United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 09-1270**
	)	**Issued: March 17, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On April 16, 2009 appellant filed a timely appeal from Office of Workers' Compensation Programs' June 3, 2008 and February 17, 2009 decisions denying his claim for recurrence of disability and request to expand his claim. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant sustained a recurrence of disability on July 27, 2004 causally related to his accepted November 13, 1999 employment injury; and (2) whether he sustained brachial plexopathy or ulnar neuropathies as a consequence of his accepted injury.

On appeal, appellant's representative argues that the report of the impartial medical examiner is insufficient to represent the weight of the medical evidence.

FACTUAL HISTORY

On November 13, 1999 appellant, then a 59-year-old mail handler, filed an occupational disease claim alleging that he had developed pain in his hands, fingers and arms as a result of his

federal employment activities. The Office accepted his claim for bilateral carpal tunnel syndrome (CTS) and bilateral median neuropathy. Appellant returned to full duty on or about May 22, 2000.

Appellant filed claims for recurrences of disability on August 16 and September 2, 2003 He stopped work on August 5, 2003 due to the accepted injury. On October 29, 2003 appellant asked the Office to expand his claim to include ulnar neuropathy and bronchial plexitis.

Appellant was treated by Dr. Scott O. Fried, a Board-certified osteopath specializing in orthopedic surgery, who diagnosed traumatically-induced median and radial neuropathy and bilateral brachial plexitis. Dr. Fried recommended that appellant be restricted to sedentary work four hours per day, two days per week. On February 26, 2004 Dr. Richard Mandel, a Board-certified orthopedic surgeon, and second opinion physician, found no evidence of ulnar neuropathy or brachial plexopathy. He advised that appellant was capable of working four hours per day, five days per week.

On August 13, 2004 appellant filed a notice of recurrence as of July 2, 2004 due to his accepted injury. In a July 27, 2004 report, Dr. Fried found that he was totally disabled from work. Examination revealed: positive brachial plexus; Tinel's both supra and infraclavicular on the right; supraclavicular tenderness on the left; significant bilateral upper trapezial spasm; moderately positive ulnar nerve bilaterally; positive radial nerve bilaterally; and markedly positive median at both wrists. Dr. Fried referenced a September 3, 2003 electromyogram/nerve conduction study (EMG/NCS) report which demonstrated: "radial nerve right 44; median nerve right 7.5, left 7.2; ulnar nerve right 45, left 43; upper plexus right 47, left 56."

The Office found a conflict in medical opinion between Dr. Fried and Dr. Mandel regarding appellant's work capacity and the extent of his work-related injuries. It referred appellant to Dr. Richard G. Schmidt, a Board-certified orthopedic surgeon, for an impartial medical examination and an opinion as to whether appellant was partially or totally disabled due to the accepted employment injury and whether he had any additional conditions as a consequence of the injury. On September 13, 2004 Dr. Schmidt found no symptoms of ongoing CTS and opined that appellant had no disability due to his accepted injury.

In a decision dated November 30, 2004, the Office denied appellant's recurrence claims, based on Dr. Schmidt's referee report.

On December 2, 2004 appellant requested an oral hearing.

Dr. Fried provided additional reports finding appellant totally disabled secondary to his work-related bilateral median neuropathies, tenosynovitis and proximal radiculopathies. On September 12, 2005 he provided a narrative report, which included a detailed factual and medical history. Dr. Fried noted that appellant's EMG and nerve conduction studies objectively corroborated his clinical complaints and showed severe median neuropathies bilaterally, as well as proximal radiculopathy.

By decision dated November 14, 2005, the Branch of Hearings and Review set aside the November 30, 2004 decision on the grounds that Dr. Schmidt's report was not sufficient to resolve the conflict in medical opinion. The hearing representative remanded for the Office to

obtain another impartial medical examiner. Dr. Schmidt was asked to address whether appellant could perform modified duties four hours per day, five days per week; whether he sustained a recurrence of disability in August 2004; and whether the diagnosis of brachial plexopathy was related to the accepted injury. The Office was advised to instruct the impartial medical examiner (IME) to obtain an EMG/NCS as necessary and to discuss its results.

