U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ELAINE P. PIATELLI and U.S. POSTAL SERVICE,
GENERAL MAIL FACILITY, Southeastern, PA

Docket No. 03-280; Submitted on the Record;
Issued April 3, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has any impairment that would entitle her to a schedule award.

On February 23, 1992 appellant, then a 52-year-old postal clerk, filed a claim for bilateral carpal tunnel syndrome, which she attributed to almost 10 years of keying on the letter sorting machine, the flat sorting machine and the small parcel bundle-sorting machine. She stated that she had pain in her hands, fingers and wrist.

In a March 27, 1992 report, Dr. Scott Fried, an osteopath, stated that appellant had a positive Tinel's sign in the supraclavicular and infraclavicular area bilaterally but no true radiation. He found a positive Tinel's sign at the right elbow radiating into the fifth finger with a similar finding on the left. Dr. Fried noted that appellant had a positive Tinel's sign over the medial nerve in the forearm radiating proximally bilaterally and a positive Tinel's sign over the median nerve of both wrists, radiating in the second and third fingers on the right hand and the first finger on the left hand. He reported subjective decreased sensation in the left thumb, index and long finger and the right fourth and fifth fingers. Dr. Fried indicated that the Phalen's test was positive on the right for numbness in the second, third and fifth fingers. He noted dysesthesias in the thumb bilaterally with Phalen's testing. Dr. Fried commented that appellant had tenderness in the long thoracic nerve distribution bilaterally. He concluded that appellant was exhibiting significant evidence of a bilateral overuse syndrome and substantial tenosynovitis bilaterally. Dr. Fried reported that appellant was showing a de Quervain's syndrome as well as flexor tenosynovitis on the left with evidence of bilateral carpal tunnel syndrome, although an electromyogram (EMG) was negative. He indicated that appellant had x-ray changes on the left consistent with repetitive use and synovitis problems.

The Office of Workers' Compensation Programs accepted appellant's claim for bilateral tendinitis and began payment of temporary total disability effective April 6, 1992.

In subsequent reports, Dr. Fried reported on appellant's progress. In a May 7, 1992 report, he stated that appellant had a mildly positive Tinel's sign over the radial sensory nerve and a mildly positive Tinel's sign over the median nerve. He diagnosed substantial overuse syndrome with synovitis and a mild underlying fibrisitis. In a July 27, 1992 report, Dr. Fried indicated that appellant had a mild positive Tinel's sign over the median nerve on the right and moderate on the left. He found a positive Tinel's over the radial nerve on the left and a mildly positive Finkelstein's test. Dr. Fried noted that appellant could perform simple grasping and fine manipulation on the right only. He stated that she could not perform firm grasping or pulling or pushing with either hand. Dr. Fried stated that appellant could not return to her former positions at the employing establishment but could find a job that did not require repetitive upper extremity activity. In an August 14, 1992 letter, Dr. Fried summarized his findings and stated that appellant's symptoms were, within a reasonable degree of medical certainty, directly related to her work activity on the letter sorting machine and the small parcel bundle-sorting machine. He found appellant's restrictions to be permanent. In an October 24, 1992 report, Dr. Fried stated that appellant had moderate plexus tenderness, a mildly positive Tinel's sign distally and a mildly positive Finkelstein's test on the left as well. He concluded that appellant was making progress.

In an April 26, 1993 report, Dr. Fried stated that appellant's examination still showed plexus irritability and long thoracic nerve irritability, especially on the left. He noted that the Tinel's sign at the median nerve was positive bilaterally. Dr. Fried also found some irritability over the ulnar nerve at the elbow. He indicated that appellant had undergone an EMG test. Dr. Fried interpreted the test as showing evidence of involvement of the right ulnar nerve at the elbow level as well as involvement in the medial nerve in the plexus on the right. He noted appellant showed bilateral medial nerve involvement at the wrist left with the left being somewhat more involved than the right. Dr. Fried reported that stress testing showed significant decrease in motor amplitude on the left with wrist extension. He stated that appellant remained quite symptomatic but was sufficiently stable in her symptoms to live with them.

