United States Department of Labor
Employees' Compensation Appeals Board

G.M., Appellant	)	
and	)	**Docket No. 14-2057**
	)	**Issued: May 12, 2015**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION, Dallas, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 29, 2014 appellant filed a timely appeal from a May 23, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that a January 24, 2008 slip and fall caused neurological injuries.

On appeal, appellant alleges that the medical evidence of record establishes that his neurological condition worsened after his January 24, 2008 slip and fall.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On January 29, 2008 appellant, a 36-year-old claims examiner, filed a traumatic injury claim alleging that on January 24, 2008 he stepped on a file, lost his balance, and fell at work. He subsequently experienced numbness and tingling in his feet, left knee pain, neck, upper and lower back strains, a knot on the left side of his face, abdominal strain, left elbow soreness, and bowel and bladder problems. Appellant stopped work on the date of injury and did not return.[2]

In several February 11, 2008 statements, appellant related that he lost his balance and fell because a paper file was on the floor. In falling, he hit his left forehead on his desk. Appellant stated that his face, neck, and back hurt, and that when he stood up he had weakness in his legs and tingling in both feet. Two coworkers helped him into his chair where he sat for approximately 30 minutes. Appellant noted that, when he tried to stand, he could not put weight on his left leg. He later informed his supervisor that he needed medical care and he was taken by ambulance to a hospital. When discharged, appellant continued to have leg numbness. When he awoke the next day his head, neck, left arm, left shoulder, mid and low back, and left knee hurt. The numbness and tingling continued in appellant's feet and he had bladder leakage. These symptoms continued through February 4, 2008. He reported difficulty finding a physician who would see him because he was not assigned a claim number until February 2, 2008.

In a January 24, 2008 emergency room report, Dr. Michael V. Passanante, Board-certified in emergency medicine, stated that appellant slipped on file folders that day and struck his head. Appellant had a prior history of Brown-Sequard syndrome with residual left leg weakness.[3] After the fall, he felt tingling in both legs, was unsteady when ambulating, and had muscle spasms. Appellant denied neck pain. Examination showed no cervical spine swelling or tenderness, chronic limited range of motion, chronic changes to the left leg, and right sensory deficit. A computerized tomography (CT) scan of the head was negative, and a cervical spine CT scan showed postoperative changes. Appellant was discharged in stable condition with a diagnosis of acute closed head injury and paresthesias. Discharge instructions were for a minor head injury. Appellant was referred to a neurosurgeon and kept off work until medically cleared.

On February 4, 2008 Dr. Michael Duchamp, an osteopath, noted that appellant was a quadriplegic from a prior injury, had a prior fusion at three neck levels, and ambulated with a cane. Appellant related a right leg injury and striking his head when he fell on January 24, 2008. He later had intermittent leg numbness with a burning sensation, some low back pain, and bowel and bladder incontinence. Appellant had mild to moderate lumbar pain and spasms with restricted low back motion and severely restricted neck motion from the previous fusion. Dr. Duchamp diagnosed bilateral sciatica, lumbar sprain, and urge incontinence. He stated that there had been a neurologic change, but appellant was difficult to evaluate because he did not have normal sensation from his previous injuries. Dr. Duchamp recommended a lumbar

[2] Social security disability benefits were approved for appellant in July 2008.

[3] Brown-Sequard syndrome is described as damage of one half of the spinal cord, resulting in ipsilateral paralysis and loss of discriminatory and joint sensation, and contralateral loss of pain and temperature sensation. Dorland's *Illustrated Medical Dictionary* (29th ed. 2000).

magnetic resonance imaging (MRI) scan, and noted that appellant could return to work on March 4, 2008.[4]

In reports dated February 14 and 19, 2008, Dr. Pierre Herding, a Board-certified neurologist, noted that appellant had fallen at work on January 24, 2008 injuring his neck and back after striking the left side of his head. He noted the prior cervical spine fracture injury and diagnosed aggravation of preexisting condition and found appellant disabled. Dr. Herding indicated that the condition was work related by checking a form box marked "yes."

On February 25, 2008 OWCP advised appellant that although it initially allowed limited medical payments, the merits of the claim had not yet been adjudicated. It informed him of the type of evidence needed to establish his claim.

On April 16, 2008 appellant asserted that his fall aggravated his preexisting condition. He submitted Dr. Passanante's January 24, 2008 examination report which described the remote cervical injury with left leg weakness and appellant's report that, since he fell at work, he had bilateral leg tingling. Appellant denied neck pain or headaches.

