U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SANDRA D. GRAHAM and U.S. POSTAL SERVICE,
POST OFFICE, Dallas, TX

Docket No. 99-1731; Submitted on the Record;
Issued October 25, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
VALERIE D. EVANS-HARRELL

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits effective April 26, 1998; (2) whether appellant met her burden of proof to establish that she developed additional medical conditions, including a left shoulder and neck condition, headaches, and right carpal tunnel syndrome, as a consequence of her accepted left carpal tunnel syndrome; and (3) whether appellant met her burden to establish that she has more than a three percent permanent impairment of the left upper extremity, for which she received a schedule award.

The Board has duly reviewed the case on appeal and finds that the Office met its burden of proof to terminate appellant's compensation benefits.

On May 3, 1989 appellant, then a 26-year-old letter sorting machine clerk, filed a claim for occupational disease alleging that she developed left hand, wrist, arm and neck pain as a result of her federal employment duties. The Office accepted appellant's claim for left wrist tendinitis, and subsequently expanded the accepted conditions to include left carpal tunnel syndrome, left carpal tunnel release surgery and post-traumatic stress disorder. Appellant lost intermittent periods from work from March 20, 1989 until May 21, 1997, when she underwent left carpal tunnel release surgery and began receiving compensation benefits for total disability.

In a letter dated March 4, 1998, the Office proposed to terminate appellant's compensation benefits. Appellant did not submit any additional factual or medical evidence, and by decision dated April 6, 1998, the Office terminated appellant's compensation and medical benefits effective April 26, 1998. On July 20, 1998 appellant filed a claim for a schedule award. In a decision dated October 14, 1998, the Office granted appellant a schedule award for a three percent permanent disability of the left upper extremity.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[1] 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.[2] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.[3] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[4]

In this case, in a report dated August 8, 1997, Dr. Kenneth Driggs, a Board-certified hand surgeon and orthopedic surgeon and appellant's primary treating physician for her left carpal tunnel syndrome, evaluated appellant's progress following her May 21, 1997 left carpal tunnel release surgery. In his report, Dr. Driggs noted that appellant was complaining of pain which extended from the front of her head, down her neck, through her left shoulder and left chest area, and down her left arm. After performing a physical examination, Dr. Driggs stated:

> "In my opinion, the patient is safe to return to work at light-duty work status, eight hours a day, three pounds maximum lifting or grasping for simple grasping activities, but she should avoid repetitious keyboard activity for at least several more weeks. She is safe to resume light-duty work August 11, 1997 and was noticeably disturbed and very emotional, even to the point of crying in the office, when I explained to her that I would not keep her off work, that she was safe to return to work, that she may not have reached full recovery, but that she was structurally sound and capable of performing these light duties as described.
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> "I explained to the patient that her hand and nerve were very safe for her to perform these types of light-duty work activities. She questioned me as to a referral for evaluation of her headache, neck and chest pains. I explained to the patient that, in my opinion, these pains were not the result of her carpal tunnel syndrome. She persisted, explaining that she thought her headache and neck pains might be related to some old injury and also the carpal tunnel syndrome. I explained to the patient that in my opinion the carpal tunnel syndrome was not the cause of any headache or neck pain. I explained that after having treated thousands of people with carpal tunnel syndrome neither headache nor neck pain would be considered related to carpal tunnel syndrome. I explained that she should consult her personal physician, Dr. Ray Smith, if she has headache or neck pain as this would be medically much … more likely related to other pathology in the head or neck. I reassured her that the carpal tunnel syndrome in my opinion was not the cause of any headache or neck pain and that any referral for

[1] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

[2] *Id.*

[3] *Furman G. Peake*, 41 ECAB 361, 364 (1990).

[4] *Id.*

evaluation would have to come from her personal physician, Dr. Ray Smith. The patient persisted that this was somehow related to some injury dating back possibly to 1989 or whatever, but I explained to her that I was making no judgment as to any prior injury and her headache and neck complaints at this time. I explained that in my opinion the headache and neck pain were not medically reasonably related in any way to her carpal tunnel syndrome, which in my opinion is healing rather well. Since I do *not* think the carpal tunnel syndrome (which is a work injury) is related to her headache or neck pain, it would not be fair to expect her insurance provider to assume responsibility for any such evaluation. (Emphasis in the original.) Finally, after reviewing the normal prognosis of ealing following carpal tunnel surgery, I explained that she was approaching a point in time when she would be able to use her hand freely and fully for all activities, whether at home or at work. Presently she is safe to resume light-duty work and in the near future will probably be safe to resume regular duties."

In a follow-up report dated October 20, 1997, Dr. Driggs stated:

"Following left CTR [carpal tunnel release], May 21, 1997, the patient appears to have reached a very safe level of recovery such that she is safe to return to regular duties at work, although she protests and explains that she will never be able to do the same job again."