The employing establishment offered to return appellant to work at a temporary assignment, which consisted of light typing, data input, filing and answering the telephone, along with other administrative duties. In a March 8, 1993 note, Dr. Fried indicated that light typing and data input posed a problem with repetitive motion for which she had no tolerance. Appellant returned to work. In an October 11, 1993 report, Dr. Fried related that appellant was significantly symptomatic with an increase in symptoms. He noted her work had consisted of answering the telephone and deskwork. Dr. Fried indicated that appellant's examination showed a positive supraclavicular and infraclavicular Tinel's especially on the left and mildly on the right. He commented that the long thoracic nerve was exquisitely uncomfortable on the left. Dr. Fried reported a positive Tinel's sign at the left median nerve radiating into the second and fourth fingers.

In a January 20, 1994 report, Dr. Fried indicated that appellant had been out of work due to stress leave and had been calmer with her hands and arms. He stated that appellant continued to be symptomatic, especially when she increased her activity level. Dr. Fried noted that appellant still had positive Tinel's sign on the left with the long thoracic nerve being irritable and arm radiation. He reported that the Tinel's sign was positive at the median nerve in the forearm

and mildly at the wrist. Appellant returned to work again on May 15, 1994 for six and a half-hours a day. The Office paid compensation for the hours appellant did not work.

In a May 16, 1995 report, Dr. David Weiss, an osteopath, stated that appellant had tenderness over the abductor brevis longus and extensor pollicis brevis tendons in the hands bilaterally on palpation. He reported a positive Tinel's sign bilaterally in the elbows at the cubital tunnel. Dr. Weiss indicated that examination of the wrists revealed a positive Tinel's sign bilaterally and a positive Phalen's sign on the right. He noted a positive Tinel's sign over the Guyon's canal bilaterally. Dr. Weiss indicated that motor strength testing was normal, as was sensory examination over the median nerve and ulnar nerve bilaterally. He reported that grip strength testing was zero kilograms of force in the right hand versus four kilograms of force in the left hand. Dr. Weiss indicated that pinch key strength revealed 4.5 kilograms on the right versus 4 kilograms on the left. He diagnosed bilateral carpal tunnel syndrome, bilateral ulnar nerve neuropathy at Guyon's canal and bilateral de Quervain's tenosynovitis. Dr. Weiss stated that appellant still suffered residuals of her traumatically induced injuries including bilateral wrist pain, numbness and pins and needles sensation in both hand and pain along the left and right radial aspect of the forearm into the wrist. He concluded that appellant had a 30 percent permanent impairment of each arm due to loss of grip strength.

In an August 14, 1995 report, Dr. Fried stated that appellant was unchanged in complaints. He noted that she had bilateral upper arm symptoms, positive infraclavicular Tinel's sign positive Tinel's sign over the median nerve at the wrists bilaterally and Phalen's tests bilaterally reproducing dysesthesias in the hands. Dr. Fried indicated that he had reviewed Dr. Weiss' report and agreed that appellant had bilateral median nerve involvement at the wrists. Dr. Fried diagnosed continued evidence of bilateral overuse syndrome and tenosynovitis bilaterally with de Quervian's syndrome and well as flexor tenosynovitis, median neuropathy bilaterally at the wrist level, upper neuropathy bilaterally at the elbows and low level proximal radiculopathy on the basis of plexopathy.

The Office referred appellant to Dr. Kathleen Maloney, a Board-certified neurologist, for an examination and second opinion. In a November 28, 1995 report, Dr. Maloney stated that appellant had not been working since March 1995. She indicated that appellant had tenderness to palpation of the wrists with positive Tinel's signs over the median and ulnar nerves at the wrists bilaterally and at the elbow on the left. She reported that the Phalen's test produced complaints of pain at the wrists without any dysesthesia. Dr. Maloney indicated that she could not elicit a Tinel's sign over the supra or infraclavicular regions. She stated that the ranges of motion of the wrist and arm joints appeared intact. Dr. Maloney noted that the Tinel's sign was negative over the radial nerves in the forearm bilaterally. She found no evidence of atrophy or fasciculation in any muscles. Dr. Maloney concluded that neurologically appellant had subjective complaints compatible with median nerve irritation at the wrist bilaterally and ulnar nerve irritation at the left elbow. She stated that appellant did not have any evidence of thoracic outlet syndrome. Dr. Maloney indicated that she could not find weakness, sensory or reflex changes and range of motion was normal. She commented that appellant's complaints were consistent with a diagnosis of overuse syndrome of both arms with some peripheral nerve irritation at the wrists and elbows. Dr. Maloney indicated that appellant had permanent restrictions against repetitive use of her arms. She recommended that appellant undergo an EMG. Dr. Maloney stated that she could not give a rating for permanent impairment because

appellant did not have a motor or sensory loss of function. She commented that the irritation at the wrists and left elbow were not associated with any neurologic deficit.

