United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 09-1526**
	)	**Issued: June 1, 2010**
DEPARTMENT OF HEALTH & HUMAN SERVICES, NATIONAL INSTITUTES OF HEALTH, Bethesda, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On May 12, 2009 appellant filed a timely appeal of an April 7, 2009 decision of the Office of Workers' Compensation Programs regarding a schedule award and a May 7, 2009 decision regarding an overpayment of compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUES

The issues are: (1) whether appellant sustained greater than a five percent impairment of his left upper extremity for which he received a schedule award; and (2) whether the Office properly determined that appellant received an overpayment in the amount of $20,475.00; and (3) whether the Office properly determined that the overpayment was not subject to waiver.

FACTUAL HISTORY

On March 22, 2004 appellant, then a 57-year-old printing specialist, filed an occupational disease claim, alleging that he sustained carpal tunnel syndrome in both hands in the performance of duty. He did not stop work. The Office accepted appellant's claim for bilateral tendinitis. On August 17, 2004 it accepted bilateral carpal tunnel syndrome. Appellant underwent right carpal tunnel release surgery in October 2004. He stopped work on January 25,

2006 to undergo left carpal tunnel release surgery. Appellant returned to work. He received appropriate compensation benefits. On September 18, 2007 the Office granted appellant a schedule award for 20 percent impairment of the right arm.

On November 1, 2007 appellant filed a claim for a schedule award for the left arm. In a November 27, 2007 report, Dr. Raymond D. Drapkin, a Board-certified orthopedic surgeon and treating physician, noted appellant's history, which included surgery on both hands and provided findings. For the left hand, he noted that appellant had a well-healed surgical scar and complained of numbness in all four fingers. Dr. Drapkin advised that, when appellant attempted to make a fist, it was difficult to get his hand into his palm. He noted that appellant had positive Tinel's and Phalen's signs. Left wrist x-rays did not reveal any evidence of fracture or dislocation and the osseous spaces were well maintained. Dr. Drapkin advised that appellant was status post carpal tunnel surgery on the left hand. He advised that, as a result of appellant's "carpal tunnel, Table 15, this is equivalent to 20 percent impairment." Dr. Drapkin opined that 20 percent to the hand was equal to 18 percent to the left upper extremity.

In an April 2, 2008 report, the Office medical adviser noted appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He noted that Dr. Drapkin did not provide a detailed sensory examination. The Office medical adviser explained that appellant underwent left carpal tunnel release on January 25, 2006. He noted that the electromyogram (EMG) and nerve conduction tests from December 19, 2006 were primarily for the right arm and included findings which "suggest the presence of a superimposed mild generalized sensorimotor neuropathy involving both median and ulnar nerves." The Office medical adviser noted that while Dr. Drapkin mentioned Table 15 in his report, he was not sure which Table 15 he referenced. He noted that it was possible he was referring to Table 16-15 and noted that the applicable tables would be Tables 16-10, 16-11 and 16-15 and page 495 of the A.M.A., *Guides.* The Office medical adviser noted that utilizing a Grade 4 sensory and motor deficit with a maximum percentage for both of 25 percent and multiplying by 45, the maximum combined motor and sensory deficit for the median nerve below the midforearm, Table 16-15, would result in an 11 percent impairment of the left arm. However, he also indicated that Dr. Drapkin did not correctly apply the A.M.A., *Guides* and questioned the rating. The Office medical adviser opined that appellant reached maximum medical improvement on January 25, 2007, one year from the date of left carpal tunnel release.

On April 15, 2008 the Office granted appellant a schedule award for 11 percent impairment of the left upper extremity. The award totaled $37,408.75 and covered a period of 34.32 weeks from January 25 to September 22, 2007.

Appellant requested a hearing that was held on August 22, 2008. He questioned the differences in impairment and noted that the Office medical adviser indicated that Dr. Drapkin did not correctly utilize the A.M.A., *Guides.* Appellant indicated that he should not be "punish[ed] for his mistake."

On December 8, 2008 an Office hearing representative determined that the April 15, 2008 decision should be vacated and the case remanded. He found that the medical evidence lacked sufficient evidence to visualize the nature and extent of appellant's permanent partial impairment. The Office hearing representative found that the Office medical adviser was not

provided with the results of the physical examination or complete citations and was therefore unable to appropriately determine the nature and extent of appellant's impairment, due to his accepted employment-related conditions. He directed the Office to refer appellant and the case file to a second opinion examination for a complete and thorough examination of the left upper extremity, including complete measurements and citations.[1]

On December 22, 2008 the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Sunjay Berdia, a Board-certified orthopedic surgeon.

