United States Department of Labor
Employees' Compensation Appeals Board

D.T., Appellant	)	
and	)	**Docket No. 05-1012**
	)	**Issued: August 23, 2006**
DEPARTMENT OF AGRICULTURE, FOREST SERVICE, PACIFIC NORTHWEST RESEARCH STATION, Portland, OR, Employer	)	

Appearances:
Jeffrey P. Zeelander, 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 March 23, 2005 appellant filed a timely appeal from May 11, 2004 and March 23, 2005 decisions of the Office of Workers' Compensation Programs that denied his request for replacement of his lift-equipped van and denied his claim for a schedule award for his penis. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUES

The issues are: (1) whether appellant has a permanent impairment of his penis related to his October 30, 1996 employment injury; and (2) whether the Office abused its discretion by denying replacement of his lift-equipped van.

FACTUAL HISTORY

On November 1, 1996 appellant, then a 52-year-old visual information specialist, filed a claim for a traumatic injury to his left hip sustained on October 30, 1996 in a fall at a job site.

The Office accepted that he sustained a fracture of his left hip. After 45 days of continuation of pay, appellant received appropriate compensation for temporary total disability.

Appellant underwent surgical stabilization of his left hip fracture on November 1, 1996, whereupon he noted profound weakness in his bilateral lower extremities with temporary loss of reflexes. In a November 13, 1996 report, Dr. Sally L. Niles, a Board-certified physiatrist, noted that appellant had a history of C7 quadriplegia approximately 30 years prior, but that he was ambulatory using a cane without frequent falls until November 1, 1996. A magnetic resonance imaging (MRI) scan of his cervical spine showed C6 vertebral body compression and severe attenuation of the cord at C5, 6 and 7. Dr. Niles concluded:

> "It appears that this patient had some sudden event causing extreme change in his lower extremity strength bilaterally, worse on the left than the right, around the time of surgical intervention. This may possibly be a spinal cord infarction. If no other explanation is found, this could somehow be an idiopathic change related to the original spinal cord injury. However, as this involves only the lower extremities and not the upper extremities, this seems less likely."

An x-ray of appellant's cervical spine of November 14, 1996 showed old compression at C6 without evidence of spinal cord compromise. He underwent further surgery on his left hip on November 19, 1996 consisting of an open reduction and internal fixation. In a January 20, 1997 report, Dr. Jeffrey J. Brown, a Board-certified neurologist, noted that an electromyogram (EMG) was "most consistent with a polyradiculopathy or potentially a widespread thoracic neuropathy although this seems unlikely." He stated:

> "We have been attributing his acute weakness to his cervical myelopathy and some type of acute change during the fall. It is also potentially possible, I suppose, that he had a polyradiculopathy such as Guillain-Barre syndrome which occurred at the time or else triggered by some endogenous cord dysfunction. This would be consistent with his subacute symmetric weakness in the lower extremities but we would never know as it is likely that his spinal fluid protein is going to be quite high due to his myelopathy."

In a February 26, 1997 report, Dr. Ronald Blanton, a Board-certified physiatrist, stated that he had been concerned that there might be a compressive thoracic spine lesion which had resulted in appellant's paraplegia, but a thoracic spine MRI scan on that date revealed no significant abnormality, leading him to conclude there did "not appear to be any upper thoracic lesion which could have explained his onset of paraplegia, following the surgery for femur fracture last November."

In a May 16, 1997 report of appellant's work limitations, Dr. Niles indicated that appellant could work four hours per day but needed a work situation with wheelchair access since he could not walk. On June 2, 1997 appellant returned to work for 20 hours per week, working at home and the Office reduced his compensation accordingly. In a July 7, 1998 report, Dr. Brown stated that he would compare appellant's long-standing cervical myelopathy "to a post polio syndrome with some loss of motor neurons accelerated during a surgery possibly due to 'friendly fire,' *i.e.*, the normal reparative process related to his leg surgery manifested as a

destructive process at the cord with a gradual loss of motor neurons over time causing progressive weakness." On October 22, 1998 the Office reimbursed appellant for the purchase of a 1992 Chevrolet modified wheelchair van, and also reimbursed him for modifications to this van, including an electric door opener, a power transfer seat base, a remote control for door and lift functions and hand controls. On April 24, 1999 the employing establishment terminated appellant's employment.

On June 28, 2001 appellant filed a claim for a schedule award. In a June 12, 2001 report, Dr. Niles noted that, among his other problems, appellant reported that he had no sexual function with no erection and no ejaculation, but that he had normal function prior to his October 30, 1996 injury. She listed neurogenic sexual dysfunction as a work-related diagnosis and indicated this constituted a 20 percent impairment of the total body.