On remand the Office referred appellant, together with a statement of accepted facts, to Dr. William Kirkpatrick, a Board-certified orthopedic surgeon. In a June 5, 2006 report, Dr. Kirkpatrick provided a history of treatment and examination findings. Appellant had full active range of motion of both shoulders, elbows, wrists and digital joints in both hands, as well as full rotation of both forearms. He had limited cervical extension because of "tightness." Appellant was able to fully flex his cervical spine to touch his chin to his chest, but limited his cervical rotation to the right and left to approximately 30 degrees. He did not describe any discomfort with palpation over the trapezius muscle on either side. Tinel's testing was negative over the brachial plexus on both sides and negative over both the supra clavicular and infra clavicular areas. Provocative plexus maneuvers were essentially unremarkable. On Roos testing, appellant described only a throbbing in both hands and elbows, as well as thumb pain with this maneuver. Tinel's testing was positive over both cubital tunnels. Elbow flexion testing was positive bilaterally. There was no tenderness with palpation over the forearms and no tenderness over the radial tunnels or pronator levels of the median nerves. There was no forearm atrophy on either side. Tinel's testing also was positive over both median nerves at the wrists. Provocative wrist maneuvers were otherwise unremarkable bilaterally. Appellant had no tenderness with palpation over the scapholunate or lunotriquetral joints or over the TFC regions. There was no ECU tendon subluxation on either side. Appellant did have tenderness with palpation directly over the palmar aspects of both thumb carpometacarpal joints. Grind testing of the thumbs was positive bilaterally. There was no thenar or interosseous muscle atrophy in either hand. Phalen's testing was positive bilaterally. There was no triggering of any of the fingers in either hand. No clawing was present in the hands and Wartenberg's sign was negative bilaterally. Appellant described slight tingling in the right thumb and index, as well as in the left thumb and index fingers. Both hands were of similar color and warmth. No trophic changes were present in the fingers, and there was no abnormal sweat or hair growth. Intrinsic muscle strength was 5/5 in both hands. Dr. Kirkpatrick diagnosed bilateral median neuropathies at wrists and bilateral ulnar neuropathies at elbows. He opined that appellant was able to perform modified duties for four hours a per day, five days a week, as of March 14, 2003; that he was not totally disabled in July 2004, as he was seen by Dr. Schmidt in September 2004, and there was no evidence of an ongoing CTS. Dr. Kirkpatrick found no evidence of a brachial plexopathy on either side. He did find evidence of bilateral ulnar neuropathies at the elbows, which was not related to appellant's employment.

The record contains a June 22, 2006 EMG report, which revealed marked right upper brachial plexus level compromise, unchanged from his previous test result of September 30, 2003; moderate, bilateral radial nerve compromise at the radial tunnel levels (the right was unchanged while the left previously was reported as normal); bilateral median nerve compromise at the wrist levels (the right was markedly abnormal but unchanged from his previous test result, and the left was moderately abnormal and relatively improved from his previous test); bilateral lunar nerve compromise at the medial elbow levels, mild on the right and significant on the left

(the right was marginally improved while the left was moderately worse than reported on his previous test).

By decision dated September 28, 2006, the Office denied appellant's recurrence claim and request to accept brachial plexopathy. It found that Dr. Kirkpatrick's report represented the weight of medical opinion. However, it approved appellant's claim reducing his hours effective August 5, 2003 to four hours a day, five days a week. On October 4, 2006 appellant requested an oral hearing.

In a decision dated June 18, 2007, an Office hearing representative vacated the September 28, 2006 decision, finding that Dr. Kirkpatrick's June 5, 2006 report was insufficient to resolve the conflict in medical opinion. The Office was instructed to obtain a supplemental report from Dr. Kirkpatrick as to whether appellant was able to work limited duty four hours a day after August 5, 2003 and, if so, whether he was able to perform the duties of a mail handler after July 27, 2004; further explanation as to why the physician concluded there was no evidence of brachial plexopathy, in light of appellant's September 30, 2003 and June 22, 2006 EMG reports; and medical rationale supporting his opinion that appellant's diagnosed bilateral ulnar neuropathies were not causally related to his accepted employment injury.

