U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of TAMMY L. MEEHAN and U.S. POSTAL SERVICE,
POST OFFICE, Southeastern, PA

Docket No. 99-1462; Submitted on the Record;
Issued November 21, 2001

DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT,
PRISCILLA ANNE SCHWAB

The issue is whether appellant has more than a 10 percent permanent impairment of both her right and left arms, for which she has received a schedule award.

The Board has given careful consideration to the issues involved, the contentions of the parties on appeal and the entire case record. The Board finds that the July 29, 1998 decision of the Office of Workers' Compensation Programs' hearing representative is in accordance with the facts and the law in this case and hereby adopts the findings and conclusions of the hearing representative.

By letter dated September 15, 1998, appellant, through her representative, requested reconsideration and alleged that her original work injury caused her present brachial plexus problems. In an August 24, 1998 report, Dr. Scott M. Fried, an osteopath, detailed her present symptomatology and therapy, and diagnosed bilateral brachial plexopathy, left greater than right, status post bilateral median nerve decompression, low level left ulnar neuropathy and right sympathetic reactivity.

By decision dated December 15, 1998, the Office denied modification of the July 29, 1998 decision finding that the evidence submitted in support was insufficient to warrant modification. The Office noted that Dr. Fried did not discuss the causal relationship of appellant's present brachial plexopathy condition to her accepted bilateral carpal tunnel syndrome or determine permanent impairment.

By letter dated February 9, 1999, appellant requested an appeal. The Board took jurisdiction of the case on March 3, 1999 and docketed it as No. 99-1462 on March 11, 1999. However, the Office also conducted a review of the case, and on May 6, 1999 denied appellant's request for a further review under 5 U.S.C. § 8128(a). Because the Board took jurisdiction of the

case prior to the Office's May 6, 1999 nonmerit decision, the Office's decision is null and void for lack of jurisdiction.[1]

The Board finds that appellant has no more than 10 percent bilateral permanent impairments of her arms, for which she has received a schedule award.

A claimant seeking compensation under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence.[3] Section 8107 provides that if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[4]

The schedule award provisions of the Act[5] specify the number of weeks of compensation to be paid for permanent loss of use of various members of the body. The Act does not, however, specify the manner in which the percentage loss of use of a member shall be determined. The method used in making such a determination is a matter that rests with the sound discretion of the Office.[6] For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants.[7] The Office through regulation has adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* as the standard for evaluating permanent impairment for schedule award purposes.

The A.M.A., *Guides* standards for evaluating the impairment of extremities are based primarily on loss of range of motion.[8] However, all factors that prevent a member from functioning normally, including pain or discomfort, should be considered, together with loss of motion, in evaluating the degree of permanent impairment.[9] Inclusion of impairment percentages due to conditions or impairment of body parts not related to or proximate to the

[1] *See* 20 C.F.R. § 10.626; *Douglas E. Billings*, 41 ECAB 880 (1990).

[2] 5 U.S.C. §§ 8101-8193.

[3] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[4] 5 U.S.C. § 8107(a). It is thus the claimant's burden of establishing that she sustained a permanent impairment of a scheduled member or function as a result of her employment injury. *See Raymond E. Gwynn*, 35 ECAB 247 (1983) (addressing schedule awards for members of the body that sustained an employment-related permanent impairment); *Philip N.G. Barr*, 33 ECAB 948 (1982) (indicating that the Act provides that a schedule award be payable for a permanent impairment resulting from an employment injury).

[5] 5 U.S.C. § 8107.

[6] *Danniel C. Goings*, 37 ECAB 781 (1986); *Richard Beggs*, 28 ECAB 387 (1977).

[7] *Henry L. King*, 25 ECAB 39, 44 (1973); *August M. Buffa*, 12 ECAB 324, 325 (1961).

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

[9] *See Paul A. Toms*, 28 ECAB 403 (1987).

accepted member's employment injury is not proper.[10] However, any previous impairment to the member under consideration is included in calculating the percentage of loss except when: (a) The prior impairment is due to a previous work-related injury, in which case the percentage already paid is subtracted from the total percentage of impairment; or (b) The Veterans Administration (VA) has already paid a claimant for a previous impairment to the same member, in which case an election will be required if the VA has increased the percentage payable due to the injury in civilian employment.[11]

Impairment due to carpal tunnel syndrome may be evaluated by two separate methods under the fourth edition of the A.M.A., *Guides*: under Table 16, "upper extremity impairment due to entrapment neuropathy," or the alternate method of grading nerve root impairment by identifying the nerve and evaluating the degree of pain and loss of strength using Tables 11, 12 and 15 as appropriate.[12] Further, the application of certain impairment tables is incompatible with the simultaneous application of other impairment tables, because this would result in duplicate measurements and an artificially high percentage of impairment. Thus, the application of Table 16 is incompatible with the simultaneous application of Tables 11, 12 and 15.[13]

In this case, appellant's physician, who found 60 percent and 72 percent upper extremity impairments, not only provided impairment ratings for body members and parts not involved with the accepted bilateral carpal tunnel syndrome, but also combined impairment values from incompatible tables, *i.e.*, Tables 11 and 16. Accordingly, his total permanent impairment ratings were not obtained in accordance with the A.M.A., *Guides.*

The Office second opinion specialist, however, properly applied Table 16, page 57, of the A.M.A., *Guides* to the results of his own physical examination and determined that appellant had a 10 percent permanent impairment of each upper extremity.

