U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JUANITA L. BRYNE and U.S. POSTAL SERVICE,
POST OFFICE, Bellmawr, NJ

Docket No. 00-1894; Submitted on the Record;
Issued September 6, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether appellant continues to suffer residuals of an employment-related injury.

On May 14, 1990 appellant, then a 35-year-old distribution clerk, filed an occupational disease claim asserting that her carpal tunnel syndrome, right wrist, was the result of constant repetitive motion. An electromyogram (EMG) report on June 6, 1990 found a moderate degree of neuropraxia of the median nerve on the right side not sufficiently elevated to suggest a real carpal tunnel syndrome. Dr. Richard Pilla, appellant's attending osteopath, reported on August 13, 1990 that appellant was suffering from neuropraxia of the median nerve on the right side. He explained that this was secondary to repetitive motions of the wrist and arm required by her place of employment. "There is no other activity the patient performs that could result in this kind of insult," he stated. On December 7, 1990 a medical adviser for the Office of Workers' Compensation Programs noted that the June 6, 1990 EMG was not fully diagnostic for carpal tunnel syndrome, but in view of clinical symptoms and signs, adequate information was of record for a diagnosis of right carpal tunnel syndrome. The Office accepted her claim for right carpal tunnel syndrome.

Dr. Paul A. Marchetto, a Board-certified orthopedic surgeon and assistant professor at Temple University, examined appellant on March 18, 1991. Reviewing appellant's complaints, findings and the June 6, 1990 EMG, Dr. Marchetto diagnosed thoracic outlet syndrome and brachial plexus lesions. An Office medical adviser noted that the evidence of record was insufficient to support a diagnosis of thoracic outlet syndrome or brachial plexus lesion; there was no sensory, motor, reflex, nerve conduction or EMG sign of a brachial plexus lesion, and there were no findings with respect to the radial or brachial pulses. On May 14, 1991 the Office advised appellant that it would not accept her claim for thoracic outlet syndrome or brachial plexus lesions and that her physician should address the deficiencies noted by the Office medical adviser. The Office advised that it needed medical rationale explaining how appellant's condition was causally related to her accepted employment injury.

On May 15, 1991 Dr. Marchetto reported as follows:

> "As you note from the letter of April 1, [1991] [appellant] is suffering from a thoracic outlet syndrome, that is impingement of the nerves coming out of her neck down her hands. This is caused by repetitive motion of the arms up over the head. Her job requires that she do repetitive lifting [of] bundles of mail which requires her to elevate her arms up over the shoulders. In so doing, this causes increasing compression of the nerve coming from the neck, going down the arms, and causing this on going complaint of pain.
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> "To emphasize, therefore, I feel that the illness is aggravated and caused by her type of employment. The repetitive lifting above the shoulders would be the reason."

On June 10, 1991 Dr. Marchetto informed the Office that appellant's diagnosis of thoracic outlet syndrome was a very difficult one to confirm without appropriate objective tests. Although subjectively appellant had the appropriate complaints, Dr. Marchetto recommended an EMG nerve conduction study performed under exercise conditions.

Dr. Marchetto referred appellant to Dr. James M. Hunter, a Board-certified orthopedic surgeon, for evaluation. On August 8, 1991 Dr. Hunter reviewed appellant's history. He noted that in 1984 appellant wrenched her arm at work while catching a stack of falling Spiegel catalogs. She improved minimally with conservative treatment and returned to work, but her neck, arm and shoulder had bothered her ever since. In 1990 appellant sought help for a new onset of symptoms, which was diagnosed as carpal tunnel syndrome. Dr. Hunter reviewed the June 6, 1990 EMG and described his findings on examination. He diagnosed thoracic outlet syndrome (neurogenic); bilateral median nerve neuropathy at the wrist, worse on the right than the left; and radial nerve irritability on the right at the elbow. He recommended, among other things, an EMG and nerve conduction velocity test.

The Office authorized the EMG and nerve conduction studies, which were obtained on September 3, 1991. Dr. Hunter reported that the EMG of September 3, 1991 clearly identified brachial plexopathy and a median neuropathy at the right wrist level aggravated by stress testing. "In my opinion," he stated, "they relate to the injury of April 24, 1990."[1] On December 19, 1991 he reported: "In the more recent period, particularly September 3, 1991, clearly determined that we have positive electromyographic findings for brachial plexus neuropathies involving the upper and lower part of the plexus. She also has some element of median nerve neuropathy at the carpal tunnel levels and these become more positive under stress testing." On November 6, 1991 Dr. Marchetto indicated that appellant had permanent residual disability as a result of her brachial plexus lesion injury.

