of my compensation at this time, nor have there ever been any." The record does not indicate that prior to March 8, 1994 appellant had any knowledge that health insurance premiums should have been deducted from her compensation. The Office received a master list from OPM indicating appellant's health and life insurance

[8] *John E. Rowland*, 39 ECAB 1377 (1988).

[9] 39 ECAB 1417 (1988).

[10] *Id.*

coverage during the period April 22, 1992 through September 17, 1994 and that no deductions had been made. There is no other evidence in the record which pertains to the issue of appellant's knowledge of her obligation to have health and life insurance deductions made from her compensation entitlement during the period April 22, 1992 through March 7, 1994 and April 22, 1992 through September 17, 1994, respectively, and nothing which should have alerted appellant that she was responsible for continuing health and life insurance premium payments. The Board finds that the CA-1049 form letters were insufficient to establish that appellant knew or should have been expected to know that she had accepted incorrect compensation amounts.[11]

For this reason, appellant is without fault in the creation of the overpayment during the periods April 22, 1992 through March 7, 1994, with regard to the health insurance deductions, and April 22, 1992 through September 17, 1994, with regard to the life insurance deductions. Therefore, the case will be remanded to the Office for further development with respect to whether appellant is entitled to waiver of the overpayment under 20 C.F.R. §§ 10.322 and 10.323.

The Board, however, finds that the Office properly determined that appellant was at fault in the creation of the overpayment of compensation for the period March 8 through September 17, 1994 with regard to the nondeduction of her health insurance premiums, which appellant knew or should have been expected to know that she accepted incorrect compensation amounts.

Appellant's March 8, 1994 letter advising the Office that OPM had advised her to notify the Office "that there are no deductions being taken out of my compensation at this time, nor have there ever been any," together with her June 7, 1994 letter to the Office advising that she was attempting to have her health insurance "deductions taken care of," establish that she was aware that health insurance premiums should have been deducted from her compensation. The Board finds that the evidence of record establishes that appellant knew or should have known of the incorrect payment of compensation based on the nondeduction of her health insurance premiums as of March 8, 1994. For this reason, the fault determination will be affirmed for this period.

The Board further finds that the case is not in posture for decision regarding the method of recovery of the overpayment.

Section 10.321 of Title 20 of the Code of Federal Regulations provides in pertinent part:

> "Whenever an overpayment has been made to an individual who is entitled to further payments, proper adjustment shall be made by decreasing subsequent payments of compensation, having due regard to the probable extent of future payments, the rate of compensation, the financial circumstances of the individual,

[11] *See John E. Rowland, supra* note 8.

and any other relevant factors, so as to minimize any resulting hardship upon such individual."[12]

The record reveals that the Office required appellant to repay the overpayment in the amount of $113.00 every four weeks. The case, however, is not in posture for decision because, as explained above, the case will be remanded for a determination regarding appellant's entitlement to waiver of the overpayment. If it is determined on remand that appellant is not entitled to such waiver, the Office should make a redetermination pertaining to recovery of the overpayment.

The Board additionally finds that the Office met its burden of proof in terminating appellant's compensation benefits effective April 27, 1996.

Once the Office has accepted a claim and pays compensation, it has the burden of proof of justifying termination or modification of compensation benefits.[13] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[14]

In the present case, the Office accepted that appellant sustained a lumbosacral strain and lumbar radiculopathy. The Office terminated appellant's compensation benefits based on the September 26, 1994 medical report of Dr. J. Martin Barrash, a Board-certified neurosurgeon, and the January 17, 1996 supplemental medical report of Dr. Leonard Hershkowitz, a Board-certified neurologist and second opinion physician. In his medical report, Dr. Barrash noted a review of medical records, a history of the August 23, 1983 employment injury and appellant's medical treatment. Dr. Barrash also noted his findings on physical, objective and neurological examination. Dr. Barrash opined that he was certain that appellant had reached recovery. Dr. Barrash stated that appellant could perform the duties of her position with difficulty due to her diabetes, advanced age and obesity. Dr. Barrash recommended physical restrictions and stated that appellant's continuing medical problems were unrelated to her employment. Dr. Barrash further stated that the degenerative pattern in appellant's back was from wear and tear, and that appellant's diabetes, silent heart attack, hypothyroidism, obesity and sleep apnea were not related to her employment.

In his November 6, 1995 medical report, Dr. Hershkowitz indicated a review of medical records, a history of the August 23, 1983 employment injury and appellant's medical treatment, and his findings on neurological examination. Dr. Hershkowitz opined that there were no objective findings of lumbar radiculopathy because the reflexes were symmetrical, there was no weakness, and sensory findings were equal and compatible with diabetic neuropathy. Dr. Hershkowitz further opined that the symptoms of radicular pain were present, which

[12] 20 C.F.R. § 10.321(a); *see Donald R. Schueler*, 39 ECAB 1056, 1062 (1988).

[13] *Curtis Hall*, 45 ECAB 316 (1994); *John E. Lemker*, 45 ECAB 258 (1993); *Robert C. Fay*, 39 ECAB 163 (1987).

[14] *Jason C. Armstrong*, 40 ECAB 907 (1989).

appellant stated had existed for four months. Regarding the lumbosacral sprain, Dr. Hershkowitz opined that the condition was present for a long time and that it was disabling given appellant's current medical condition and being overweight. Dr. Hershkowitz stated that appellant could perform limited-duty work with physical restrictions. Dr. Hershkowitz further stated that appellant's current disability was nonwork related and was more likely related to her other concurrent medical conditions.

