U. S. DEPARTMENT OF LABOR

# Employees' Compensation Appeals Board

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In the Matter of ANTHONY CIRCELLI and U.S. POSTAL SERVICE,
MAIN POST OFFICE, New Castle, PA

*Docket No. 01-955; Submitted on the Record;*
*Issued May 3, 2002*

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DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant sustained an ulnar nerve condition or reflex sympathetic dystrophy (RSD) as a result of his accepted employment injury; and (2) whether appellant is entitled to an amended schedule award for permanent impairment to his left arm.

On November 1, 1990 appellant, then a 52-year-old general mechanic, sustained a traumatic injury while in the performance of his duties. He was checking a sprinkler system and releasing air out of a water line. Water flowed through the pipe with such force that the pipe slammed appellant's left hand against a brick wall. The Office of Workers' Compensation Programs accepted his claim for a crush injury and laceration of the left hand.

Appellant underwent surgery on November 23, 1990, which the Office authorized. In his operative report, Dr. James J. Barber, appellant's attending plastic surgeon and hand specialist, described the surgery as follows: "Debridement to the area of the fifth digit with removal of nonviable tissue, rearrangement closure area of the tip, fourth finger had a debridement with rearrangement and closure to the area of the skin with repair partial flexor tendon injuries at deposition with repair of neurovascular bundle."

Appellant underwent active range of motion therapy and began to show signs of carpal tunnel syndrome. On January 29, 1991 Dr. Robert S. Vandrak, a specialist in electrodiagnostic medicine, reported an abnormal nerve conduction study:

> "The primary deficit at this time seems to be in the left ulnar sensory nerve component which demonstrates a decreased amplitude probably due to some damaged sensory fibers secondary to a trauma event. Nevertheless the motor component of the ulnar nerves seems to be intact with only slightly abnormal motor unit recruitment pattern and firing frequency. No evidence of carpal tunnel is demonstrated. It should be noted that the patient could be starting to demonstrate some signs of reflex sympathetic dystrophy, however, more close medical correlation is needed to make this determination."

Dr. Barber indicated on a form report that appellant's ulnar nerve entrapment was caused or aggravated by employment activity.

Dr. Barber performed an operation on March 1, 1991 to release the ulnar nerve at the wrist and elbow. He reported his postoperative diagnosis as "entrapment of the ulnar nerve, wrist and Guyon's canal and also the area of the elbow in the cubital tunnel."

Appellant showed good sensation after the surgical release and subsequent therapy but continued to have wrist complaints. He also had complaints of pain in his left shoulder and elbow. X-rays showed these areas to have diffuse arthritis. Dr. Barber reported a positive Tinel's sign and Phalen's test.

Appellant was seen in consultation by Dr. Dennis J. Courtney, a specialist in pain management, who diagnosed myofascial pain syndrome secondary to a work-related injury sustained on November 1, 1990. He added: "As a result of that accident the patient developed complaints of left shoulder, arm and hand pain." Dr. Courtney stated that a thermogram might be needed to rule out RSD.

On August 15, 1991 Dr. Barber addressed the impairment of appellant's left arm:

> "With regards to the overall functioning of his limb, he is indeed reached his maximum effort and ability to improve in this regard with formal therapy. It is very difficult to establish a percentage of loss for the area of the left limb, he is limited certainly by the diffuse arthritis of his elbow and shoulder as well as the hand injuries that he has suffered and the complaints of numbness and weakness that he is showing. The percentage of strength that has been lost is somewhere between 40 percent to 56 percent loss to the area of that limb compositely, this may be corroborated by [appellant's therapist] who worked these measurements out with both dynamometer as well as on grip strength management and evaluation."

On September 9, 1991 appellant filed a claim for a schedule award.

In a report dated November 29, 1991, Dr. Michael R. Zernich, an orthopedic surgeon and Office referral physician, opined that appellant's ulnar nerve entrapment, left forearm symptoms and arthritis of the elbow and shoulder were "undoubtedly unrelated" to the November 1, 1990 accident: "I failed to reveal how these findings could possibly be related to his having sustained a crush injury to his hand." Although x-rays showed no serious evidence of RSD, Dr. Zernich reported that RSD still existed as a minor possibility.

