United States Department of Labor
Employees' Compensation Appeals Board

M.R., Appellant	)	
and	)	**Docket No. 08-610**
	)	**Issued: August 22, 2008**
U.S. POSTAL SERVICE, NORTHERN ILLINOIS PERFORMANCE CLUSTER, Carol Stream, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 26, 2007 appellant filed a timely appeal of the November 29, 2007 merit decision of the Office of Workers' Compensation Programs, which found that she received an overpayment of compensation, and an April 30, 2007 Office hearing representative's schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

ISSUES

The issues are: (1) whether appellant has established more than 15 percent right upper extremity impairment and more than 10 percent left upper extremity impairment, for which she received schedule awards; (2) whether appellant received an overpayment of $4,852.01 for the period November 20, 2004 through July 8, 2006; and (3) whether the Office properly denied waiver of the overpayment.

FACTUAL HISTORY

On September 4, 2003 appellant, a 39-year-old mail processor clerk, filed an occupational disease claim for bilateral wrist and arm pain she attributed to her employment. The Office accepted her claim for bilateral carpal tunnel syndrome, bilateral tendinitis of the hands and wrists, and bilateral cubital tunnel syndrome and paid appropriate benefits.[1] Appellant was unable to work from November 2003 through September 2004 as a result of several surgeries to her hands. She returned to work in a limited-duty position.

On April 20, 2005 appellant filed a Form CA-7 claim for a schedule award. In an April 13, 2005 report, Dr. Jacob Salomon, a general surgeon, reviewed medical records and set forth his examination findings of November 20, 2004. He opined that appellant had 34 percent left arm impairment and 22 percent right arm impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). Dr. Salomon advised that appellant had de Quervain's syndrome and arthritis of the thumbs and included such conditions in the impairment rating.

The Office forwarded Dr. Salomon's report, together with the medical evidence of file and a statement of accepted facts, to an Office medical adviser for review. In an October 9, 2005 report, the Office medical adviser found that appellant reached maximum medical improvement on November 20, 2004, the date of Dr. Salomon's examination. Based on the findings contained in Dr. Salomon's April 13, 2005 report, the Office medical adviser opined that appellant had 21 percent right arm impairment and 14 percent left arm impairment.

By decision dated November 22, 2005, the Office granted appellant schedule awards for 21 percent right upper extremity impairment and 14 percent left upper extremity impairment. The period of the schedule award was 109.20 weeks, from November 20, 2004 through December 24, 2006.

Appellant disagreed with the Office's November 22, 2005 decision and requested an oral hearing before an Office hearing representative. By decision dated March 2, 2006, an Office hearing representative found the case not in posture for decision due to a medical conflict between Dr. Salomon and the Office medical adviser. The hearing representative found that, while the medical adviser based his opinion on the physical findings noted in Dr. Salomon's report, he did not address why he disagreed with Dr. Salomon's impairment rating. The hearing representative further noted that there was no indication that the Office had accepted appellant's de Quervain's syndrome and arthritis of the thumbs as work related, thus clarification was needed with respect to bilateral thumb impairment. The case was remanded to the Office for referral to an impartial medical examiner.

The Office referred appellant, together with a copy of the medical record, a statement of accepted facts, and a list of questions, to Dr. Mukund Komanduri, a Board-certified orthopedic

[1] The record reflects appellant had five separate surgeries, including the carpal tunnel release of the right hand, carpal tunnel release of the left hand, two separate de Quervain's releases, and revision of her keloid scar of her right wrist.

surgeon, for an impartial medical evaluation to assess appellant's bilateral upper extremity impairment pursuant to the A.M.A., *Guides.* In a May 2, 2006 report, Dr. Komanduri noted the history of injury, his review of the medical record, and presented findings on examination. He noted a substantial diminishment of grip strength and thenar atrophy, as well as weakness of her thumb abductors. Tenderness and pain over all of her incisions and scars with a positive Tinel's sign over her right cubital tunnel was also noted. Appellant had chronic fatigue and pain and discomfort associated with her eight-hour workday. Examination findings revealed abductor pollicis brevis (APB) strength in both hands as 4/5, full motion of the metacarpophalangeal (MP) thumb joints and interphalangeal (IP) joints and full adduction in both thumbs. Both wrists had a mildly positive Finkelstein maneuver, with full flexion of 60 degrees and full extension of 70 degrees, and full supination and pronation. Radial and ulnar deviation was normal. Dr. Komanduri advised that appellant's multiple levels of nerve entrapment and tendon triggering were a classic picture for other causes, such as an autoimmune disorder, hypothyroidism, diabetes or obesity. He advised that, until those conditions have been proven not to exist, he could not assign causality to all of appellant's complaints. Dr. Komanduri stated that it was reasonable to assign causality for her carpal tunnel syndrome to her work activities and possibly even the de Quervain's tenosynovitis. However, he opined that the cubital tunnel syndrome, which was only confirmed in the right elbow, the alleged lateral epicondylitis and shoulder pain were not causally connected to her work activities at this time. Dr. Komanduri stated that appellant reached maximum medical improvement on or about January 2005. He further stated that his findings, in correlation with A.M.A., *Guides*, were substantially less than that reported by Dr. Salomon and opined that he would rate such deficits as 11 percent of the right arm and 7 percent of the left arm.