[1] Appellant indicated on her claim form that she first became aware of the condition on April 24, 1990.

On January 2, 1992 the Office notified appellant that it had expanded the accepted conditions to include right shoulder strain.[2] Appellant received compensation for temporary total disability on the periodic rolls.

Dr. Hunter obtained another EMG on October 20, 1992. This test was reported to show evidence of a Grade II level neuropathy affecting the right ulnar nerve at the level of the cubital tunnel, as well as continued evidence of Grade I level neuropathies affecting the median nerves at the carpal tunnel level, both relatively unchanged from previous testing.

A repeat EMG obtained on April 29, 1993 was reported to show right ulnar nerve cubital tunnel level neuropathy, Grade I-II level slowing, localized on stress testing to the supracondylar segment; and continued evidence of Grade I level bilateral median nerve carpal level neuropathies with negative stress tests bilaterally and relatively unchanged from previous studies performed on these nerves. Dr. Hunter reported on April 29, 1993 as follows:

> "There is bilateral cervical ribs in [appellant's] background and she is carrying a right ulnar nerve cubital tunnel neuropathy with Grade II slowing, Grade I median neuropathy. The earlier EMG's almost two years ago were significant for brachial plexopathy, and I would feel that they have advanced. She is really a classic thoracic outlet syndrome with weakness of the muscles of the hands."

On January 13, 1994 Dr. Hunter reported that appellant had reached a point of medical treatment termination. Her diagnosis was brachial plexus traction injury and two associated neuropathies in the right extremity, specifically the ulnar nerve at the right elbow and the median nerve at the right wrist and hand. Congenital rib anomalies had some bearing on her treatment but had no bearing on her injury. They were a secondary part of the process of surgery, he stated, which appellant had expressed great concerns about having done. Dr. Marchetto continued to report the same diagnosis and on April 6, 1994 noted that appellant's clinical course had reached a plateau.

On July 11, 1994 Dr. Frank A. Mattei, a Board-certified orthopedic surgeon to whom the employing establishment had referred appellant, related appellant's history and findings and reviewed medical records and x-ray films. He reported with reasonable medical certainty that appellant was suffering from congenital ribs abnormalities "which is the true cause of the thoracic outlet syndrome and involvement of the brachial plexy. He explained that any stretching of the cervical spine in flexion, extension and rotation would eventually cause her clinical condition, but this was a congenital abnormality and not the result of injury. Appellant did not have a true thoracic outlet syndrome due to the pathology being a cervical rib and not a scalenus anticus muscle involvement. Dr. Mattei opined that appellant was not totally disabled.

On April 12, 1995 Dr. Marchetto prepared a follow-up report reiterating appellant's diagnosis of brachial plexus traction injury and noting that her clinical course was unchanged, as was the relationship of the condition found and the history of injury. "The stress of overhead activity would provoke this syndrome worsening her condition." Dr. Marchetto found appellant

[2] The Office's Form CA-800, Nonfatal Summary, indicates that the Office accepted appellant's claim for the condition of thoracic outlet syndrome.

totally disabled from her prior work requirements. On December 5, 1995 he completed a work capacity evaluation form indicating that appellant had limitations on lifting and reaching related to her employment injury but could work three hours a day with those limitations. He also indicated that appellant was unable to perform repetitive motions of the wrist or elbow.

The Office referred appellant, together with medical records and a statement of accepted facts, to Dr. Robert Bachman, a Board-certified orthopedic surgeon, for a second opinion evaluation. On January 5, 1996 Dr. Bachman related appellant's complaints, job requirements, history of present illness and findings on physical examination. He reviewed cervical spine films obtained on August 9, 1991 and noted a computerized tomography report of the cervical spine, which showed mild degenerative changes and bilateral ribs. He reviewed particular medical reports, which he identified, together with the statement of accepted facts and appellant's job description. Dr. Bachman reported that his orthopedic examination was within normal limits; there were no objective findings, including the examination with regard to the accepted work-related carpal tunnel syndrome and sprain of the right shoulder. He diagnosed degenerative disc disease of the cervical spine and bilateral cervical ribs. He concluded that appellant would have difficulty performing all of the duties of her job because of the bilateral cervical ribs, the presence of which probably caused some degree of thoracic outlet syndrome in some of the duties required, such as repeated lifting above shoulder level and the need to lift sacks of mail that appellant stated were 70 pounds. Dr. Bachman saw no need for medical treatment. "It is my opinion," he stated, "based on today's examination, that the effects of her activities at work in 1990 have ceased to be a cause of ongoing difficulties." He indicated on a work capacity evaluation form, also dated January 5, 1996, that appellant could work eight hours a day with restrictions on reaching and lifting, that these restrictions were not due to the employment injury, and that appellant was able to perform repetitive motions of the wrist and elbow.