Also submitted were new reports from Dr. Herding. On February 12, 2008 he noted complaints of urinary incontinence and foot numbness and acknowledge a 1990 cervical spine fracture with operative repair and subsequent symptoms. Dr. Herding noted a January 24, 2008 fall where appellant struck the left side of his head and had developed occasional urinary leakage along with one episode of bowel incontinence. Examination showed no leg atrophy, and clonus and spasticity on the left. The right arm and leg had diminished pinprick sensation and appellant reported diminished sensation of the bottoms of both feet. Vibratory sensibility was modestly reduced bilaterally. Dr. Herding diagnosed possible recurrent spinal cord injury. In reports dated February 25 and March 3, 2008, he advised that appellant had been evaluated for aggravation of preexisting cervical spine injury and could not return to work until April 3, 2008 due to a cervical/lumbar injury.

In a February 27, 2008 attending physician's report, Dr. Duchamp reported that, after the January 24, 2008 work fall, appellant reported foot numbness and incontinence. He reiterated his diagnoses and stated that the fall at work could have caused a back sprain and change from appellant's baseline. Dr. Duchamp advised that appellant remained totally disabled.

In March 2008, appellant relocated from Texas to Oklahoma. On March 14, 2008 Dr. John W. Ellis, Board-certified in family medicine noted that, in 1990, appellant was thrown from a boat and had a C5 fracture, followed by surgery and rehabilitation. Appellant left a rehabilitation hospital in February 1991. He also had a 1988 motor vehicle accident that caused facial lacerations, lost teeth, and fractured a finger. In 2003, appellant fell and fractured his left elbow. He began work with the employing establishment in August 2003, at which time he walked with a right forearm crutch and had marked left arm and leg weakness with some

[4] A February 12, 2008 lumbar spine MRI scan showed pars defects at L5 without obvious spondylolisthesis of L5, and mild disc bulging at L4-5 with no significant central or foraminal stenosis. A February 14, 2008 lower extremity electromyogram and nerve conduction study showed delayed latency of the right peroneal motor nerve and diminished recruitment of the left leg muscles.

weakness in the right arm and sequelae of Brown-Sequard syndrome. Appellant described the January 24, 2008 fall at work, stating that he reinjured his neck. Dr. Ellis stated that, after the workplace fall, appellant developed more left arm and leg weakness and continued to have neck, lower thoracic, and lumbar pain, tingling in the bottoms of both feet, and increased left toe drag. Examination showed spine tenderness, scabbing on the left elbow from a recent fall, hypertrophy of the right medial epicondyle, left hand atrophy with finger retraction, obvious left arm atrophy, and left leg weakness and atrophy, consistent with Brown-Sequard syndrome due to the 1990 injury. Dr. Ellis diagnosed resolved left forehead contusion; muscle tendon unit strain of the left side of the neck and shoulder girdle muscles and ligaments; neck strain with spinal cord injury in a previous area of injury; thoracic strain; muscle tendon unit strain of the back and right iliolumbar ligaments; left elbow contusion; and contusion of the left knee, patellar tendon, patella, and lateral joint line.[5] He opined that appellant's work caused or aggravated all diagnoses. Dr. Ellis stated that, because appellant had preexisting weakness, he fell harder on January 24, 2008, causing muscle strain on the left side of his neck and shoulders, somewhat on the right, with the sudden jarring aggravating the preexisting spine injury, which caused the left arm and left leg to become weaker and more sensitive. It also caused a spinal cord contusion that caused numbness and tingling in the bottom of his feet, and bladder difficulties. Dr. Ellis noted that a thoracic spinal cord compression was possible, noting a normal lumbar MRI scan study at L5-S1, and abnormal electrodiagnostic study findings which "could be due to an injury in the lumbar area, the thoracic area or even the cervical area." He noted that, before January 2008, appellant fell approximately once yearly, but that, since then, he fell more frequently and had more left foot drop. Dr. Ellis found that appellant was totally disabled since January 24, 2008. He advised that appellant be very careful with neck movements as constant data entry and writing with his head flexed "would probably be very detrimental to his spinal cord at this time."

Appellant returned to Texas in March 2008. On April 7, 2008 Dr. Herding found appellant's condition unchanged. In reports dated April 18, 2008, Dr. Ellis stated that appellant's neurological problems had worsened since the work fall, noting that he was developing cauda equina syndrome that affected bowel and bladder function. He recommended more testing and continued to find appellant totally disabled.