In a report dated January 7, 2009, Dr. Berdia described appellant's history of injury and treatment and utilized the A.M.A., *Guides.* He noted that examination of the hands showed well-healed scars over the transverse carpal ligament bilaterally and had no appreciable thenar atrophy. Dr. Berdia indicated that appellant had 5/5 palmar abduction and two-point discrimination of five millimeters in his median and ulnar distribution bilaterally. He advised that appellant had difficulty with active flexion of his left hand although he was passively able to get all of his tips down to his palm. Dr. Berdia diagnosed bilateral residual carpal tunnel syndrome and bilateral hand pain. He opined that, while appellant currently had residuals of carpal tunnel syndrome after carpal tunnel release, due to the March 24, 2004 work injury, no further medical treatment was warranted. Dr. Berdia noted that appellant reached maximum medical improvement in January 2007, about one year after his surgery. He opined that appellant had a permanent impairment due to residuals of carpal tunnel syndrome and indicated that his distal motor latency on the left side improved from a 7.2 to 5.5. Dr. Berdia referred to page 495 of the A.M.A., *Guides,* regarding carpal tunnel syndrome which sets for three possible scenarios after optimum recovery from surgical decompression. He determined that appellant had normal sensibility and opposition strength with abnormal sensory and motor latencies. Dr. Berdia opined that appellant had five percent impairment of the left arm.

In a February 7, 2009 report, the Office medical adviser noted appellant's history and utilized the A.M.A., *Guides.* He noted that appellant complained of pain and decreased strength in both hands. The Office medical adviser noted the physical examination findings from Dr. Berdia and that nerve conduction studies showed some improvement after the release. He referred to page 495 of the A.M.A., *Guides* and opined that five percent of the left upper extremity was warranted. The Office medical adviser determined that in cases with normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, a residual carpal tunnel syndrome was still present, and an impairment rating not to exceed five percent of the upper extremity was justified. The Office medical adviser opined that appellant reached maximum medical improvement on January 25, 2007, one year from the date of the more recent carpal tunnel release.

On April 7, 2009 the Office granted appellant a schedule award for five percent permanent impairment of the left upper extremity. The award totaled $16,933.75 and covered a period of 18.82 weeks from January 25 to May 14, 2007.

[1] A hearing representative initially issued a November 13, 2008 which erroneously referred to Dr. Drapkin as an Office referral physician. The December 8, 2008 decision corrected the errors in the November 13, 2008 decision.

By notice dated April 7, 2009, the Office advised appellant of its preliminary determination that an overpayment of $20,475.00 was created as he received $37,408.75 in compensation for 11 percent left upper extremity impairment, whereas he only had 5 percent impairment, entitling him to $16,933.75. Appellant was afforded the opportunity to submit financial information and request a prerecoupment hearing. He did not respond.

By decision dated May 7, 2009, the Office finalized its preliminary determination of a $20,475.00 overpayment of compensation. It found that appellant was not at fault in the creation of the overpayment. The Office further found that the overpayment was not subject to waiver as appellant did not contest the overpayment or provide financial information indicating eligibility for waiver. It directed appellant to repay the overpayment by a lump-sum payment or to contact the Office to make other arrangements.

LEGAL PRECEDENT -- ISSUE 1

Section 8107 of the Federal Employees' Compensation Act[2] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[3] The Act, however, does not specify the manner by which the percentage loss of a member, function, or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[4] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

The fifth edition of the A.M.A., *Guides*, regarding carpal tunnel syndrome, provides that, if, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias and/or difficulties in performing certain activities, three possible scenarios can be present: (1) positive clinical findings of median nerve dysfunction and electrical conduction delay(s), the impairment due to residual CTS is rated according to the sensory and/or motor deficits; (2) normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles, a residual CTS is still present and an impairment rating not to exceed five percent of the upper extremity may be justified; and (3) normal sensibility (two-point discrimination and Semmes-Weinstein monofilament testing), opposition strength and nerve conduction studies, in which case there is no objective basis for an impairment rating.[6]

The standards for evaluating the percentage of impairment of extremities under the A.M.A., *Guides* are based primarily on loss of range of motion. In determining the extent of loss of motion, the specific functional impairments, such as loss of flexion or extension, should be

[2] 5 U.S.C. §§ 8101-8193.

[3] *Id.* at § 8107.

[4] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[5] 20 C.F.R. § 10.404.

[6] *Silvester DeLuca*, 53 ECAB 500 (2002). A.M.A., *Guides* 495.

itemized and stated in terms of percentage loss of use of the member in accordance with the tables in the A.M.A., *Guides*.[7] However, all factors that prevent a limb from functioning normally should be considered, together with the loss of motion, in evaluating the degree of permanent impairment.