The Office referred appellant for a second opinion evaluation. In a December 7, 2001 report, Dr. Thomas L. Gritzka, a Board-certified orthopedic surgeon, listed a history that following the November 1, 1996 surgery, appellant experienced significant weakness and paralysis with sexual dysfunction. Dr. Gritzka stated that appellant's quadriparesis due to severe attenuation of the cervical spinal cord with severe atrophy and myelomalacia at C6 was probably a complication of the surgical procedure done on November 1, 1996. He stated that appellant had a Class 2 sexual impairment as a consequence of a spinal cord injury, which constituted a 20 percent impairment of the whole person. Dr. Gritzka concluded that the sexual dysfunction was "the result of [appellant's] cervical cord injury, which has appeared as a complication of the surgery that was performed on his left hip."

On May 23, 2002 the Office granted appellant schedule awards for 100 percent impairment of the left leg, 33 percent impairment of the right arm and 34 percent impairment of the left arm. Appellant elected to receive benefits under the Civil Service Retirement Act in lieu of those under the Federal Employees' Compensation Act during the period of the schedule awards, December 1, 2001 to June 11, 2011. In a June 12, 2002 letter, the Office advised appellant that there was no need for an election, as he could receive both benefits.

In a May 29, 2002 letter, counsel for appellant contended that he should also receive schedule awards for impairment of his right leg and his penis. In a June 11, 2002 report, Dr. Morley Slutsky, an Office medical consultant Board-certified in preventive and occupational medicine, stated that appellant's sexual dysfunction needed to be addressed by a focused history and physical examination by a neurologist. On January 18, 2003 the Office referred appellant, a statement of accepted facts and the medical records, to Dr. Christopher Horn, a Board-certified orthopedic surgeon, and Dr. Stephen Zinmeister, a Board-certified neurologist, for a second opinion whether appellant's sexual dysfunction was causally related to his October 30, 1996 employment injury.

In a February 4, 2003 report, Drs. Horn and Zinmeister stated that they believed appellant's sexual dysfunction was related to his employment injury, explaining that "he apparently suffered a number of symptoms compatible with a myelopathy after his hip surgery or surgeries. This was characterized by the increased weakness, loss of bowel control and impotence, including inability to attain an erection." In response to an Office request to explain how appellant's symptoms fit a pattern of myelopathy and were caused by the work injury, and

to rate the impairment of the penis, Drs. Horn and Zinmeister stated in an April 8, 2003 addendum, as follows:

> "The symptoms fit a pattern of myelopathy because of the spasticity observed in the lower extremities with bilateral upgoing toes, as well as increased weakness following the work injury. The symptoms of bowel incontinence and impotence would also fit a pattern of myelopathy which seemed to date itself from the time of the injury. The etiology of the myelopathy is unclear, but is temporally related to the time of the injury and his initial surgeries.
>
> "The actual rating for permanent impairment due to penile disease would be Class 3 or 20 percent impairment of the whole person because no sexual function is possible."

In an April 22, 2003 report, Dr. David Koon, a Board-certified physiatrist, stated that appellant's history was so complex it was difficult to determine what was primarily responsible for his current clinical condition, but that it seemed unlikely the nerve injury was at the spinal cord level, as there was no evidence of major radicular pain. He continued, "As far as the segments of the body, it is almost impossible to determine what happened at the time of his hip fracture that resulted in a paraplegic state…. The only thought that I would have would be some type of a vascular accident, due possibly to hypotension and with a thrombosis of a spinal artery that could result in an increase in his neurological deficit." In a May 6, 2003 letter, the Office advised Dr. Zinmeister that a temporal relationship was not sufficient and that it needed further medical rationale on causal relation. In a May 13, 2003 report, Dr. Zinmeister stated:

> "It is my opinion that the bowel incontinence and impotence which started after the injury and his first surgery are a pattern of myelopathy. I am unable to specify the cause of the myelopathy, but there certainly is the change in his condition immediately after the injury and surgery. The claimant has compromise of his cervical spinal cord which could be more vulnerable than usual to possible hypotension or anoxia during the first surgical procedure in Montana. Other possibilities include a positioning of the neck during the surgery which may have compromised blood circulation to the cervical cord. These, of course, are speculations, but certainly need to be considered as the most likely etiology of his increased cervical myelopathy post the surgery.
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> "Because the surgery would not have been done unless he had been injured, the cause of the myelopathy, in my opinion, would therefore be the injury. This is on a more probable than not basis."