In letters dated April 29, 2008, OWCP asked Drs. Herding and Duchamp to review a statement of accepted facts and provide a reasoned opinion regarding whether appellant's current conditions were caused or aggravated by his federal employment. In a May 5, 2008 statement, appellant related that he went about 16 years without treatment after the 1990 cervical spine injury. He maintained that the January 2008 work fall aggravated his preexisting condition.

In a May 13, 2008 report, Dr. Herding reiterated appellant's history. He stated that his initial impression was a "possible recurrent spinal injury, possibly aggravating his preexisting condition." Further testing was recommended. Dr. Ellis continued to submit reports advising that appellant was totally disabled because his injuries were extensive and would require long-term treatment and rehabilitation.

[5] Dr. Ellis also diagnosed right elbow medial epicondylitis. Appellant filed an occupational disease claim for this condition, adjudicated under a separate claim. This matter is not presently before the Board.

The employing establishment provided a January 24, 2008 incident report, indicating that appellant refused medical assistance immediately after the fall.

In a July 25, 2008 decision, OWCP denied the claim because the medical evidence was insufficient to establish causal relationship. It noted that appellant had not submitted medical evidence regarding the 1990 injury or describing his condition before the January 24, 2008 fall.

Appellant requested reconsideration. Additional reports from Dr. Ellis noted appellant's status, advised that he was falling more frequently, and found him totally disabled. On November 19, 2008 he noted reviewing OWCP's decision. Dr. Ellis opined that the work fall worsened appellant's condition, as his spinal cord could be very sensitive to even small trauma. He noted reviewing records from appellant's 1990 hospitalization and asserted that his current symptoms were consistent with a previously impaired, very sensitive spinal cord that was injured again, causing more symptoms.

A December 1, 2008 thoracic spine MRI scan showed diffuse myelomalacia of the spinal cord and mild degenerative disc disease of the upper and mid-thoracic spine. A December 1, 2008 cervical spine MRI scan showed diffuse myatomalacia with suggestion of a focal syrinx at C5-6 that was not well demonstrated; solid fusion of C4-5 and C5-6; and discogenic and spondylitic changes at C6-7, which contributed to moderate left and mild right neural foraminal stenosis.

In a decision dated March 20, 2009, OWCP found the medical evidence insufficient to warrant modification of the prior decision.

Appellant requested reconsideration and submitted evidence concerning the 1990 injury. On July 6, 1990 Dr. Charles F. Engles, a Board-certified neurosurgeon, noted that appellant struck his head in shallow water and was paralyzed. X-rays showed a compression fracture dislocation at C5. On August 16, 1990 Dr. Engles and Dr. J.P. Livingston, a Board-certified orthopedic surgeon, performed a cervical spine fusion and appellant was discharged to rehabilitation on August 30, 1990. Appellant later regained some movement. Incomplete spinal cord injury at C6 and C5 fracture were diagnosed.

In a January 26, 2009 report, Dr. Engles noted that appellant did very well after the 1990 injury. Although he had not seen appellant since 1990, appellant reported that he had completed schooling, had productive employment, was married, and fathered children. Dr. Engles described appellant's report of the January 24, 2008 work fall. He noted appellant's report of increased symptoms from that date, such as a significant, precipitous, and acute decline in neurologic function, including loss of bowel and bladder control, and a greatly reduced ability to ambulate. Dr. Engles noted that initial tests did not reveal any hard evidence for fracture or disc rupture and advised that further studies were needed to fully understand his condition. He concluded that appellant's impairment affected his ability to be employed.

In a February 10, 2009 treatment note, Dr. Ellis indicated that the December 1, 2008 MRI scan studies showed a progression of the spinal cord impairment in appellant's neck such that he could not work as a claims examiner because he could not sit, use a computer, perform data entry

type, or write, and could barely use a cellular telephone. He later referred appellant to Dr. Tom Ewing[6] and to Dr. Michael E. Goodrich, a neurologist.

In a June 16, 2009 form report, Dr. Brian Lamkin, an osteopath, noted that appellant had fallen seven hours earlier and had a history of frequent falls over the past year. He diagnosed left elbow, wrist, and shoulder contusions and discussed use of a motorized scooter. In a July 14, 2009 report, Dr. Goodrich noted the 1990 spinal cord injury which left appellant with left arm paresis and a current complaint of numbness and tingling in the little and ring fingers bilaterally. Electrodiagnostic studies from that date showed no evidence of cervical motor radiculopathy and ruled out an underlying peripheral neuropathy.