The Office referred appellant to Dr. Cynthia Farrell, an osteopath, for an EMG and nerve conduction studies. In a February 27, 1997 report, Dr. Farrell stated that the tests were compatible with residual from past axonal dropout throughout the bilateral arms, but no carpal tunnel syndrome, ulnar neuropathy, nor acute denervating cervical radicular process.

The Office referred appellant to Dr. Steven Valentino, an osteopath, for a schedule award evaluation. In an October 17, 1997 report, he stated that appellant had normal ranges of motion of the shoulders, elbows, wrists and hands. Dr. Valentino found no sensory or motor impairment of the wrists. He reported that all tests, including Tinel's tests, were negative. Dr. Valentino diagnosed resolved bilateral tendinitis. He stated that appellant had no residuals from her history of work-related tendinitis and had recovered from any potential carpal tunnel syndrome or thoracic outlet syndrome with residual effects. Dr. Valentino concluded that appellant could return to her preinjury job without restrictions. He stated that appellant's objective findings were normal and reported that she had zero permanent impairment of both arms.

The Office referred appellant to Dr. Bong S. Lee, a Board-certified orthopedic surgeon, for a second opinion examination. In a January 19, 1998 report, he noted local tenderness on palpation of the carpometacarpal joint with the left thumb more prominent than the right. He reported limitation in the web space between the thumb and the index fingers of both hands, with motion limited to 70 degrees in the right thumb and 80 degrees in the left thumb. Dr. Lee indicated that the remainder of the ranges of motion of the digits was normal with full flexion and extension. He noted that the sensory tests of both hands were normal with no deficit, negative Phalen's and negative Tinel's signs. Dr. Lee reported that both wrists showed normal configuration with no swelling or palpable mass. He found a full range of motion in the wrists with no tenderness of the wrist joint and no tenderness of the extensor compartment. Dr. Lee reported that the forearms and elbows demonstrated normal configuration with a full range of motion of both elbows and no local tenderness of the epicondyles. He diagnosed mild degenerative joint disease of the carpometacarpal joints of both thumbs. Dr. Lee concluded that appellant's present findings were not the result of any work injury. He commented that she might have had a mild carpal tunnel syndrome or de Quervain's disease as a result of the employment injury but stated that the employment injury had resolved with no permanent residuals or disability. Dr. Lee indicated that, if appellant had any minimal disability, with was due to mild degenerative joint disease, which was a part of the normal aging process rather than the employment injury. He concluded that appellant did not have any permanent impairment from the employment injury.

In a September 18, 1998 decision, the Office denied appellant's claim for a schedule award on the grounds that there were no residuals or permanent impairment due to appellant's occupational disease. The Office found that Dr. Lee's report was that of an impartial specialist resolving a conflict in the medical evidence.

Appellant's attorney requested a hearing before an Office hearing representative, which was conducted on March 23, 1999. In a June 7, 1999 decision, the Office hearing representative found that the weight of the medical evidence rested with Dr. Lee, acting as an impartial

specialist, who found no permanent impairment or residual disability due to the employment injury. She, therefore, affirmed the Office's September 18, 1998 decision.

Appellant appealed to the Board. In a March 14, 2001 decision, the Board noted that while Dr. Lee had been considered by the Office to be an impartial specialist, the Office, in referring appellant to Dr. Lee, did not inform her that the purpose of the referral was to resolve a conflict in the medical evidence. The Board found that Dr. Lee could not serve as an impartial medical specialist because appellant had no opportunity to object to him. The Board, therefore, set aside the Office's June 6, 1999 and September 18, 1998 decision and remanded the case for referral of appellant to an appropriate impartial medical specialist.[1]