In an August 6, 2003 memorandum, the Office advised Dr. Slutsky, its medical consultant, that it had accepted appellant's sexual dysfunction as a consequential injury due to his October 30, 1996 employment injury. The Office asked Dr. Slutsky to rate appellant's permanent impairment due to his sexual dysfunction. In an August 11, 2003 report, Dr. Slutsky agreed with Dr. Zinmeister's rating of 20 percent of the whole person for appellant's penile impairment.

In a May 11, 2003 report, Dr. W. Brewster Smith, a Board-certified neurologist, stated that he suspected appellant's chronic cervical myelopathy was related to his initial traumatic spinal cord injury at age 19 "and possibly a superimposed ischemic cord injury following his hip surgery." He noted that appellant, following his initial traumatic cord injury, "did well until he underwent hip surgery six years ago, awakening from surgery with recurrence of quadriparesis. One can only guess that he suffered some type of ischemic cord injury to an already compromised spinal cord as a result of hip surgery." In a September 25, 2003 report, Dr. Esmond Braun, Board-certified in surgery and in urology and an associate of Drs. Horn and Zinmeister, noted that appellant claimed he had adequate sexual function until the 1996 injury, and stated: "Without objective information as to his neuralgic status prior to 1996, I cannot say with confidence that the hip fracture and subsequent treatment was the cause of his spinal cord dysfunction.… I think that, with his multiple neurologic deficits, including neurogenic bladder, that the likelihood of erectile dysfunction is great, the only question being the contribution of his recent surgery and disability to what is likely to be a progressive myelopathy after his cervical injury at the age of 19."

In a September 25, 2003 letter, appellant requested that the Office authorize purchase of a new wheelchair van, as his 1992 Chevrolet van was nearly 12 years old with over 100,000 miles. He stated that there had been so many safety and accessibility revisions to these types of vehicles that updating his existing vehicle was not reasonable, that this vehicle had broken down twice on the freeway in the past six weeks with minor incidents, and that it had become apparent there was an electrical problem that continually drained the battery such that he could not depend on the vehicle starting. Appellant stated that he had been trapped inside because the ramp system failed and had to be repaired and that the ramp on his vehicle limited his efforts to find a new scooter that would fit its platform, neither of which were issues with new wheelchair vans. The record contains invoices from two repairs of appellant's 1992 van: a December 17, 2001 emergency service call to replace a switch and fuse that made the lift inoperable and replacement of the lift's remote control on October 2, 2002.

On October 24, 2003 the Office advised appellant that it needed the medical records from his cervical spine injury at age 19 sent to Dr. Braun for an opinion on the cause of his sexual dysfunction. On November 5, 2003 appellant replied that he had no such records, that the hospital where he was treated no longer existed, and that he had not been treated for cervical spine problems since the age of 19. In a January 14, 2004 letter, the Office advised Dr. Braun of the absence of medical documentation of appellant's cervical spine injury and requested his opinion whether the work-related hip surgeries hastened his progressive myelopathy. In a January 27, 2004 report, Dr. Braun stated:

> "From the history, it appears that there was a major degradation in his neurologic function coincident with the injury and surgery of his hip in 1996.
>
> "The specific mechanism of the progression of the myelopathy I cannot comment on; it would only be conjecture. It is possible that there was a hypotensive episode or misplacement of his neck during surgery, but I am unable to specify the reason for the rapid progression of his neurologic dysfunction.

"The impairment provided by the A.M.A., *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, would be 20 percent of the whole person based on his total inability of erection, as noted on page 156, Table 7-5. As instructed, and given that [appellant] is over 40 years of age, this would equate to a 10 percent impairment of the whole person. Using the formula A/B = X/100, the impairment rating for the penile organ would be as follows:

10 percent divided by 20 percent = X divided by 100;

10 percent ÷ 20 percent = X ÷ 100;

X equals 50, thus the impairment rating of the organ is 50 percent."

By decision dated March 8, 2004, the Office denied appellant's claim for a schedule award for sexual dysfunction on the basis that he had not established this condition was related to his employment injury.