In a January 14, 2010 report, Dr. Ellis reiterated his previous findings and found new objective conditions of thoracic paraspinous and rhomboideus atrophy, which was indicative of an acute spinal cord injury, opining that it would take months after the fall for the atrophy to appear. Dr. Ellis noted current MRI scan findings of diffuse myelomalacia were in the thoracic spine while appellant's 1990 injury was to the cervical spine.

In a January 22, 2010 report, Dr. Gabriel Pitman, a Board-certified neurologist, noted the 1990 injury and a January 2008 injury to the head and neck. After the latter injury, appellant developed increased tingling in the feet that had improved, persistent increased weakness and stiffness in the left arm, increased falling, worsening gait disturbance due to increased leg weakness, constant neck pain, and bowel and bladder incontinence. He had a spastic gait and decreased cervical motion, left arm atrophy and decreased strength, and decreased sensation in the arms. Dr. Pitman reviewed the December 1, 2008 MRI scan studies and the July 14, 2009 electrodiagnostic study and suspected that appellant had experienced flexion/extension injury in January 2008 with likely additional injury to the spinal cord. He indicated that appellant's examination was consistent with a Brown-Sequard syndrome as far as sensory loss in the feet, that he was hyperreflexic, was clearly weak in the left arm and leg, and had a gait abnormality. Dr. Pitman recommended more testing and a neurosurgery consultation.[7]

In a May 24, 2010 merit decision, OWCP found that there were no medical reports supporting a material worsening of the preexisting condition due to the January 24, 2008 work incident. It found the medical evidence insufficient to warrant modification of the prior decisions.

Appellant requested reconsideration, stating that he did not need medical care from 1990 to 2008 as his condition was stable. He also submitted medical evidence. On March 5, 2010 Dr. Pitman reviewed the February 16, 2010 MRI scan studies and diagnosed cervical

[6] A report from Dr. Ewing is not found in the case record.

[7] A February 16, 2010 cervical spine MRI scan showed bone fusion across C4-5 and C5-6; reversal of cervical lordosis; a focal expansile cystic lesion in the cervical cord from C4 through C6 that appeared to separate and displace the atretic cervical spinal cord along the lateral margins; significant diffuse atrophy of the cervical and upper thoracic spinal cord; disc osteophyte complex at C6-7 with probable small superimposed central disc protrusion. A February 16, 2010 thoracic spine MRI scan showed diffuse symmetric thoracic cord atrophy without focal signal abnormality to suggest syrinx formation or myelomalacia; no evidence of spinal canal or foraminal stenosis; no significant disc bulge; and normal marrow signal of the thoracic vertebral bodies.

myelopathy. He advised that appellant's old spinal cord injury was likely exacerbated by the 2008 neck trauma which caused increased symptoms. Dr. Pitman also diagnosed mid-thoracic and neck pain, indicating that a disc osteophyte complex at C6-7 could be contributing to some of appellant's pain problem, which he suspected was directly related from the head and neck injury in 2008.

On December 27, 2010 Dr. Engles reported that on January 24, 2008 appellant tangled his foot in cords and fell forward, striking his head on a desk and since had a significant decline in neurologic function. He advised that a cervical myelogram with postmyelogram CT scan study demonstrated a very solid fusion and tethering of the spinal cord with three points of fixation at the site of his old injury.[8] Dr. Engles opined that the January 2008 fall placed appellant's neck suddenly in hyperextension which stretched his cord and produced a profound injury without overt evidence of trauma on plain films or on an MRI scan study. He concluded that appellant's current neurologic problems were caused by appellant's fall at work on January 24, 2008 and recommended referral to a physiatrist for conservative management.[9]

On May 13, 2011 OWCP denied modification of its prior decision. Appellant requested reconsideration. He stated that he was not under medical care for 15 years before the January 24, 2008 incident such that there were no medical records with his baseline condition before the incident. Appellant noted being in a 1988 automobile accident, but had no residuals, and afterward played football and completed basic training. In 2003, he fell, broke his left arm, was placed in a cast, and returned to work a few weeks later. Appellant did not recall who treated him. He also submitted medical evidence. A December 6, 2010 cervical myelogram showed an inferior extradural defect at C5-6. A cervical CT scan study of the same date showed postfracture and postsurgical changes from C4 through C6 and a disc bulge at C6-7, which could cause some neural foraminal narrowing of unknown significance, and no cord impingement. An addendum advised that at the peripheral aspect of the cord at the site of the prior trauma near the C5 level appeared to enhance somewhat and could be related to granulation tissue or changes in the nature of the tissue at this area. No discrete syrinx was identified.