On July 25, 2007 the Office provided Dr. Kirkpatrick with an updated record and statement of accepted facts. It requested that he clarify his June 5, 2006 report. Dr. Kirkpatrick was asked to provide a well-reasoned medical opinion, based on objective findings, on the following issues: whether appellant's need for modified duty on March 4, 3003 was due to the accepted bilateral carpal tunnel condition; whether appellant's need to reduce his modified duty to four hours per day on August 4, 2003 was due to the accepted condition; whether appellant's complete work stoppage on July 27, 2004 was due to the accepted bilateral carpal tunnel condition; whether there was no evidence of brachial plexopathy on either side, in view of the EMG reports of record; whether appellant's bilateral ulnar neuropathies were not causally related to his employment; whether the claimant was capable, on and after July 27, 2004 of performing for four hours per day the modified work duties he had been performing since August 5, 2003 and whether appellant was capable of working with restrictions.

In a supplemental report dated August 6, 2007, Dr. Kirkpatrick responded to the Office's questions. He opined that the need for modified duty on Mach 4, 2003 was related to appellant's accepted bilateral carpal tunnel condition, based on Dr. Mandel's December 23, 2002 findings, which revealed ongoing bilateral median neuropathy with complaints of numbness in both hands the thumb, index and long and ring fingers, as well as positive bilateral carpal tunnel compression testing. Dr. Kirkpatrick also stated that the need to reduce his modified duty to four hours a day on August 4, 2003 was related to his accepted condition, as he continued to have ongoing symptoms and positive findings.

Dr. Kirkpatrick opined that appellant's complete work stoppage on July 27, 2004 was not solely due to the accepted bilateral carpal tunnel condition, as Dr. Fried was treating him for multiple neuropathies not specifically related to his accepted bilateral carpal tunnel condition. He further opined that he was not totally disabled on July 27, 2004 and would have been capable of continuing to perform four hours a day in modified duty as he had been doing since August 5,

2003, in light of his accepted bilateral CTS. Dr. Kirkpatrick had not sustained any new work injuries and was at maximum medical improvement with regards to his accepted bilateral CTS.

Dr. Kirkpatrick stated that there was no evidence of a brachial plexopathy on either side, in view of electrodiagnostic studies performed on November 30, 1999 and on January 20, 2003, which were unremarkable regarding the brachial plexus. Although subsequent EMGs performed by a physical therapist suggested bilateral plexopathies, he stated, "In light of no objective findings suggesting a brachial plexopathy on examination, clinical correlation supports the absence of a bilateral brachial plexopathy as noted on his initial EMG studies."

Dr. Kirkpatrick opined that the bilateral ulnar neuropathies at the elbows were not directly related to appellant's employment, as there was no evidence of bilateral ulnar neuropathies until well after his evaluation by Dr. Mandel on February 26, 2004.

By decision dated August 17, 2007, the Office denied appellant's request to expand his claim to include brachial plexopathy or ulnar neuropathy and denied his claim for total disability beginning August 2004. It found that appellant was entitled to compensation for four hours per day, five days per week as of August 5, 2003. On August 29, 2007 appellant requested an oral hearing.

By decision dated February 19, 2008, the Branch of Hearings and Review vacated the August 17, 2007 decision and remanded the case for further development of the medical evidence, including a rationalized opinion from Dr. Kirkpatrick as to whether both of the accepted work-related conditions recurred and caused appellant to stop working on July 27, 2004, and whether he could perform the his duties for four hours a day, five days a week, beginning August 5, 2003, as a result of the accepted conditions. The hearing representative also instructed the Office to update the statement of accepted facts to include a detailed description of appellant's limited duties beginning in March 2003.

On March 4, 2008 the Office forwarded to Dr. Kirkpatrick an updated statement of accepted facts, which included a detailed description of appellant's limited duties beginning in March 2003. Informing him that the issue for determination was whether appellant had established that he sustained a recurrence of total disability on July 27, 2004 due to his employment-related bilateral CTS and median neuropathy, the Office asked the IME to submit a supplemental report which contained a well-reasoned medical opinion based on objective findings on whether the accepted work-related conditions (bilateral CTS and bilateral median neuropathy) recurred and caused appellant to stop working on July 27, 2004, and an opinion as to whether he could perform the modified duties as described in the updated statement of accepted facts for four hours a day, five days a week, beginning August 5, 2003, as a result of the accepted conditions.