In a February 6, 2004 letter, the Office asked appellant to address the cause of his van's breakdowns, whether these conditions and the lift and electrical problems had been resolved, and whether the new electric scooter he obtained with its authorization fit in the van. It also advised him it needed the report of a certified automotive mechanic. In a March 7, 2004 letter, appellant stated that his two recent breakdowns were due to a broken serpentine belt and alternator, that these problems had been repaired and that the lift problem that prevented him from getting out of the van was due to an electrical overload and had been repaired. He stated that the cause of the electrical drain of the battery had not been identified or resolved, that the electrical door locks and power windows worked sporadically and that replacement of brake pads, front-end parts and shock absorbers had helped but not resolved the shaking that occurred when making a sudden stop. Appellant stated that the new scooter fit the lift only when it was in three-wheel mode, but that he used it in four-wheel mode most of the time, since it was too tippy and not stable for him to use outdoors and in the shop area. He submitted an undated report from Ted B. Kelley of Ted Kelley Enterprises listing the parts that should be replaced on his van: window motor and regulator, headlight switch, oxygen sensor, brake rotors and lining, differential and axel bearings, idler and lower sway bar bushings, and tie rods. Appellant stated that the transmission was making an abnormal noise, that the cooling system was full of rust and needed to be flushed and that the front intake manifold, valve cover gaskets, timing seal and oil pan gaskets were leaking. Mr. Kelley estimated these repairs "could run from $2,900.00 to $3,900.00 depending on what else is wrong at that time." Appellant also submitted February 20, 2004 estimates for repairs from Les Schwab Tire Center: $768.93 for brakes and $1,398.95 for steering and suspension. St. Helen's Automotive Center, Inc. indicated on March 3, 2004 that extra time would be needed to trace the van's battery drain. Another undated estimate from an unidentified source indicated a cost of $2,118.45 to repair or service 12 items.

By decision dated May 11, 2004, the Office found that the evidence did not demonstrate that appellant's van needed to be replaced, as it did not show it was beyond repair. The Office authorized reasonable and necessary repairs and maintenance of the lift system.

Appellant requested hearings on both issues. In a telephonic hearing on November 19, 2004, he contended that he could not change the scooter from four to three wheels by himself and that two unsuccessful attempts to repair the van's electrical problem had been made since the Office rejected his request for a new van. Appellant submitted a May 19, 2004 letter from Mr. Kelley stating that, although appellant had appropriately maintained his van over the years, it had "reached the end of its life in terms of its designed use as a wheelchair accessible vehicle that must be relied upon by a disabled person," that it could not be considered a reliable vehicle because its components and operating systems were beginning to fail because of its age and high mileage, that various vehicle systems needed to be renewed and that "the engine and transmission should be expected to fail in the future as well." He described an intermittent electrical problem that has not been able to be tracked down, and stated that this problem had rendered the vehicle unreliable because appellant was stranded inside or outside the vehicle when this problem occurred. Appellant also stated that the vehicle was obsolete in that it did not have anti-lock brakes, air bags and other safety features that were standard on current vehicles, and concluded that it should be replaced based upon its age, mileage and condition.

By decision dated March 23, 2005, an Office hearing representative found that the medical evidence was too speculative that appellant's sexual dysfunction was related to his employment injury. The hearing representative also found that the Office did not abuse its discretion by not authorizing purchase of a new van.

LEGAL PRECEDENT -- ISSUE 1

An employee has the burden of establishing by the weight of the reliable, probative and substantial evidence that his condition was caused or adversely affected by his federal employment. It is the claimant's burden to establish that he or she sustained permanent impairment of a scheduled member or function as a result of an employment injury.[1] As part of this burden, the claimant must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relation. While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, neither can the opinion be speculative or equivocal. Medical reports not containing sufficient rationale on causal relationship are of diminished probative value.[2]

ANALYSIS -- ISSUE 1

The medical evidence of record is not sufficient to establish that the etiology of appellant's sexual dysfunction was due to the October 30, 1996 left hip fracture or resulting surgeries.

Dr. Niles, a Board-certified neurologist, noted that appellant had a history of C7 quadriplegia and discussed an MRI scan of the cervical spine which showed a C6 vertebral body compression. She stated that it appeared appellant had experienced some sudden event causing extreme change to the lower extremities, possibly a spinal cord infarction. If no other

[1] *See Tammy L. Meehan*, 53 ECAB 229 (2001).

[2] *See Lois E. Culver (Clair L. Culver)*, 53 ECAB 412 (2002).

explanation could be found, the weakness to the lower extremities could somehow be an idiopathic change related to the original spinal cord injury. The report from Dr. Niles is clearly speculative on the issue of causal relationship and does not provide a rationalized opinion addressing appellant's claimed sexual dysfunction. Her opinion is not clear as to how any weakness to the lower extremities or loss of sexual function would be causally related to the changes noted involving the cervical spine, specifically the C6 vertebral body compression.