To resolve a conflict of medical opinion, the Office referred appellant, a statement of accepted facts and the relevant case record to Dr. Easwaran Balasubramanian, a Board-certified orthopedic surgeon, for an impartial medical examination. In his July 22, 1997 report, Dr. Balasubramanian provided appellant's history of injury and treatment and his findings on physical examination, and concluded that appellant had a 10 percent permanent impairment of each upper extremity. In accordance with the procedures set out in Chapter 2.808 of its procedure manual, the Office had its medical adviser review appellant's case. That adviser concurred with Dr. Balasubramanian's opinion. Accordingly, appellant was granted a schedule award on October 27, 1997 for 10 permanent impairment of her upper extremities.

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[10] *See, e.g., Ralph W. Hawekotte*, 17 ECAB 357 (1966) (impairment due to cervical arthritis and incipient hand contracture not to be considered when calculating schedule award for employment-related left wrist fracture).

[11] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.7(a) (March 1995).

[12] *Michael D. Nielsen*, 49 ECAB 453 (1998).

[13] *See* Federal (FECA) Procedure Manual, Part 3 – *Medical, Schedule Awards*, Chapter 3.700, Exhibit 4 (October 1995).

Appellant, however, contends that her schedule award should be greater because of various preexisting conditions. She argues that, pursuant to 5 U.S.C. § 8107(a), "FECA-PM Chapter 3.600m" and the holding in *Raymond E. Gwynn*, 35 ECAB 247, 253 (1983), the Office was required to incorporate all preexisting impairments to the schedule member in making a schedule award determination. Therefore, appellant's schedule award should be increased to include preexisting impairments of her cervical spine, shoulders and elbows.

Although preexisting impairments of the body are to be included, in determining the amount of a schedule award,[14] the medical evidence of record in this case fails to establish any preexisting impairments of appellant's cervical spine, the shoulder, the elbow or the brachial plexus.

Dr. Fried, in his initial report of October 28, 1992, noted a history of stiff neck with time lost from work in 1987, but stated that appellant "otherwise relates no prior history of problems along these lines." Dr. Fried referred to appellant's complaints of pain radiating from her hands to her elbows and a sore right shoulder and diagnosed bilateral neuritis with median nerve and bilateral plexitus involvement but made no mention of a cervical or shoulder diagnosis, preexisting or otherwise.

Moreover, in his July 22, 1997 impartial medical examination, Dr. Balasubramanian noted that appellant had "a normal examination of the cervical spine. She has full flexion-extension, lateral flexion and rotation. There is no evidence of any restriction of motion in the neck." He further noted that there was no evidence of any atrophy or sensory changes in the upper extremities related to her cervical radiculopathy. Therefore, the Board finds that appellant was not entitled to a schedule award for preexisting impairment to the cervical spine that allegedly resulted in upper extremity sensory and motor deficits.

The 1992 EMG/nerve conduction velocity (NCV) study showed mild to moderate involvement of the right medial cord of the lower brachial plexus. In his October 28, 1992 report, Dr. Fried noted a prior EMG study. However, this report is not in the record. Furthermore, Dr. Fried noted that this prior EMG/NCV study did not bear out a diagnosis of carpal tunnel syndrome and Dr. Weiss, the physician who examined appellant at her attorney's request, noted that that study was within normal limits. Therefore, the medical evidence of record does not support appellant's contention that the brachial plexus condition predated the work injury.

The Board also finds that the alleged preexisting ulnar nerve entrapment at appellant's elbow is not supported by the evidence of record. The first EMG/NCV studies of both upper extremities on November 30, 1992 indicated moderate motor and sensory component neuropathies involving right more than left median nerves at the level of the wrist and mild to moderate neuropathic involvement of the right medial cord of the lower brachial plexus. This EMG showed no evidence of ulnar nerve involvement at the elbows. Another EMG/NCV study on July 22, 1998 specifically provided: "No evidence of ulnar nerve involvement at either the elbow or wrist level."

[14] *See Walter R. Malena*, 46 ECAB 983 (1995).

In his May 13, 1993 report, Dr. Fried first mentions sympathetic reactivity in the right arm. However, he opined that appellant did not have reflex sympathetic dystrophy (RSD) at that time. In a May 24, 1993 report, Dr. Fried noted that appellant had some evidence of mild RSD symptomatology, but "she is really not showing a classic RSD." None of Dr. Fried's reports diagnoses RSD. He continued to refer to the clinical findings of color and temperature changes as being "sympathetically reactive," as opposed to RSD.

In a second opinion examination on January 29, 1996, Dr. Andrew B. Sattel, a Board-certified orthopedic surgeon, noted: "There was no swelling noted about the forearm, wrists or digits. No tropic or vasomotor changes indicative of reflex sympathetic dystrophy [were noted]." Even if the condition of RSD had previously existed, Dr. Weiss indicated, in a December 30, 1996 report, no clinical findings consistent with a diagnosis of RSD. Therefore, the Board finds no basis for including RSD in appellant's schedule award calculation.

Appellant's occupational disease claim was accepted only for bilateral carpal tunnel syndrome, for which she underwent bilateral releases. No conditions related to her cervical spine or radiculopathy, shoulders or elbows have been established as being preexisting or accepted as being employment related. Therefore, there is no medical basis for including these conditions in determining appellant's schedule award and appellant is not entitled to a schedule award for impairment of these members.[15]

The December 15 and July 29, 1998 decisions of the Office of Workers' Compensation Programs are hereby affirmed. The May 6, 1999 decision of the Office is null and void.

Dated, Washington, DC
November 21, 2001

David S. Gerson
Member

Bradley T. Knott
Alternate Member

Priscilla Anne Schwab
Alternate Member

[15] *See supra* notes 3 and 4.