In a letter dated April 24, 2008, Dr. Kirkpatrick stated that he had "no evidence that the accepted work-related condition of bilateral CTS recurred to cause Mr. Hubbard to stop working on July 21, 2004," noting that, according to Dr. Mandel, he was at maximum medical improvement at that time with regards to his bilateral CTS, and there was no evidence of recurrence. He stated that appellant "would have been able to continue in his modified-duty employment. There was no evidence of a 'spontaneous change' in his medical condition."

Dr. Kirkpatrick also stated that appellant would have been able to perform the modified duties for four hours a day, five days a week, beginning on August 5, 2003, based upon the status of his accepted work-related condition of bilateral CTS.

By decision dated June 3, 2008, the Office denied appellant's claim for recurrence of total disability beginning July 27, 2004. It found that the weight of medical evidence, which was represented by Dr. Kirkpatrick's well-rationalized opinion, supported the fact that appellant was capable of working four hours per day, five days per week restricted duty beginning August 5, 2003 and was entitled to retroactive compensation for four hours per day, five days per week as of that date. Further, as there was no objective evidence of brachial plexopathy or the development of ulnar neuropathies, the Office denied appellant's request to expand his claim.

On June 6, 2008 appellant requested an oral hearing. At the November 20, 2008 hearing, appellant's representative argued that Dr. Kirkpatrick's reports were insufficient to carry the weight of the medical evidence, in that he provided no medical rationale to support his opinions.

By decision dated February 17, 2009, the Office hearing representative affirmed the June 3, 2008 decision, finding that Dr. Kirkpatrick's well-reasoned opinion constituted the weight of the medical evidence on the issues of recurrence of disability and expansion of appellant's claim.

LEGAL PRECEDENT

A recurrence of disability means an inability to work after an employee has returned to work caused by a spontaneous change in a medical condition, which resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[1] This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[2]

Appellant has the burden of establishing by the weight of the substantial, reliable and probative evidence a causal relationship between his recurrence of disability and his employment injury.[3] This burden includes the necessity of furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to employment factors and supports that conclusion with sound medical reasoning.[4]

[1] 20 C.F.R. § 10.5(x).

[2] *Id.*

[3] *Carmen Gould*, 50 ECAB 504 (1999).

[4] *Mary A. Ceglia*, 55 ECAB 626 (2004).

Section 8123(a) of the Act provides, 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] The implementing regulations state that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[6] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME 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.[7]

In a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[8] If the IME is unable to clarify or elaborate on his original report, or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[9]

ANALYSIS

The Board finds that this case is not in posture for a decision as to whether appellant sustained a recurrence of disability, in that there exists an unresolved conflict in medical opinion. The Office accepted his claim for bilateral CTS and bilateral median neuropathy. Appellant claimed that he sustained a recurrence of disability as of July 27, 2004. In order to resolve a conflict between appellant's treating physician, Dr. Fried, who opined that appellant was totally disabled due to conditions causally related to his employment, and Dr. Mandel, who opined that appellant was not disabled due to his accepted conditions, the Office referred appellant to Dr. Kirkpatrick, who provided a total of three reports containing an opinion that appellant did not sustain a recurrence of disability. The Board finds, however, that Dr. Kirkpatrick's reports are insufficiently rationalized to resolve the conflict.

In his initial June 5, 2006 report, Dr. Kirkpatrick provided examination findings and diagnosed bilateral median neuropathies at wrists and bilateral ulnar neuropathies at the elbows,

[5] 5 U.S.C. § 8123(a).

[6] 20 C.F.R. § 10.321.

[7] *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002).

[8] *L.R. (E.R.)*, 58 ECAB 369 (2007); *Phillip H. Conte*, 56 ECAB 213 (2004); *Guiseppe Aversa*, 55 ECAB 164 (2003).