In a July 18, 2006 report, an Office medical adviser opined that appellant had a 15 percent impairment of the right arm and a 10 percent impairment of the left arm based on the findings contained in Dr. Komanduri's May 2, 2006 report. He noted that the range of motion findings for both the thumb and wrist on both sides were documented as full in Dr. Komanduri's report as therefore resulted in no impairment. For the finding of loss of strength of 4/5 of the APB, the medical adviser awarded three percent impairment for both the left and right arms under Table 16-11, page 484 and Table 16-15, page 492 of the A.M.A., *Guides*. For impairments due to pain in the right arm, he awarded 12 percent impairment. Under Table 16-10, page 482 and Table 16-15, page 492 of the A.M.A., *Guides*, the medical adviser calculated a two percent impairment resulting from a Grade 3 sensory deficit in the distribution of the dorsal radial sensory nerve branch to the wrist; five percent impairment resulting from Grade 4 sensory deficit in the distribution of the median nerve, and five percent impairment resulting from a Grade 4 sensory deficit in the distribution of the ulnar nerve. Utilizing the Combined Values Chart, he found that appellant had 12 percent right arm impairment from pain/sensory deficits. For impairments due to pain in the left arm, the medical adviser awarded seven percent impairment. Under Table 16-10, page 482 and Table 16-15, page 492 of the A.M.A., *Guides,* he calculated two percent impairment resulting from a Grade 3 sensory deficit in the distribution of the dorsal radial sensory nerve branch to the wrist and five percent impairment resulting from Grade 4 sensory deficit in the distribution of the ulnar nerve. Utilizing the Combined Values Chart, the medical adviser found that appellant had seven percent right arm impairment from pain/sensory deficits. He used the Combined Values Chart to find 15 percent right arm impairment and 10 percent left arm impairment. The medical adviser stated that, under page 494

of the A.M.A., *Guides*, additional impairment values are not given for decreased grip in compression neuropathies. He additionally advised that maximum medical improvement was obtained on November 20, 2004, as previously reported.

By decision dated August 15, 2006, the Office granted appellant a schedule award for 15 percent right arm impairment and 10 percent left arm impairment.

Also on August 15, 2006 the Office notified appellant of its preliminary determination that she received an overpayment in the amount of $4,852.01 for the period November 20, 2004 through May 19, 2006 based on the fact that the schedule award of her upper extremities had been recalculated. From its compensation worksheets, the Office noted that she had received $56,594.36 in benefits for a permanent impairment rating for 14 percent left upper extremity impairment and 21 percent right upper extremity impairment for the period November 20, 2004 through July 8, 2006 when she should have been paid $51,742.35 in benefits for 15 percent right upper extremity impairment and 10 percent left upper extremity impairment for the period November 20, 2004 through May 19, 2006. The Office further informed appellant of its preliminary determination that she was without fault in creating the overpayment and requested that she submit financial information within 30 days. It noted that waiver would be denied if she failed to furnish the information requested.

Appellant disagreed with the Office's August 15, 2006 schedule award determination and requested an oral hearing, which was held February 14, 2007. In a March 6, 2007 report, Dr. Salomon noted his findings on examination and opined that appellant had 39 percent left arm impairment and 38 percent right arm impairment under the A.M.A., *Guides*.

By decision dated April 30, 2007, an Office hearing representative affirmed the Office's August 15, 2006 schedule award determination. The hearing representative found that the weight of the medical opinion evidence was represented by Dr. Komanduri and the Office medical adviser.[2]

By decision dated November 29, 2007, the Office finalized the overpayment determination and found that appellant was not entitled to waiver of the $4,852.01 overpayment of compensation created as a result of the schedule award recalculation. It directed that appellant either repay the overpayment in full or contact the Office to arrange a repayment plan.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act[3] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of

[2] The Office's hearing representative noted that appellant did not wish to address the overpayment issue at the hearing.