ANALYSIS -- ISSUE 1

The Office accepted that appellant sustained bilateral tendinitis and bilateral carpal tunnel syndrome. Appellant underwent left carpal tunnel release surgery in January 2006.

As noted above, the A.M.A., *Guides* provide three scenarios for determining the permanent impairment due to carpal tunnel syndrome after an optimal recovery time following surgical decompression.[8] Utilizing these scenarios, the Board finds that the medical evidence does not establish that appellant was entitled to receive more than five percent impairment of the left upper extremity, for which he received a schedule award.

In support of his claim for a schedule award, appellant submitted a November 27, 2007 report from his treating physician, Dr. Drapkin, who diagnosed status post carpal tunnel syndrome. Dr. Drapkin noted that appellant complained of numbness in all four fingers and had some difficulty making a fist. He opined that appellant was entitled to receive a 20 percent impairment of the hand or an 18 percent impairment of the left arm according to "Table 15" for his carpal tunnel syndrome. Although, Dr. Drapkin indicated that he had utilized the A.M.A, *Guides*, the Board is unclear how he arrived at this determination. For example it is unclear to which Table 15 he was referring or how he arrived at this conclusion as he did not refer to specific provisions or grading schemes in the A.M.A., *Guides*. Furthermore, Dr. Drapkin did not provide any objective findings to justify his conclusion or explain how this determination comported with the A.M.A., *Guides*.[9] He also did not indicate that appellant's accepted tendinitis was ongoing or that it caused any impairment. Thus, the Board finds that this report is insufficient to establish entitlement to a schedule award.

Likewise, the April 2, 2008 report from the Office medical adviser, based on a review of Dr. Drapkin's report, provides insufficient support for a greater degree of impairment. While he calculated 11 percent impairment, his report was equivocal as he acknowledged that it was unclear how Dr. Drapkin rated impairment noting that the information was limited and that no detailed sensory examination was made. The Office medical adviser indicated that he was speculating as to which tables Dr. Drapkin was referring when he attempted to calculate impairment and questioned whether 11 percent impairment was correct. The Board has held that

[7] *See William F. Simmons*, 31 ECAB 1448 (1980); *Richard A. Ehrlich*, 20 ECAB 246, 249 (1969) and cases cited therein.

[8] *See supra* note 5.

[9] *See I.F.*, 60 ECAB ___ (Docket No. 08-2321, issued May 21, 2009) (an opinion which is not based upon the standards adopted by the Office and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of a claimant's permanent impairment).

speculative and equivocal medical opinions regarding causal relationship have limited probative value.[10]

In a January 7, 2009 report, Dr. Berdia examined appellant and provided examination specific findings that included normal palmar abduction and two-point discrimination of five millimeters in his median and ulnar distribution, and the ability to passively get his finger tips to his palm. He explained that appellant's distal motor latency on the left side improved from a 7.2 to 5.5. After considering examination findings and a review of the record, Dr. Berdia advised that appellant still had residuals of carpal tunnel syndrome after carpal tunnel release. Using the criteria for rating carpal tunnel syndrome set forth on page 495 of the A.M.A., *Guides*, he concluded that appellant fell under the second scenario and had five percent impairment. Dr. Berdia explained this finding noting that appellant had normal sensibility and opposition strength but with abnormal sensory and motor latencies. In a February 7, 2009 report, an Office medical adviser reviewed Dr. Berdia's report, noted findings and concurred with his impairment assessment.

Both Dr. Berdia and the Office medical adviser referred to page 495 of the A.M.A., *Guides*, the section on carpal tunnel syndrome. The Board notes that this provision provides for three possible scenarios after optimum recovery time following surgical decompression in carpal tunnel cases. As noted, the second scenario allows for up to five percent impairment of the arm where residual carpal tunnel syndrome is present and there is normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles. The physicians concluded that appellant had residual carpal tunnel syndrome, explained the findings that supported the rating under the second scenario and opined that appellant would be entitled to an impairment rating of five percent of the left upper extremity. They found that appellant reached maximum medical improvement on January 25, 2007, one year after his carpal tunnel release.

The Board finds that the weight of the medical evidence, as represented by the opinions of Dr. Berdia and the Office medical adviser, establishes that appellant has no more than five percent impairment of the left arm. There is no other medical evidence of record, based upon a correct application of the A.M.A., *Guides*, to establish that appellant has more than five percent permanent impairment of the left arm for which he received a schedule award.