[9] *Nancy Keenan*, 56 ECAB 687 (2005); *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071 (1979); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810(11)(c)(1)-(2) (April 1993).

which he opined were not related to his employment. He opined that appellant was able to perform modified duties for four hours a day, five days a week, as of March 14, 2003 and that he was not totally disabled in July 2004. However, Dr. Kirkpatrick failed to provide an explanation for his opinions; therefore, his report was of limited probative value.[10]

Following the June 18, 2007 decision of the Office hearing representative, which found that the IME's June 5, 2006 report was insufficient to resolve the conflict in medical opinion, Dr. Kirkpatrick was asked to provide a supplemental report to clarify and explain the basis for his opinions. In an August 6, 2007 response, Dr. Kirkpatrick opined that the need for modified duty on Mach 4, 2003 was related to appellant's accepted bilateral carpal tunnel condition; that the need to reduce his modified duty to four hours a day on August 4, 2003 was related to his accepted condition; that appellant's complete work stoppage on July 27, 2004 was not solely due to the accepted bilateral carpal tunnel condition, as Dr. Fried was treating him for multiple neuropathies not specifically related to his accepted bilateral carpal tunnel condition; and that he was not totally disabled on July 27, 2004 and would have been capable of continuing to perform four hours a day in modified duty as he had been doing since August 5, 2003, in light of his accepted bilateral CTS. He opined that the bilateral ulnar neuropathies at the elbows were not directly related to appellant's employment. Dr. Kirkpatrick's blanket responses are devoid of rationale and, therefore, are of minimal probative value.

On February 19, 2008 the Branch of Hearings and Review again remanded the case for further development of the medical evidence, including a rationalized opinion from Dr. Kirkpatrick as to whether both of the accepted work-related conditions recurred and caused appellant to stop working on July 27, 2004 as a result of the accepted conditions. The Office forwarded to Dr. Kirkpatrick an updated statement of accepted facts, which included a detailed description of appellant's limited duties beginning in March 2003 and asked him to provide a supplemental report, which contained a well-reasoned medical opinion based on objective findings on whether the accepted work-related conditions (bilateral CTS and bilateral median neuropathy) recurred and caused appellant to stop working on July 27, 2004, and an opinion as to whether he could perform the modified duties as described in the updated statement of accepted facts for four hours a day, five days a week, beginning August 5, 2003, as a result of the accepted conditions. In a one-page report dated April 24, 2008, Dr. Kirkpatrick stated that he had "no evidence that the accepted work-related condition of bilateral CTS recurred to cause Mr. Hubbard to stop working on July 21, 2004," noting that, according to Dr. Mandel, he was at maximum medical improvement at that time with regards to his bilateral CTS, and there was no evidence of recurrence. Dr. Kirkpatrick stated that appellant "would have been able to continue in his modified-duty employment. There was no evidence of a 'spontaneous change' in his medical condition." He also stated that appellant would have been able to perform the modified duties for four hours a day, five days a week, beginning on August 5, 2003, based upon the status of his accepted work-related condition of bilateral CTS. In spite of the Office's specific request for a well-reasoned medical opinion based on objective findings, Dr. Kirkpatrick provided no examination findings or rationale for his opinions. Rather, he merely cited Dr. Mandel's report

[10] *Michael E. Smith*, 50 ECAB 313 (1999).

as support for his opinion that appellant was not disabled after July 27, 2004. The Board has held that a medical opinion that is not fortified by rationale is of diminished probative value.[11]

As Dr. Kirkpatrick's supplemental report was also lacking in rationale, the Office was obliged to obtain an additional supplemental report or to submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[12] The Office failed to do so.

The Office's obligation to secure clarification of the IME's report was not automatically satisfied by its request for a supplemental report. The Office's obligation continues until it receives a proper report. Therefore, the case shall be remanded to the Office for a supplemental opinion, which provides clarification and elaboration. If Dr. Kirkpatrick is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate specialist. After such further development as the Office deems necessary, an appropriate decision should be issued regarding this matter.