[3] 5 U.S.C. § 8107.

permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides.*[4]

Office procedures[5] provide that upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using section 16.5d and Tables 16-10, 16-11 and 16-15.[6]

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[7] When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[8]

Office procedures provide that, after obtaining all necessary medical evidence, the file should be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the Office medical adviser providing rationale for the percentage of impairment specified.[9]

ANALYSIS -- ISSUE 1

Due to the conflict in the medical opinion evidence between Dr. Salomon and the Office medical adviser as to the permanent impairment of appellant's right and left upper extremity conditions, the Office properly referred appellant to Dr. Komanduri for an impartial medical examination. After obtaining Dr. Komanduri's opinion, the Office then sought an opinion from an Office medical adviser.

The Board has carefully reviewed Dr. Komanduri's report of May 2, 2006 which determined appellant's impairment to her left and right arms. Although Dr. Komanduri determined that appellant sustained 11 percent impairment of the right upper extremity and 7 percent impairment of the left upper extremity, it is not clear how he made this rating in accordance with the relevant standards of the A.M.A., *Guides*.[10] Dr. Komanduri noted

[4] *See* 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001). *See also Linda Beale*, 57 ECAB 429 (2006).

[5] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 4 (June 2003). *See also Cristeen Falls*, 55 ECAB 420 (2004).

[6] A.M.A., *Guides* 491, 482, 484, 492, respectively; *see Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

[7] *J.M.*, 58 ECAB ___ (Docket No. 06-661, issued April 25, 2007); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

[8] *Phillip H. Conte*, 56 ECAB 213 (2004).

[9] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002).

[10] *See Tonya R. Bell*, 43 ECAB 845, 849 (1992).

appellant's complaints of pain; found that the APB strength in both hands was 4/5; and that the range of motion findings for MP thumb joints and IP joints, the thumb, and the wrist were normal. However, he failed to cite to the tables or charts of the A.M.A., *Guides* to support his impairment rating or provide any rationale for his findings. Additionally, the Board notes that Dr. Komanduri disagreed with some of the conditions accepted by the Office.[11] Dr. Komanduri also noted that he could not assign causality to all of appellant's complaints. To the extent that he did not consider impairment caused by preexisting conditions, the Board has held that, in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[12]

The medical adviser utilized the findings in Dr. Komanduri's May 2, 2006 report and determined that appellant had 15 percent right upper extremity impairment and 10 percent left upper extremity impairment. The Board has held that to properly resolve a conflict in medical opinion, it is the impartial medical specialist who should provide a reasoned opinion as to a permanent impairment to a scheduled member of the body in accordance with the A.M.A., *Guides.* An Office medical adviser may review the opinion, but the resolution of the conflict is the responsibility of the impartial medical specialist.[13] As the Office did not request a supplemental opinion from Dr. Komanduri, the selected impartial medical specialist, the Board finds that the conflict in medical opinion remains unresolved.

The case will be remanded for the Office to secure a supplemental report from Dr. Komanduri regarding the extent of appellant's permanent impairment of the right and left upper extremities. If Dr. Komanduri is unable to clarify or elaborate on his opinion or if the opinion is not forthcoming, the Office should refer the case to another appropriate impartial medical examiner.[14] After such further development as the Office deems necessary, it should issue a *de novo* decision on the extent and degree of any employment-related impairment involving appellant's upper extremities which may entitle appellant to a schedule award.[15]

CONCLUSION

The Board finds that the conflict in the medical evidence was not properly resolved and the case requires further development.

[11] For example, the Office accepted bilateral cubital tunnel syndrome as employment related but Dr. Komanduri indicated that this was not employment related. A medical report that does not adequately reflect the basic facts is of little probative value. *See Vernon R. Stewart*, 5 ECAB 276, 280 (1953).

[12] *Peter C. Belkind*, 56 ECAB 580, 586 (2005).

[13] *See Richard R. LeMay*, 56 ECAB 341 (2005); *Thomas J. Fragale*, 55 ECAB 619 (2004).

[14] *See Nancy Keenan*, 56 ECAB 687 (2005); *see also Leonard W. Waggoner*, 35 ECAB 461 (1983).

[15] Due to the disposition of the schedule award issue, the fact and amount of any overpayment are not established.

ORDER

IT IS HEREBY ORDERED THAT the November 29 and April 30, 2007 decisions of the Office of Workers' Compensation Programs be set aside. The case is remanded for further development consistent with this decision of the Board.

Issued: August 22, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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