In treatment notes dated January 18 to August 25, 2011, Dr. A.J. Bisson, a Board-certified physiatrist, noted the 1990 boating accident and that on January 24, 2008 appellant was struck on the back of his head by files falling. Appellant reported that his condition had declined since January 2008 with progressive weakness in his arms and legs and occasional episodes of urinary and bowel incontinence. He initially diagnosed spastic quadriparesis related to cervical spinal cord injury in 1990, status post surgical intervention, and gait difficulties caused by the 1990 injury. On April 12, 2011 Dr. Bisson opined that the workplace injury of January 24, 2008

[8] An August 5, 2010 cervical spine CT scan showed a solid fusion at C4-6. An August 18, 2010 cervical spine MRI scan showed increased T2 weighted signal that likely represented gliosis and myelomalacia from C4 to the C6; postoperative changes; and the possibility of a syrinx dorsal to the lower C6 vertebral body.

[9] The record also includes one page of a September 20, 2010 report from Dr. Pitman's office, noting that appellant was seen in follow up.

resulted in an exacerbation of appellant's medical condition and, as such, the issues he currently dealt with would be employment related.[10]

On October 25, 2011 OWCP denied modification of the prior decision. Appellant requested reconsideration and submitted Dr. Bisson's November 22, 2011 report that reiterated his diagnoses and opined that appellant's recent symptoms were due to the January 24, 2008 work incident when files struck him on the head. On December 6, 2011 Dr. Bisson noted that appellant contacted him and stated that, files did not fall on his head but, rather, he tripped over a file on the floor, fell forward, and hit his head on the desk.

By decision dated February 27, 2012, OWCP denied modification of the prior decisions.

Appellant, through counsel, requested reconsideration on December 11, 2012. In a January 8, 2010 report, Dr. Glenn L. Smith, a Board-certified osteopath specializing in orthopedic surgery, noted appellant's report of the 1990 injury with ensuing partial paralysis, and that he tripped and fell at work, hitting his head on a desk, which caused ongoing problems. He described appellant's complaint of achy and burning neck pain. Dr. Smith noted examination findings of guarded, painful cervical spine range of motion, tenderness, and muscle spasm, and advised that a cervical spine x-ray demonstrated postsurgical changes. He diagnosed status post fusion with residual paralysis and partial recovery.

In January 28 and February 15, 2012 reports, Dr. Graciela Gallardo, Board-certified in family medicine, reported seeing appellant for chronic pain. She noted a history of cervical spine fusion in 1990 and described examination findings. Dr. Gallardo diagnosed chronic neck and thoracic back pain, chronic pain syndrome, and high risk medication management.

In a February 5, 2013 report to counsel, Dr. Engles repeated the history of the July 6, 1990 accident and fusion surgery. He indicated that, over the next few years, he interacted with appellant by correspondence and telephone, and that he next saw appellant on January 26, 2009 when appellant reported a significant deterioration in neurologic function over the past year. Dr. Engles reported his findings that day. He opined that appellant had a profound injury in 1990, but did well until the January 24, 2008 fall at work which caused an immediate deterioration in his neurologic function. Dr. Engles advised that a December 6, 2010 cervical myelogram with postmyelogram CT scan showed clear abnormalities of appellant's spinal cord at the C5 level near the point of his maximum injury in 1990, stating that his spinal cord was tethered to the dura at three points from post-traumatic scarring. He continued:

> "The medical literature shows evidence that spinal cords can be tethered by scar tissue after traumatic injury and from surgery. The medical literature notes that there can be delayed post[-]traumatic decline in neurologic function from this tethering. The medical literature also notes that there is a physiologic basis for a tethered spinal cord injury due to local spinal cord ischemia and impairment due to increased strain from sheer forces that are caused by local external injury of the

[10] Appellant also submitted a July 28, 2011 treatment note from Dr. Richard E. Herlihy, a Board-certified urologist, which is illegible. On August 25, 2011 Dr. Bisson noted that Dr. Herlihy did not feel that there was anything to offer appellant regarding his urinary incontinence.