On February 12, 1996 the Office issued a notice of proposed termination of compensation. The Office found that Dr. Bachman's opinion constituted the weight of the medical evidence.

On February 26, 1996 Dr. Marchetto stated that it was his opinion that the thoracic outlet syndrome "was flared up" from the injury appellant had while at work: "Although the cervical ribs were there since birth, she had no prior symptoms of neck and arm pain. It was subsequent to the fall that she had this tremendous flare-up of pain down the arm which really follows the problem with thoracic outlet."

In a decision dated March 14, 1996, the Office terminated appellant's compensation benefits.

In a report dated November 20, 1996, Dr. Marchetto described appellant's job duties. He reported her definitive diagnosis as neurologic thoracic outlet syndrome, brachial plexopathy and median nerve neuropathy at the right wrist, right sided. He noted that multiple EMG and nerve conduction studies indicated brachial plexopathy involving the upper and lower trunk and median nerve neuropathy at the right wrist. He described findings from his most recent

examination on July 17, 1996. Dr. Marchetto reiterated his opinion on causal relationship and disability. He concluded:

> "In summary, it is my opinion to a reasonable degree of medical certainty that [appellant's] present medical condition is directly causally related to her job as a manual, distribution clerk in the [employing establishment]. The congenital bilateral cervical ribs did not cause any symptoms until [appellant] worked as a manual distribution clerk in the [employing establishment]. It is the very nature of that repetitive lifting and twisting that put undue stress on the brachial plexus causing this chronic and ever debilitating syndrome. It is my opinion that she will never be able to return to that type of job that requires her to do those provocative upper extremity motions."

In a decision dated January 31, 1997, an Office hearing representative affirmed the March 14, 1996 termination of appellant's compensation. She found that the weight of the medical evidence at the time of the termination decision rested with the opinion of Dr. Bachman and established that appellant's employment-related disability had ceased; however, subsequent opinion evidence from Dr. Marchetto created a conflict necessitating referral to an impartial medical specialist.

On remand the Office referred appellant, together with the case file and a statement of accepted facts, to Dr. Howard Zeidman, a Board-certified orthopedic surgeon, to resolve the conflict.[3] The Office authorized Dr. Zeidman to obtain further diagnostic procedures.

In a report dated January 6, 1998, Dr. Zeidman stated that he examined appellant on December 8, 1997. He related her general history and complaints. Dr. Zeidman noted the June 6, 1990 EMG, x-rays in March 1991 and the CT scan of the cervical spine on August 26, 1991. He noted Dr. Mattei's report of July 11, 1994, various reports of Dr. Marchetto and the January 5, 1996 report of Dr. Bachman. Dr. Zeidman related his own findings on examination. The cervical spine was found to have a good range of motion without spasm or tenderness. Motion of the upper extremities was intact throughout. The neurologic examination was unremarkable. Tinel's sign was unremarkable. Dr. Zeidman concluded:

> "In summary, it would appear the patient does have evidence of degenerative disc disease in the cervical spine and congenital cervical rib problems. There is a paucity of objective physical findings. There does not appear to be any objective functional loss or permanent disability.
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> "While the patient does have a history of various problems, these appear to be more related to underlying difficulties than to any specific injury which could be identified from the information supplied.
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> "Please note that the only x-rays which I have been able to review were the original films of August 8, 1991 of the cervical spine and hand. None of the MRIs or other studies were available for review.

[3] The statement of accepted facts advised that thoracic outlet syndrome was not job related.

"I trust this note provides information of value. If I can be of further help, please let me know. If any of the other information or studies should become available, I would be happy to review that and offer additional comment as indicated."

In a decision dated June 26, 1999, the Office found that appellant had no continuing medical condition causally related to the occupational disease claim of April 24, 1990.

In a decision dated February 2, 2000, a hearing representative affirmed the Office's June 26, 1999 decision. She found that the weight of the medical evidence lay with Dr. Bachman and Dr. Zeidman, who opined that appellant had no current objective finding of the accepted conditions.