In response to the Office's January 9, 1996 letter, requesting clarification of his report regarding whether appellant had any disabling residuals and back pain due to the August 23, 1983 employment injury, Dr. Hershkowitz opined in a January 17, 1996 supplemental medical report that there were no disabling residuals from the employment injury and that appellant's current pain was related to continuing obesity rather than as a residual of her previous injury. The Board finds that the opinions of Drs. Barrash and Hershkowitz are well rationalized and based on an accurate factual and medical background to support a finding that appellant was no longer disabled due to the accepted August 23, 1983 employment injury.

The Office received the October 2, 1995 medical report of Dr. Andrew P. Kant, a Board-certified orthopedic surgeon and appellant's treating physician, noting appellant's complaints of persistent back pain and weakness of the right foot which was diagnosed as gout. Dr. Kant noted his findings on objective and physical examination. Dr. Kant stated that appellant had a flare-up of her radiculopathy which was resolving spontaneously. The Office also received Dr. Kant's January 31, 1996 medical report revealing appellant's medical treatment, and his findings on physical, neurological and objective examination. Dr. Kant diagnosed diabetes, gout, hypothyroidis, spondylolisthesis with lumbar radiculopathy and peripheral neuropathy. Inasmuch as Dr. Kant failed to attribute appellant's conditions to the August 23, 1983 employment injury, the Board finds that his medical reports are insufficient to establish continued disability due to the August 23, 1983 employment injury.

In a February 21, 1996 medical report, Dr. Kant stated that appellant's electromyogram was consistent with a mild sensory and motor peripheral neuropathy which was consistent with appellant's history of diabetes and with a "possible" mild lumbar radiculopathy. Dr. Kant further stated appellant's magnetic resonance imaging (MRI) findings indicated degenerative changes and peripheral neuropathy. Dr. Kant's report is speculative inasmuch as he did not provide an exact diagnosis with regard to the existence of lumbar radiculopathy[15] and failed to explain how or why appellant's disability was caused by this accepted condition. Therefore, Dr. Kant's report is insufficient to establish continued disability causally related to the August 23, 1983 employment injury.

Dr. Kant's February 26, 1996 medical report revealed that based on an electromyogram, there was evidence of a peripheral sensory motor neuropathy which was probably related to appellant's diabetes and that there was no evidence of a lumbosacral radiculopathy.

The February 8, 1996 electromyography results of Dr. Samuel J. Alianell, a physiatrist, provided a history of appellant's condition and medical treatment, as well as, his findings on

[15] *William S. Wright*, 45 ECAB 498 (1994); *Nino V. Digrezio*, 39 ECAB 366 (1988).

physical and objective examination. Based on the electromyography results, Dr. Alianell opined that the study was abnormal, that the findings were consistent with mild sensory motor peripheral neuropathy noting that the prolonged F-wave latencies were a nonspecific finding that could be related to peripheral neuropathy, "possibly" a lumbar radiculopathy. Dr. Alianell further opined that there was no electrodiagnostic evidence on needle examination to document active lumbosacral radiculopathy. Dr. Alianell stated that an absent sural sensory response could be normal in a 62-year-old individual as it was frequently absent after this age. The Board has held that, while the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty,[16] neither can such opinion be speculative or equivocal. The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.[17] Dr. Alianell's report as to whether appellant's condition was due to a lumbar radiculopathy is equivocal and speculative. Therefore, it has little probative value and is insufficient to establish continued disability due to the August 23, 1983 employment injury.

A February 19, 1996 MRI report from Dr. Madan Kulkarni, a Board-certified nuclear radiologist, revealed that appellant had degenerative changes with the disc bulging and spurring, and grade-I spondylolisthesis at L4-5 which was "most likely" due to degenerative spondylolisthesis with right lateral recess compromise. Dr. Kulkarni's report is insufficient to establish continued disability inasmuch as it is speculative as to the cause of appellant's condition[18] and fails to attribute appellant's condition to the accepted employment injuries of lumbosacral strain and lumbar radiculopathy.

As the opinions of Drs. Barrash and Hershkowitz constitute the weight of the reliable, probative and substantial evidence, the Board finds that the Office properly terminated appellant's compensation benefits.

[16] *See Kenneth J. Deerman*, 34 ECAB 641 (1983).

[17] *Phillip J. Deroo*, 39 ECAB 1294 (1988); *Margaret A. Donnelly*, 15 ECAB 40 (1963); *Morris Scanlon*, 11 ECAB 384 (1960).

[18] *Id.*

The April 8, 1996 decision of the Office of Workers' Compensation Programs is hereby affirmed. The June 12, 1995 decision of the Office is hereby affirmed in part with respect to the fact and amount of the overpayment, reversed in part with respect to the fault determination for the period April 22, 1992 through March 7, 1994 regarding health insurance deductions and for the period April 22, 1992 through September 17, 1994 regarding life insurance deductions; affirmed in part with respect to the fault determination for the period March 8 through September 17, 1994 regarding health insurance deductions; and remanded on the issue of waiver. The case is remanded to the Office for further proceedings consistent with this decision of the Board to be followed by an appropriate decision.

Dated, Washington, D.C.
October 28, 1998

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member