> spinal cord. The spinal cord has been noted in normal motion to stretch in its length and a stretch associated injury is accepted as the principal factor of myelopathy in experimental models of neural injury, tethered cord syndrome, and diffuse axonal injury. In my opinion, [appellant] had a traumatic quadriplegia from a fracture at the C5 level in 1990. [Appellant] was quadriplegic. He had surgery and did show recovery although incomplete. This abruptly changed with the single fall on January 24, 2008 while [appellant] was employed with [the employing establishment]. It is my opinion that the hyperextension mechanism of action stretched his tethered spinal cord to a degree that axonal injury resulted causing his reported new impairment and decline of neurologic function. This was a new injury aggravating [appellant's] preexisting but quiescent tethered myelopathic cord."

Dr. Engles indicated that the original diagnosis due to the 1990 injury was closed fracture of C5 with cord injury and that his current diagnosis was spinal cord injury without evidence of spinal bone injury. He attached a list of supportive medical literature.

In a decision dated February 25, 2013, OWCP denied modification of the prior decisions.

On February 18, 2014 appellant requested reconsideration. He submitted an October 18, 2010 report in which Dr. Caple A. Spence, a Board-certified neurosurgeon, noted that appellant was in a 1990 boating accident that caused quadriparesis but that he had improved until about 2008 when he struck his head on a file and since that time had difficulty with weakness. Dr. Spence indicated that from the history it appeared that appellant had an incomplete Brown-Sequard syndrome, and since he struck his head while tripping over files at work, he had increased falling, worsening gait, and associated leg weakness with increased back pain. He diagnosed Brown-Sequard syndrome, status post cord injury; hemiparesis secondary to cord injury; and cervicalgia. Dr. Spence indicated that no additional surgery was needed.

On February 5, 2014 Dr. Engles essentially repeated his previous conclusions. He stated that September 2005 and 2006 urgent care records did not mention any impairment of motor or ambulatory function. Dr. Engles opined that appellant's fall at home when he fractured his arm did not have any untoward injury to his head and neck. He also noted reviewing ambulance service and emergency room records from the January 24, 2008 injury. Dr. Engles stated:

> "My interpretation of these records is that they support [appellant's] report of his injury. It supports his report that there was indeed a change in his neurologic function after the injury. It supports [appellant's] report that he struck his head in the course of the fall with secondary hyperextension movement of the neck. The neurologic examination in the emergency room is not detailed, but only refers to what [appellant] reported to the [physician]. The records do support the causal relation of his slip and fall on the file folders at work, striking his head, hyperextending his neck, and the resultant deterioration in his neurologic

> function. This is not a result of natural progression but rather a significant traumatic aggravation of his preexisting Brown-Sequard syndrome and spinal cord injury, which was prior to the fall, stable, and functional."

He indicated that an example for a spinal cord injury without a bony injury was the rare situation of adult tethered cords, which are most commonly tethered at the sacral end. These typically involve adults with falls or flexion injuries and subsequent new neurologic deficit in the legs or a paraparesis with some loss of bowel or bladder control. Dr. Engles noted that appellant's tethered cord was an unusual and uncommon traumatic tethering and scarring of his injured cervical spinal cord at the level of his cervical spine injury, which was also the level of his surgery and that had been quiescent and stable until he hyperextended his neck in the 2008 fall which stretched his spinal cord, causing the injury. He concluded that this was known and described in the literature, but was rare and not seen very often. Dr. Engles reiterated that the fall on January 24, 2008 stretched appellant's spinal cord such that an axonal injury resulted in new impairment and decline of neurologic function and again attached the list of supportive publications.

In a merit decision dated May 23, 2014, OWCP denied modification of the prior decisions. It found Dr. Engles' opinion of insufficient rationale to support a causal relationship between the January 24, 2008 work injury and any diagnosed condition.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[11]

OWCP regulations, at 20 C.F.R. § 10.5(ee) define a traumatic injury as a condition of the body caused by a specific event or incident or series of events or incidents within a single workday or shift.[12] To determine whether an employee sustained a traumatic injury in the performance of duty, OWCP must determine whether "fact of injury" is established. First, an employee has the burden of demonstrating the occurrence of an injury at the time, place, and in the manner alleged, by a preponderance of the reliable, probative, and substantial evidence. Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish a causal relationship between the employment incident and the alleged disability and/or condition for which compensation is claimed. An employee may establish that