Findings from a January 21, 1992 thermogram were interpreted as compatible with RSD involving the left upper extremity and with fibromyositis involving the left scapular area of the upper back.

On September 8, 1992 appellant advised the Office that he was going to need surgery on his wrist again. An Office medical adviser reported that a confirming opinion on causal relationship was needed before authorization because the original injury was to two crushed fingers and the proposed surgery was for carpal tunnel syndrome and de Quervain's syndrome.

Responding to an Office request for a reasoned medical opinion on how the proposed surgery was causally related to the original work injury. Dr. Barber reported the following on January 23, 1993:

> "I am asked to write a letter for [appellant] explaining the cause and relationship to his work-related injury. In my experience, and I have seen this a great deal, I have seen a number of patients with similar presentations. The development of a carpal tunnel syndrome if not immediately related to the workplace, remains subclinical prior to an injury and then develops full-blown signs and symptoms. This occurs either after rehabilitation, malus or overuse of the hands. Whether these were indeed developed by the injury itself, or whether they were dormant prior to this, I cannot comment. I certainly do approximately 50 to 75 depositions and/or letters per year involving similar circumstances surrounding the development of nerve entrapment symptoms after hand or upper extremity injury."

The Office once again sought a second opinion from Dr. Zernich. In a report dated October 5, 1993, Dr. Zernich stated that it was somewhat doubtful that appellant had carpal tunnel syndrome. He recommended conservative measures and advised against further surgery unless absolutely necessary.

The Office found a conflict in medical opinion with respect to the need for surgery and referred appellant, together with the case record and a statement of accepted facts, to Dr. H. Andrew Wissinger, a Board-certified orthopedic surgeon. On April 13, 1994 Dr. Wissinger diagnosed the following: (1) multi-system injury, left ring and little fingers, causally related to the injury of November 1, 1990, recovered with impairment; (2) left ulnar nerve dysfunction, not related to the injury of November 1, 1990; and (3) no evidence of left median nerve dysfunction. Dr. Wissinger added: "On the basis of my examination, the proposed surgery has nothing to do with [appellant's] work injury of November 1, 1990."

On November 16, 1994 the Office issued a schedule award for a 13 percent permanent impairment of the left arm. The Office based this award on the clinical findings reported by Dr. Wissinger, which an Office medical adviser interpreted as showing a sensory and motor deficit of the radial nerve below the elbow.

On January 18, 1995 Dr. Vandrak, the specialist in electrodiagnostic medicine, reported that an electromyogram (EMG) and nerve conduction study revealed no evidence of carpal tunnel syndrome or radiculopathy. He noted that appellant did have residual left ulnar sensory neuropathy across the left elbow with no significant change from May 20, 1991 but with some improvement from January 29, 1991. Dr. Vandrak also noted that appellant's ulnar nerve entrapment at the wrist was markedly improved.

In a decision dated March 20, 1995, an Office hearing representative found that a supplemental report from Dr. Wissinger was required to clarify whether appellant's ulnar nerve dysfunction and left shoulder complaints were causally related to the accepted employment injury.

In a report dated May 25, 1995, Dr. Wissinger explained that appellant's ulnar nerve dysfunction was not causally related to the work injury of November 1, 1990 because there was no history of injury to the left elbow on that date; the problems with the ulnar nerve presented themselves much later. Also, because appellant had never complained to him of any shoulder problem, Dr. Wissinger had no reason to believe that appellant had shoulder difficulties that could be related to his injury of November 1, 1990.

Dr. Barber replied on August 6, 1996:

> "In response to Dr. Wissinger and in review of my charts and with the patient's recollection, [appellant] began to complain of ulnar nerve complaints not too long after the injury of November 1, 1990 with sensitivity to the area of the left elbow radiated to the area of the fourth and fifth digit. The patient was unable to start therapy until January 1991 postop[erative] recovery having been in a sling and post repair to the area of those wounds. He did complain of continued pain in the area of the left elbow and wrist necessitating Dr. Vandrak in New Castle and St. Francis Hospital to do a nerve conduction study in January 1991 showing an ulnar nerve being entrapped at the left wrist and left elbow. He underwent release to that on March 1, 1991."