The Office referred appellant to Dr. Brett Horwitz, a Board-certified orthopedic surgeon, to resolve the conflict in the medical evidence. In an October 31, 2001 report, Dr. Horwitz found appellant's reflexes to be normal. He found no focal neurologic deficit. Dr. Horwitz stated that motor strength appeared to be normal in all groups with no deficit. He indicated appellant had no sign of impingement of the shoulders, no external rotation weakness and no instability. Dr. Horwitz reported that appellant had a negative Tinel's sign at the thoracic outlet, cubital tunnel and carpal tunnel bilaterally as well as a negative Phalen's test bilaterally. He commented that appellant had no evidence of significant thenar atrophy. Dr. Horwitz stated that examination of the wrists showed some moderate discomfort at the extremes of both flexion and extension on the left side although no obvious synovitis, warmth or restrictions were noted. He found full ranges of motion in the elbows and shoulders. Dr. Horwitz concluded that appellant had resolved symptomatic carpal tunnel syndrome and bilateral tendonopathy with mild degenerative joint disease of the carpal metacarpal joints of the thumbs. He stated that it appeared that the repetitive stress disorder that produced appellant's symptoms had resolved completely. Dr. Horwitz concluded that appellant did not have any disability related to her employment injury.

In a November 30, 2001 report, the Office denied appellant's claim for a schedule award on the grounds that the weight of the medical evidence established that appellant had no residual disability from the employment injury which would entitle her to a schedule award.

Appellant requested a hearing before an Office hearing representative, which was conducted on May 15, 2002. In a July 23, 2002 decision, the Office hearing representative found that Dr. Horwitz's report represented the weight of the medical evidence that appellant's residuals from the employment injury had ceased. The Office hearing representative, therefore, affirmed the Office's November 30, 2001 decision.

The Board finds that appellant does not have an employment-related permanent impairment which would entitle her to a schedule award.

[1] Docket No. 00-232 (decision remanding case issued March 14, 2001).

The schedule award provisions of the Federal Employees' Compensation Act[2] and its implementing regulation[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. 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. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.

Dr. Fried, in numerous reports, reported many positive tests, particular positive Tinel's tests over the median nerve bilaterally and positive EMG results involving the left median nerve at the plexus and the right ulnar nerve at the elbow. He diagnosed tenosynovitis, mild carpal tunnel syndrome and de Quervain's syndrome. Dr. Weiss also report several positive test results and concluded that appellant had a 30 percent permanent impairment of each hand due to loss of grip strength. He diagnosed bilateral carpal tunnel syndrome and de Quervain's tenosynovitis. Dr. Maloney identified positive Tinel's signs at the median and ulnar nerves at the wrist and in the ulnar nerve in the left elbow. She, however, noted that appellant had no loss in the ranges of motion or in motor or sensory function. Dr. Maloney concluded that appellant had symptoms of an overuse syndrome with peripheral nerve involvement. She recommended an EMG. Dr. Farrell reported that the EMG and nerve conduction studies showed residua from past axonal dropout throughout the bilateral arms, but no carpal tunnel syndrome, ulnar neuropathy, nor acute denervating cervical radicular process. Dr. Valentino found that appellant had no loss of motion and normal sensory and motor function of the wrists. He found all Tinel's tests to be negative. Dr. Valentino concluded that appellant's bilateral hand condition had resolved without residuals and had recovered from her employment injuries. He concluded that appellant had no permanent impairment. Dr. Lee reached a similar conclusion, that appellant's condition from the employment injury had resolved with no residual effects. He did note that appellant had degenerative joint disease in the thumbs, which he related to the natural aging process.

The Office, to resolve the conflicting reports of Dr. Fried and Dr. Weiss on the one hand and Dr. Valentino and Dr. Lee on the other hand, referred appellant to Dr. Horwitz to act as the impartial medical specialist. Dr. Horwitz found that appellant had a negative Tinel's sign at the thoracic outlet, cubital tunnel and carpal tunnel bilaterally as well as a negative Phalen's test bilaterally. He found normal ranges of motion with some discomfort at the extremes of extension and flexion of the left wrist but no physical explanation for the discomfort. Dr. Horwitz concluded that appellant's carpal tunnel syndrome and bilateral tendonopathy, due to repetitive stress, had resolved. He found that appellant had no disability that would entitle him to a schedule award. In situations where there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[4] The report of Dr. Horwitz is

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (1999).

[4] *James P. Roberts*, 31 ECAB 1010 (1980).

thorough and well rationalized and rests on an accurate medical history. Dr. Horwitz's report, therefore, is entitled to special weight and constitutes the weight of the medical evidence in this case.

The decisions of the Office of Workers' Compensation Programs dated July 23, 2002 and November 30, 2001 are hereby affirmed.

Dated, Washington, DC
April 3, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member