Similarly, the report of Dr. Brown, a Board-certified neurologist, is speculative on the issue of causal relationship. He reviewed diagnostic testing and stated that an EMG was "most consistent with a polyradiculopathy or potentially a widespread thoracic neuropathy although this seems unlikely." Dr. Brown noted it was "potentially possible" that appellant's lower extremity weakness was due to cervical myelopathy but also raised the prospect of Guillain-Barre syndrome occurring at or about the time of injury. He subsequently stated that he would compare appellant's long-standing cervical myelopathy to a post-polio syndrome "with some loss of motor neurons accelerated during a surgery possible due to 'friendly fire,'" in which the normal reparative process manifested as a destructive process at the cord over time. Dr. Blanton, a Board-certified physiatrist, raised the possibility of a compressive thoracic spine lesion but noted that an MRI revealed no significant abnormality.

Dr. Gritzka, a Board-certified orthopedic surgeon to whom the Office referred appellant, concluded in a December 7, 2001 report that appellant's sexual impairment was a complication of his left hip surgery. Office referral physicians, Dr. Horn, a Board-certified orthopedic surgeon, and Dr. Zinmeister, a Board-certified neurologist, stated in a February 4, 2003 report that appellant's sexual dysfunction was a symptom that fit a pattern of myelopathy, for which the etiology was unclear following the hip surgery. Dr. Braun, a Board-certified urologist to whom the Office referred appellant, stated that he was unable to specify the reason for the rapid progression of appellant's neurologic dysfunction after that surgery. Dr. Koon posited that the condition might be due to some type of vascular accident at the time of the surgery. Dr. Braun also stated this was a possible cause of appellant's sexual dysfunction, as was misplacement of his neck during surgery.

The medical evidence of record does not provide a rationalized medical opinion on the issue of causal relationship. Rather, the physicians posited various etiologies giving rise to appellant's sexual dysfunction, several noting the temporal relationship between appellant's complaint of sexual dysfunction with the surgeries following the 1996 hip injury. In assessing the weight of medical opinion, the Board has held that the number of physicians supporting one position or another is not controlling. Rather, the weight of medical evidence is determined by its reliability, its probative value and its convincing quality.[3] Factors that comprise the evaluation of medical evidence include the opportunity for and the thoroughness of physical examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's stated opinion.[4] The Board finds that the evidence of record is not sufficient to

[3] *See Anna M. Delaney*, 53 ECAB 384 (2002).

[4] *Id*.

establish that appellant's sexual dysfunction was caused or contributed to by the accepted left hip fracture and surgeries of November 1 or 19, 1996.

LEGAL PRECEDENT -- ISSUE 2

Section 8103(a) of the Federal Employees' Compensation Act states in pertinent part:

> "The United States shall furnish to an employee who is injured while in the performance of duty the services, appliances and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation."[5]

In interpreting this section of the Federal Employees' Compensation Act, the Board has recognized that the Office has broad discretion in approving services, appliances and supplies provided under the Federal Employees' Compensation Act. The Office has broad administrative discretion in choosing the means to achieve the goals of section 8103 of the Federal Employees' Compensation Act. As the only limitation on the Office's authority is reasonableness, abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions which are contrary to both logic and probable deductions from known facts.[6]

ANALYSIS -- ISSUE 1

The Office did not abuse its discretion by refusing to replace appellant's wheelchair lift-equipped vehicle. The only evidence that his present van needed to be replaced was a May 19, 2004 letter from Mr. Kelley, who earlier indicated that the vehicle could be repaired. Estimates from other repair facilities also indicated that the present van could be repaired. The Office did not abuse its discretion by authorizing repair of appellant's existing vehicle rather than purchasing a new one.[7]

CONCLUSION

The Board finds that appellant has not established that his sexual dysfunction is causally related to his October 30, 1996 injury. The Office did not abuse its discretion by refusing to replace appellant's wheelchair lift-equipped vehicle.

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[5] 5 U.S.C. § 8103(a).

[6] *Janice Kirby*, 47 ECAB 220 (1995).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Housing and Vehicle Modifications*, Chapter 2.1800.5a(9) states that equipment furnished for a vehicle by the Office should be maintained and repaired at Office expense and may be replaced after normal wear and tear.

ORDER

IT IS HEREBY ORDERED THAT the March 23, 2005 and May 11, 2004 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 23, 2006
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