In the prior appeal of this case,[1] the Board found that the opinion of the referee medical specialist, Dr. Wissinger, was not sufficiently rationalized to constitute the weight of the medical evidence. The Board ordered further development of the evidence:

> "On remand, the Office should incorporate the operative reports in the record, prepare a statement of accepted facts and list of specific questions and refer appellant to an appropriate Board-certified specialist to resolve the existing conflicts of medical opinion evidence regarding the causal relationship between his ulnar nerve condition and his employment injury, the causal relationship between the diagnosed reflex sympathetic dystrophy and his employment injury, whether appellant has preexisting arthritis which affects his schedule member and determining any permanent impairment due to accepted conditions."

The Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Jack P. Failla, a Board-certified orthopedic surgeon, to resolve the outstanding conflict on whether appellant's ulnar nerve condition or RSD was causally related to the employment injury of November 1, 1990.

On July 5, 2000 Dr. Failla reported that he evaluated the medical record and examined appellant that day. He related appellant's history of injury and medical treatment. Findings on physical examination were as follows:

> "On examination today, the patient presents as a pleasant gentleman who is right-hand dominant. He has a right forearm that is one centimeter greater in circumference than the left. The diameter of the right hand is the same as the left

[1] Docket No. 98-732 (issued December 1, 1999).

hand and there is no evidence of obvious atrophy. He does have evidence of previous scars over the fourth and fifth digits of his left hand as well as a well-healed scar over the canal of Guyon and over the cubital tunnel. He lacks 10 degrees of full flexion of the left elbow compared to the right. He is able to make a fist with his left hand, but subjectively is not able to generate much grip strength. There is no evidence of skin shininess, loss of turgor or decrease in sweat pattern suggesting any neuropathic condition. Examination of the sensation of his entire left forearm and hand were different than the right, although he could not identify if it were sharp or dull. It was just that it was different and did not follow any particular dermatome. He had no clinical or physical evidence of carpal tunnel syndrome, although he was sensitive any time you touched him anywhere about the hand, forearm and elbow, again, not consistent with any particular pathological complex."

X-rays of both hands demonstrated no changes that would be consistent with RSD. Dr. Failla reported that there was not much difference in the bony architecture of either hand. There was no deformity from injuries or fractures.

Dr. Failla diagnosed status post crush injury to the left hand with poor response to surgery and rehabilitation and possible inadequacy of appropriate rehabilitation toward a more beneficial end. He stated: "The patient has no clinical evidence of reflex sympathetic dystrophy at this time, although he may have had this condition in the past there certainly is no evidence that he has it at the present time." Dr. Failla reported that the any preexisting arthritis affecting the right upper extremity was, in his considered opinion, a nonissue: "It has no relevance to the crush injury of November, 1990."

To further clarify whether appellant had an ulnar nerve condition, Dr. Failla ordered a current EMG and nerve conduction study. He also ordered a functional evaluation by a hand specialist.

Following these evaluations, Dr. Failla submitted an addendum report dated October 4, 2000. He noted that an EMG study obtained on July 13, 2000 was within normal limits, indicating no evidence of neurological dysfunction or disorder. Findings on hand evaluation examination were limited to range of motion and sensation because appellant declined to perform lifting tasks and because findings on attempted strength testing were inconsistent and gave some indication of suboptimal effort. Dr. Failla reported that evaluations of range of motion and sensory testing demonstrated a total extremity impairment of 22 percent using the impairment criteria of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4$^{th}$ ed. 1993).

On October 26, 2000 an Office medical adviser reviewed Dr. Failla's reports and concurred with the impairment rating of 22 percent for the left upper extremity.

In a decision dated October 31, 2000, the Office found that the opinion of the referee medical specialist, Dr. Failla, represented the weight of the medical evidence and established that appellant had no ulnar nerve condition, RSD or arthritis causally related to his federal employment.

On November 14, 2000 the Office issued an amended schedule award for an additional 9 percent permanent impairment of the left upper extremity.

The Board finds that this case is not in posture for decision.