* * *

"I explained to the patient that she was, at this point and time, perfectly safe to resume a normal lifestyle with activities at home, work, or with recreation, etc. The patient should be able to perform her duties fully considering her apparent recovery and improvement. If she were to have problems, she is to call my nurse … and we would refer her to a rehab[ilitation] program for final training. There is nothing more we can offer her from our office at this time."

On November 6, 1997 the Office referred appellant, together with a statement of accepted facts, the medical opinions of record and a list of issues to be addressed, to Dr. Bernie L. McCaskill, a Board-certified orthopedic surgeon, for a second opinion evaluation. The Office specifically asked Dr. McCaskill to determine whether, in addition to her left carpal tunnel syndrome, appellant had any additional diagnoses which should have been accepted by the Office as employment related. In his report dated December 12, 1997, Dr. McCaskill noted appellant's complete medical history as well as her complaints of left-sided neck pain and headaches. Dr. McCaskill performed a complete physical examination, noting that appellant had full active range of motion of the cervical spine, both upper extremities, and the lumbar spine; no abnormal neurologic findings of either the upper or lower extremities; and no obvious swelling, atrophy, deformity or other objective evidence of a significant musculoskeletal injury. After reviewing the electrodiagnostic study results, all of which were essentially normal, Dr. McCaskill concluded that appellant could return to work, eight hours a day, with no restrictions, stating:

> "I do not feel that additional diagnoses should be accepted as work related. I personally do not believe that the patient has a significant physical injury of any type and believe that the patient's complaints are of a motivational origin. I do not believe that the patient has any residuals from any injury which she might have sustained on March 14, 1989. I base that opinion upon my examination of the patient and review of the previous diagnostic studies."

The Board finds that the weight of the medical opinion evidence rests with Dr. McCaskill's well-rationalized narrative report, as supported by the report of Dr. Driggs, appellant's treating physician. Dr. McCaskill provided a history of injury and appellant's medical history, reviewed the results of diagnostic tests, and performed a complete physical examination. He concluded that appellant was not disabled for her usual work, but could return to work, without restrictions, eight hours a day. In addition, Dr. McCaskill did not indicate a need for any further medical treatment causally related to appellant's March 14, 1989 accepted left carpal tunnel syndrome. Therefore, the Office properly relied on Dr. McCaskill's report in terminating appellant's benefits. Furthermore, the record contains no contrary medical evidence, as appellant's treating physician for her left carpal tunnel syndrome released appellant to full duty on October 20, 1997, and appellant's treating psychologist, Dr. Jesse C. Ingram, released appellant from care on May 26, 1993. Therefore, while the record contains evidence that appellant may have some degree of permanent impairment as a result of her accepted left carpal tunnel syndrome and associated surgeries, as both Dr. McCaskill and appellant's treating physician, Dr. Driggs, opined that appellant could perform her usual work eight hours a day, without restrictions, and as neither physician indicated any need for additional treatment causally related to her accepted conditions, the Offfice met its burden of proof to terminate appellant's compensation benefits effective April 26, 1998.

The Board further finds that appellant failed to meet her burden of proof to establish that she developed any additional conditions, such as a left neck and shoulder condition, headaches, or right carpal tunnel syndrome, as a result of her left carpal tunnel syndrome.

Both Dr. McCaskill, the Office second opinion physician, and Dr. Driggs, appellant's treating physician, clearly opined that appellant did not have any additional headache, neck or shoulder conditions causally related to her federal employment, and could return to full unrestricted duty. In addition, while Dr. McCaskill specifically noted appellant's complaints of right wrist and radial hand pain, he specifically opined that appellant did not have any residuals from any injury which she might have sustained on March 14, 1989. While the record does contain medical reports dated October 10 and November 19, 1990 and December 8, 1995, from appellant's prior treating physician, Dr. Waymon Drummond, an internist, in which he diagnoses bilateral carpal tunnel syndrome, these reports contain no medical rationale and are unsupported by the electrodiagnostic studies of record. Therefore, these reports are of insufficient probative value to outweigh the well-rationalized report of Dr. McCaskill. Accordingly, appellant has not met her burden of proof to establish that she has any additional medical conditions causally related to her accepted left carpal tunnel syndrome.

Finally, the Board finds that appellant has no more than a three percent permanent impairment of her left upper extremity, for which she received a schedule award.