On appeal, appellant alleged that he felt he was entitled to greater than the five percent permanent impairment of the left upper extremity. He alleged that he was being punished because Dr. Drapkin did not correctly apply the A.M.A., *Guides*. However, the evidence currently in the record does not support a greater impairment.

LEGAL PRECEDENT -- ISSUE 2

The Act provides that the United States shall pay compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of his duty.[11]

[10] *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal).

[11] 5 U.S.C. § 8102(a).

When an overpayment has been made to an individual 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 the individual is entitled.[12]

If a claimant receives a schedule award and the medical evidence does not support the degree of permanent impairment awarded, an overpayment of compensation may be created.[13]

ANALYSIS -- ISSUE 2

Appellant received a schedule award for 11 percent impairment of the left upper extremity. The medical evidence, as discussed, only supports total impairment of five percent. Appellant therefore erroneously received compensation for six percent impairment of his left upper extremity to which he was not entitled. This additional amount represents an overpayment of compensation. The Board notes that appellant initially received a payment of $37,408.75 for 11 percent impairment of the left upper extremity. The Office subsequently determined that he was only entitled to receive an impairment of five percent to the left upper extremity, for which he was entitled to receive a payment of $16,933.75. It subtracted the amount appellant should have received from the amount he received ($37,408.75 - $16,933.75) and determined that he received an overpayment in the amount $20,475.00. The Board finds that the Office properly determined the fact and amount of overpayment. Therefore, the Board will affirm the Office's determination as to fact and amount of overpayment.

LEGAL PRECEDENT -- ISSUE 3

Section 8129 of the Act[14] provides that an overpayment must be recovered unless "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." (Emphasis added.) Thus, a finding that appellant was without fault does not automatically result in waiver of the overpayment. The Office must then exercise its discretion to determine whether recovery of the overpayment would defeat the purpose of the Act or would be against equity and good conscience.[15]

Section 10.436 of the implementing federal regulations[16] provide that recovery of an overpayment will defeat the purpose of the Act if recovery would cause undue hardship by depriving a presently or formerly entitled beneficiary of income and resources needed for ordinary and necessary living expenses and outlines the specific financial circumstances under which recovery may be considered to "defeat the purpose of the Act."

[12] *Id*. at § 8129(a).

[13] *See Michael Reed*, Docket No. 04-734 (issued October 5, 2004).

[14] 5 U.S.C. § 8129.

[15] *Wade Baker*, 54 ECAB 198 (2002).

[16] 20 C.F.R. § 10.436.

Section 10.437 provides that recovery of an overpayment is considered to be against equity and good conscience when an individual who received an overpayment would experience severe financial hardship attempting to repay the debt and when an individual, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse.[17]

Section 10.438(a) provides that the individual who received the overpayment is responsible for providing information about income, expenses and assets as specified by the Office, as this information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the Act or be against equity and good conscience.[18] This information would also be used to determine the repayment schedule, if necessary. Section 10.438(b) provides that failure to submit the requested information within 30 days of the request shall result in denial of waiver.[19]

ANALYSIS -- ISSUE 3

In its April 7, 2009 preliminary overpayment determination, the Office informed appellant of actions available if he believed that he should receive a waiver. It advised appellant to submit a completed overpayment recovery questionnaire as well as information and evidence regarding his income and expenses. Appellant did not respond to the preliminary notice or provide financial documentation.

Appellant did not submit a completed overpayment recovery questionnaire form nor did he submit financial information outlining his income and expenses. As a result, there was no evidence before the Office establishing that recovery of the overpayment would defeat the purpose of the Act or would be against equity and good conscience.[20] As appellant failed to submit the requested information, as required by section 10.438 of its regulations, he was not entitled to a waiver.[21] The Board finds that the Office properly denied waiver of recovery of the overpayment of compensation.

CONCLUSION

The Board finds that appellant did not sustain greater than a five percent impairment of his left upper extremity for which he received a schedule award. The Board also finds that the Office properly determined that appellant received an overpayment in the amount of $20,275.00 and determined that the overpayment was not subject to waiver.

[17] *Id*. at § 10.437.

[18] *Id.* at § 10.438(a).

[19] *Id*. at § 10.438(b).

[20] *See* 20 C.F.R. § 10.438(a) (in requesting waiver, the overpaid individual has the responsibility for providing financial information).

[21] *See T.S.*, 60 ECAB ___ (Docket No. 08-1604, issued March 13, 2009).

ORDER

IT IS HEREBY ORDERED THAT decisions of the Office of Workers' Compensation Programs dated May 7 and April 7, 2009 are affirmed.

Issued: June 1, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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