LEGAL PRECEDENT -- ISSUE 2

It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of, and in the course of, employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct. Once the work-connected character of any injury has been established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause and so long as it is clear that the real operative factor is the progression of the compensable injury, associated with an exertion that in itself would not be unreasonable under the circumstances.[13]

ANALYSIS -- ISSUE 2

The Board finds that this case is not in posture for a decision as to whether appellant developed brachial plexopathy or ulnar neuropathies as a consequence of his accepted injury, in that there exists an unresolved conflict in medical opinion. The Office accepted appellant's claim for bilateral CTS and bilateral median neuropathy. On October 29, 2003 appellant asked the Office to expand his claim to include ulnar neuropathy and bronchial plexitis. In order to resolve the conflict in medical opinion between Dr. Fried, who opined that appellant had developed the claimed conditions as a consequence of his accepted injury, and Dr. Mandel, who found no evidence of ulnar neuropathy or brachial plexopathy, the Office referred appellant to an impartial medical examiner. However, none of the referee physician's reports are sufficiently rationalized to resolve the conflict.

[11] *Cecilia M. Corley*, 56 ECAB 662 (2005).

[12] *Supra* note 9.

[13] *See Robert J. Wescoe*, 54 ECAB 162 (2002).

In his June 5, 2006 report, Dr. Kirkpatrick opined that appellant had not developed brachial plexopathy or ulnar neuropathies as a consequence of his accepted injury. He found no evidence of a brachial plexopathy on either side. Although Dr. Kirkpatrick did find evidence of bilateral ulnar neuropathies at the elbows, he opined that the condition was not related to appellant's employment. He provided no rationale for his opinions. Moreover, Dr. Kirkpatrick did not obtain EMG and nerve conduction studies, as he was instructed; nor did he discuss the results of EMGs of record, which suggested bilateral plexopathies.[14] Therefore, his report is of limited probative value.

The Office requested a supplemental report explaining his opinions that there was no evidence of brachial plexopathy on either side, in view of the EMG reports of record, and that appellant's diagnosed bilateral ulnar neuropathies were not causally related to his employment. In a supplemental report dated August 6, 2007, Dr. Kirkpatrick opined that there was no evidence of a brachial plexopathy on either side, in view of electrodiagnostic studies performed on November 30, 1999 and on January 20, 2003, which were unremarkable regarding the brachial plexus. Although subsequent EMGs performed by a physical therapist suggested bilateral plexopathies, he stated, "In light of no objective findings suggesting a brachial plexopathy on examination, clinical correlation supports the absence of a bilateral brachial plexopathy as noted on his initial EMG studies." Dr. Kirkpatrick's statement is an attempt to support a negative conclusion. Further, he did not explain why he failed to obtain an updated EMG/NCS performed by a physician, which would have assisted him in his determination. Dr. Kirkpatrick did not provide the examination findings on which he based his opinion. He also opined that the bilateral ulnar neuropathies at the elbows were not directly related to appellant's employment, as there was no evidence of bilateral ulnar neuropathies until well after his evaluation by Dr. Mandel on February 26, 2004. Dr. Kirkpatrick did not explain, however, how the lack of evidence of ulnar neuropathies until after February 26, 2004 led to his conclusion that the condition was not a consequence of his accepted injury. Dr. Mandel's April 24, 2008 report does not address whether appellant developed a consequential condition as a result of his accepted injury. Therefore, the report is of no probative value on this issue.

The Board finds that Dr. Kirkpatrick's reports are insufficiently rationalized to resolve the conflict in medical opinion as to whether appellant developed brachial plexopathy or ulnar neuropathies as a consequence of his accepted injury. Therefore, the case shall be remanded to the Office for a supplemental opinion, which provides clarification and elaboration. If Dr. Kirkpatrick is unwilling or unable to clarify and elaborate on his opinion, the case should be referred to another appropriate specialist. After such further development as the Office deems necessary, an appropriate decision should be issued regarding this matter.

CONCLUSION

The Board finds that this case is not in posture for a decision as to whether appellant sustained a recurrence of disability, or as to whether he developed brachial plexopathy or ulnar neuropathies as a consequence of his accepted injury.

[14] The Board notes that, while the EMGs referenced by Dr. Fried were performed by a physical therapist, rather than a physician, their implications were sufficient to warrant follow-up testing by Dr. Kirkpatrick.

ORDER

IT IS HEREBY ORDERED THAT the February 17, 2009 and June 3, 2008 decisions of the Office of Workers' Compensation Programs are set aside and remanded for further development of the medical evidence in accordance with the terms of this decision.

Issued: March 17, 2010
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board