The Board finds that this case is not in posture for decision. A supplemental report is required from the impartial medical specialist.

Prior to the Office accepting appellant's claim, an Office medical adviser explained that the June 6, 1990 EMG was not fully diagnostic for carpal tunnel syndrome. Thereafter, Dr. Marchetto reviewed appellant's complaints, findings and the June 6, 1990 EMG. He diagnosed thoracic outlet syndrome and brachial plexus lesions. Dr. Hunter subsequently reported that brachial plexopathy and a median neuropathy at the right wrist level were clearly identified by multiple electrodiagnostic studies. He reported that appellant had a classic thoracic outlet syndrome. Dr. Marchetto described appellant's diagnosis as "definitive": neurologic thoracic outlet syndrome, brachial plexopathy and median nerve neuropathy at the right wrist, right sided. In his reports of May 15, 1991, February 26 and November 20, 1996, he offered sound medical reasoning to support that appellant's neuropathies were causally related to her federal employment. Though Dr. Mattei believed that a congenital cervical rib condition was the "true cause" of appellant's thoracic outlet syndrome and involvement of the brachial plexy, he explained that any stretching of the cervical spine in flexion, extension and rotation -- such as occurred in appellant's federal employment -- would eventually cause her clinical condition. On April 12, 1995 Dr. Marchetto reported that appellant was totally disabled from her prior work requirements and that this was a permanent condition. On November 20, 1996 he reported that appellant would never be able to return to a job that required her to do repetitive lifting and twisting.

When Dr. Bachman, the Office referral physician, reported that the effects of work activities in 1990 had ceased to be a cause of ongoing difficulties, a conflict arose as to whether appellant continued to suffer residuals of the disabling neuropathies that Dr. Marchetto and Dr. Hunter had related to her federal employment. When the Office referred appellant to Dr. Zeidman, it authorized further diagnostic studies but failed to ask the impartial medical specialist whether residuals of the diagnosed neuropathies (apart from the accepted carpal tunnel syndrome) were still present. Instead, the Office provided Dr. Zeidman with a statement of accepted facts advising that thoracic outlet syndrome was not job related. Dr. Zeidman obtained no further electrodiagnostic studies and reported that he had reviewed none of the previous studies, even though the record contains several such studies and reports.

The Board finds that further development of the medical evidence is warranted. When the Office secures an opinion from an impartial medical specialist for the purpose of resolving a

conflict in the medical evidence and the opinion from the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting a defect in the original report. When the impartial medical specialist's statement of clarification or elaboration is not forthcoming or if the specialist is unable to clarify or elaborate on the original report or if the specialist's supplemental report is also vague, speculative or lacks rationale, the Office must submit the case record together with a detailed statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question.[4] Unless this procedure is carried out by the Office, the intent of Section 8123(a) of the Federal Employees' Compensation Act[5] will be circumvented when the impartial specialist's medical report is insufficient to resolve the conflict of medical evidence.[6]

The Board will set aside the Office's February 2, 2000 and June 26, 1999 decisions and remand the case for a supplemental report from Dr. Zeidman. The Office shall provide Dr. Zeidman a proper statement of accepted facts which lists all conditions accepted in this case, together with the entire case record, including previous electrodiagnostic studies and reports, which may be marked or identified for convenient reference.[7] The Office shall request that Dr. Zeidman obtain further diagnostic studies and discuss whether residuals of the previously diagnosed neuropathies are still present and, if so, whether they are related to the duties that appellant performed in her federal employment. The impartial specialist should be requested to address whether appellant's work dates aggravated her conditions and if so, the period of any such aggravation. After such further development of the evidence as may be necessary, the Office shall issued an appropriate final decision on appellant's entitlement to benefits.

[4] *See Nathan L. Harrell*, 41 ECAB 402 (1990).

[5] 5 U.S.C. § 8123(a) provides the following: "An employee shall submit to examination by a medical officer of the United States, or by a physician designated or approved by the Secretary of Labor, after the injury and as frequently and at the times and places as may be reasonably required. The employee may have a physician designated and paid by him present to participate in the examination. If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

[6] *Harold Travis*, 30 ECAB 1071 (1979).

[7] Relevant results of the June 6, 1990 EMG are reported at page 23 of the record. The September 3, 1991 studies and report appear at pages 20. The report of the October 20, 1992 study appears at page 35. And the EMG evaluation of April 29, 1993 appears at page 265.

The February 2, 2000 and June 26, 1999 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, DC
September 6, 2001

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member