An employee seeking compensation under the Federal Employees' Compensation Act[5] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence,[6] including that he sustained an injury in the performance of duty as alleged and that his disability, if any, was causally related to the employment injury.[7] Section 8107 of the Act 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.[8] Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Office has adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*, 4th ed. 1993) as a standard for evaluating schedule losses and the Board has concurred in such adoption.[9]

In this case, the Office accepted that as a result of her employment duties, appellant developed left wrist tendinitis and left carpal tunnel syndrome, necessitating left carpal tunnel release surgery. On July 20, 1998 appellant filed a claim for a schedule award. By award of compensation dated October 14, 1998, the Office awarded appellant a schedule award for a three percent permanent impairment of her left upper extremity.

In support of her claim for a schedule award, appellant submitted a medical report dated July 13, 1998 from Dr. Driggs, her treating physician for her left carpal tunnel syndrome, who noted that following her carpal tunnel release surgery, appellant had regained full range of motion as well as continued normal sensation in her hand. He concluded that testing with the Jamar Dynamometer showed 10 to 12 kilograms left, and 20 kilograms right grip strength, even with rapid alternating movements. Dr. Driggs concluded that appellant had reached maximum medical improvement and, pursuant to the A.M.A., *Guides*, had a three percent permanent impairment of the left upper extremity due to diminished grip strength. In response to a request

[5] 5 U.S.C. §§ 8101-8193.

[6] *Donna L. Miller*, 40 ECAB 492, 494 (1989); *Nathaniel Milton*, 37 ECAB 712, 722 (1986).

[7] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[8] 5 U.S.C. § 8107(a).

[9] *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989); *Charles Dionne*, 38 ECAB 306, 308 (1986).

by the Office for a more detailed explanation of his conclusions, in a follow-up report dated September 22, 1998, Dr. Driggs stated:

> "According to the [A.M.A.], *Guides to the Evaluation of Permanent Impairment*, Third Edition Revised, the patient has a loss of strength that is permanent impairment not already taken into account by any neurologic or motion measurements of the upper extremity elsewhere in the [A.M.A.], *Guides*. Loss of strength according to page 53 of the [A.M.A.], *Guides* is a valid factor to consider regarding impairment, such as in this case for this patient in my opinion.
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> "In my opinion, there is a 3 percent upper extremity impairment resulting from diminished grip strength, or loss of strength as defined in the [A.M.A.], *Guides*."

On October 9, 1998, at the request of the Office, Dr. H. Mobley, an Office medical adviser and Board-certified internist, reviewed Dr. Driggs' reports as they pertained to appellant's left upper extremity. Dr. Mobley noted that Dr. Driggs' findings were improperly based on the third edition, revised, of the A.M.A., *Guides*, but concurred with Dr. Driggs' finding of a three percent permanent impairment of the left upper extremity, stating that "conversion from the third edition A.M.A., *Guides* to the fourth edition A.M.A., *Guides* is considered accurate in this instance, because the description of the impairment and the method of determination of the impairment by Dr. Driggs is so clear."[10]

The Board has held that if an examining physician does not properly use the A.M.A., *Guides* to calculate the degree of permanent impairment, it is proper for an Office medical adviser to review the record and apply the A.M.A., *Guides* to the examination findings reported by the examining physician.[11] As the Office medical adviser properly applied the relevant portions of the A.M.A., *Guides* to the physical findings described in Dr. Driggs' report, and provided full rationale for his conclusions, and as there is no rationalized medical evidence in the record supporting more than a three percent permanent impairment of appellant's left upper extremity, the Board finds that appellant has no more than a three percent permanent impairment of her left upper extremity.

[10] In the present case, the fourth edition of the A.M.A., *Guides* provides the appropriate standards for evaluating appellant's left upper extremity impairment in that appellant's initial schedule award for impairment was granted by the Office after November 1, 1993, the effective date of the fourth edition of the A.M.A., *Guides; see* FECA Bulletin No. 94-4 (issued November 1, 1993).

[11] *Lena P. Huntley*, 46 ECAB 643 (1995).

The decisions of the Office of Workers' Compensation Programs dated October 14 and April 6, 1998 are affirmed.[12]

Dated, Washington, DC
October 25, 2000

Michael J. Walsh
Chairman

David S. Gerson
Member

Valerie D. Evans-Harrell
Alternate Member

[12] The Board notes that subsequent to the filing of her appeal with the Board, postmarked April 5, 1999, appellant requested reconsideration before the Office of its October 14, 1998 schedule award. In a decision dated May 3, 1999, the Office found that the evidence submitted in support of appellant's application for review was not sufficient to warrant review of its prior decision. The Board finds that the Office's May 3, 1999 decision, in so far as it pertains to appellant's request for reconsideration of the Office's October 14, 1998 schedule award decision, is null and void as both the Board and the Office cannot have jurisdiction over the same issue in the same case. *Douglas E. Billings*, 41 ECAB 880 (1990).