[11] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[12] 20 C.F.R. § 10.5(ee) (1999, 2011); *Ellen L. Noble*, 55 ECAB 530 (2004).

the employment incident occurred as alleged, but fail to show that his or her disability and/or condition relates to the employment incident.[13]

Under FECA, when employment factors cause an aggravation of an underlying physical condition, the employee is entitled to compensation for the periods of disability related to the aggravation.[14] Where the medical evidence supports an aggravation or acceleration of an underlying condition precipitated by working conditions or injuries, such disability is compensable.[15] However, the normal progression of untreated disease cannot be stated to constitute "aggravation" of a condition merely because the performance of normal work duties reveal the underlying condition.[16] For the conditions of employment to bring about an aggravation of preexisting disease, the employment must cause acceleration of the disease or precipitate disability.[17] When the aggravation is temporary and leaves no permanent residuals, compensation is not payable for periods after the aggravation ceased.[18]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[19] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[20] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[21]

ANALYSIS

The record supports that the January 24, 2008 work incident occurred as alleged. Appellant indicated that he slipped on a file folder and fell, striking the left side of his head on a desk. However, the medical evidence is insufficient to establish that the January 24, 2008 employment incident caused or aggravated a diagnosed medical condition.

Appellant sustained a severe nonemployment-related C5 cervical spine fracture in July 1990. He had cervical spine fusion surgery at that time and, at discharge, was diagnosed

[13] *Gary J. Watling*, 52 ECAB 278 (2001).

[14] *Raymond W. Behrens*, 50 ECAB 221, 222 (1999); *James L. Hearn*, 29 ECAB 278, 287 (1978).

[15] *A.C.*, Docket No. 08-1453 (issued November 18, 2008).

[16] *See Glenn C. Chasteen*, 42 ECAB 493 (1991).

[17] *Supra* note 15.

[18] *Raymond W. Behrens, supra* note 14.

[19] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[20] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[21] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

with C6 incomplete spinal cord injury and C5 fracture. Appellant then underwent physical rehabilitation. The rehabilitation records, however, are not in the case record before the Board. Appellant also fell and fractured his left elbow in 2003. There is no medical evidence of record regarding this prior injury. Appellant asserted that his quadriplegic condition had stabilized and that he needed no significant medical care after he was discharged from rehabilitation. The record contains no contemporaneous medical evidence regarding appellant's condition, neurological or otherwise, between his 1990 hospital discharge and the emergency room records of January 24, 2008. The ambulance report from January 24, 2008 is also not in the record. Thus, there is no medical evidence to establish appellant's neurological baseline following the 1990, injury or his condition in January 2008 prior to the fall at work. Without documentation bridging appellant's medical condition during this period, it is difficult to assess his baseline condition prior to that time.[22]

The medical evidence of record most contemporaneous with the January 24, 2008 fall are the January 24, 2008 emergency room records. Dr. Passanante described the remote cervical injury and appellant's development of Brown-Sequard syndrome with residual left leg weakness. He related appellant's report that he slipped on file folders and struck his head as he fell, and since the fall, he felt tingling in the legs, felt unsteady when ambulating, had muscle spasms, and denied neck pain. Examination demonstrated no swelling or tenderness of the cervical spine with chronic limited range of motion, chronic changes to the left leg, and right sensory deficit. Dr. Passanante stated that a CT scan study of the cervical spine that day demonstrated postoperative changes. Appellant was discharged in stable condition with a diagnosis of acute closed head injury and paresthesias. Discharge instructions were for a minor head injury. Dr. Passanante did not clearly state whether the work incident caused or aggravated a specific condition.

Dr. Engles provided the most extensive opinion on causal relationship. He, however, did not see or examine appellant from the time of his hospital discharge in August 1990 until January 2009. While Dr. Engles indicated that appellant had done well since his 1991 discharge from rehabilitation until the January 2008 fall, this opinion was based solely on appellant's description. A physician's report is of little probative value when it is based on a claimant's belief rather than the physician's independent judgment.[23] Dr. Engles also noted two descriptions of the January 2008 injury. He first indicated that appellant tangled his foot in cords when he fell and later reported a history that appellant slipped on a file on January 24, 2008. Dr. Engles advised that a December 6, 2010 myelogram with postmyelogram CT scan showed clear abnormalities of appellant's spinal cord at C5 near the point of his maximum injury in 1990. He indicated that appellant sustained an unusual and uncommon traumatic tethering and scarring of his injured cervical spinal cord at the level of his cervical spine injury. Dr. Engles noted that the spinal cord at that level had been quiescent and stable until appellant hyperextended his neck with the 2008 fall which stretched his spinal cord, causing injury. He asserted that medical literature confirmed that a stretch associated cord injury is accepted to be a principal factor of neural injury, tethered cord syndrome, and diffuse axonal injury. Dr. Engles noted that appellant's condition abruptly changed after the January 24, 2008 work fall, opining

[22] *See C.W.*, Docket No. 14-730 (issued January 8, 2015).