A conflict arose on the issue of whether appellant's ulnar nerve condition or RSD was causally related to the accident that occurred at work on November 1, 1990. Dr. Barber, appellant's attending plastic surgeon and hand specialist, indicated that appellant's ulnar nerve entrapment at the left wrist and elbow was caused or aggravated by employment activity. Dr. Courtney, a consulting specialist in pain management, indicated that appellant's complaints of left shoulder, arm and hand pain were a result of the November 1, 1990 accident. Dr. Zernich, an orthopedic surgeon and Office referral physician, disagreed. He indicated that appellant's ulnar nerve entrapment, left forearm symptoms and arthritis of the elbow and shoulder were "undoubtedly unrelated" to the crush injury appellant sustained to his hand on November 1, 1990.

To resolve this conflict, the Office referred appellant to Dr. Failla, a Board-certified orthopedic surgeon,[2] who reported that a current EMG study showed no evidence of neurological dysfunction or disorder. He further reported that appellant had no current clinical evidence of RSD, "although he may have had this condition in the past." While these findings are probative on the issue of whether appellant currently suffers residuals of an ulnar nerve condition or RSD, they do not address the fundamental question of whether appellant sustained an ulnar nerve condition or RSD as a result of the accident that occurred at work on November 1, 1990.

The medical record supports that appellant suffered from a left ulnar nerve condition. The medical record also includes some evidence of RSD. On January 29, 1991 Dr. Vandrak, the specialist in electrodiagnostic medicine, reported an abnormal nerve conduction study. He stated that the primary deficit seemed to be in the left ulnar sensory nerve component, "which demonstrates a decreased amplitude probably due to some damaged sensory fibers secondary to a trauma event." Dr. Vandrak also reported that appellant could be starting to demonstrate some signs of RSD, though closer medical correlation was needed to make such a determination. Dr. Barber performed surgery on March 1, 1991 to release the ulnar nerve at the wrist and elbow. Dr. Courtney stated that a thermogram might be needed to rule out RSD. On November 29, 1991 Dr. Zernich reported that RSD existed as a minor possibility, though x-rays showed no serious evidence of the condition. A thermogram obtained on January 21, 1992 was interpreted as compatible with RSD involving the left upper extremity. Finally, Dr. Vandrak reported an abnormal electromyographic study on January 18, 1995. He reported that appellant had residual left ulnar sensory neuropathy across the left elbow with no significant change from May 20, 1991 but with some improvement from January 29, 1991. He also reported that appellant's ulnar nerve entrapment at the wrist was markedly improved.

The question for determination which Dr. Failla did not address is whether appellant sustained an ulnar nerve condition or RSD as a result of the November 1, 1990 injury or as a result of the November 23, 1990 surgery.

[2] 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. 5 U.S.C. § 8123(a).

When the Office secures an opinion from a referee 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 referee 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 referee specialist for a rationalized medical opinion on the issue in question.[3] Unless this procedure is carried out by the Office, the intent of section 8123(a) of the Federal Employees' Compensation Act[4] will be circumvented when the referee specialist's medical report is insufficient to resolve the conflict of medical evidence.[5]

The Board will set aside the Office's October 31, 2000 decision and remand the case for a supplemental opinion from Dr. Failla on whether appellant sustained an ulnar nerve condition or RSD as a result of the accident that occurred at work on November 1, 1990 or as a result of the authorized surgery of November 23, 1990.

The Board will also set aside the schedule award of November 14, 2000. The Office accepted that appellant injured his left hand on November 1, 1990 but has not accepted as employment related any injury to the left arm. Where the residuals of an injury to a member of the body specified in the schedule[6] extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member.[7] The Office issued an amended schedule award for an additional 9 percent permanent impairment to the left arm, for a total impairment of 22 percent, but such an award is premature without a reasoned medical opinion addressing whether permanent residuals of appellant's November 1, 1990 employment injury extend beyond the hand and into the arm. The Office shall obtain such an opinion from Dr. Failla on remand.

After such further development as may be necessary the Office shall issue an appropriate final decision on whether appellant sustained an ulnar nerve condition or RSD as a result of his accepted employment injury and on whether appellant is entitled to an amended schedule award for permanent impairment to his left arm.

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

[4] *See* note 2.

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

[6] 5 U.S.C. § 8107.

[7] *Asline Johnson*, 42 ECAB 619 (1991); *Manuel Gonzales*, 34 ECAB 1022 (1983).

The November 14 and October 31, 2000 decisions of the Office of Workers' Compensation Programs are set aside. The case is remanded for further action consistent with this opinion.

Dated, Washington, DC
May 3, 2002

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member