[23] *Earl David Seale*, 49 ECAB 152 (1997).

that this aggravated his preexisting but quiescent tethered cord. He explained that hyperextension stretched appellant's tethered spinal cord to a degree that axonal injury resulted and this caused new impairment and a decline of neurologic function. Dr. Engles also noted reviewing the January 24, 2008 ambulance record and medical records from 2005 and 2006. These records, however, are not in the case record before the Board. As Dr. Engles had not examined appellant since August 1990, he was not familiar with appellant's baseline neurological condition prior to the fall at work and he could not explain how specific medical literature applied to appellant's specific situation. Furthermore, he did not mention appellant's elbow fracture in 2003 or a history that he fell approximately once a year, as reported by Dr. Ellis.[24] For these reasons, Dr. Engles' opinion is of insufficient probative value to establish that appellant's current condition was caused by the January 24, 2008 slip and fall.

Appellant submitted a number of reports from Dr. Ellis beginning on March 14, 2008. Dr. Ellis noted appellant's preexisting condition and indicated that he had developed more weakness in his left arm and leg with continued neck and back pain and tingling of the bottoms of both feet and left toe drag after the January 2008 fall. Therefore, caused a sudden jarring that aggravated the preexisting spinal cord injury, opining that appellant's spinal cord could be very sensitive to even small trauma. Dr. Ellis indicated that appellant's current symptomatology was consistent with a previously impaired, very sensitive spinal cord that was reinjured, causing more symptomatology. He, however, exhibited limited knowledge of appellant's condition prior to the January 24, 2008 fall at work and did not explain how the work incident aggravated his condition and why his current conditions or symptoms were not due solely to progression of the preexisting condition and his other nonemployment-related falls and injuries. A mere conclusion without the necessary rationale explaining how and why the physician believes that a claimant's accepted exposure could result in a diagnosed condition is not sufficient to meet a claimant's burden of proof.[25]

Reports from other physicians are also insufficient to establish the claim. On February 4, 2008 Dr. Duchamp reported findings and advised that, although appellant fell on January 24, 2008, it was difficult to evaluate his condition because he did not have normal sensation from his previous injuries. On February 27, 2008 he reported that appellant's neurologic change with foot numbness and incontinence could have been caused by a back sprain due to the January 24, 2008 fall at work. While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[26] As Dr. Duchamp couched his opinion in equivocal terms, his reports are insufficient to establish a neurological injury on January 24, 2008. Dr. Herding's reports dated February 14 to May 13, 2008 are also of little probative value. On February 19, 2008 he diagnosed aggravation of preexisting condition and checked a form box "yes," indicating that the condition was caused or aggravated by

[24] *See L.G.*, Docket No. 09-1692 (issued August 11, 2010) (to be of probative value a medical opinion must be based on a complete and accurate factual and medical background; medical opinions based on an incomplete or inaccurate history are of diminished probative value).

[25] *J.D.*, Docket No. 14-2061 (issued February 27, 2015).

[26] *Ricky S. Storms*, 52 ECAB 349 (2001).

employment. The Board has long held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, that opinion has little probative value and is insufficient to establish a causal relationship.[27] Dr. Herding opined that the January 2008 fall was a possible recurrent spinal injury, possibly aggravating appellant's preexisting condition but this opinion is also speculative and lacks rationale explaining the reasons for the opinion.

Likewise, the reports from Dr. Pitman, are also speculative. He first saw appellant on January 22, 2010, two years after the fall at work. Dr. Pitman described a history that included the 1990 injury and that appellant had an additional head and neck injury in January 2008, after which he developed increased neurological symptoms including increased falling and frequent bowel and bladder incontinence. He stated that he "suspected" appellant had a flexion/extension injury in January 2008 with likely additional injury to the spinal cord. On March 10, 2010 Dr. Pitman diagnosed cervical myelopathy and mid-thoracic and neck pain, noting a disc osteophyte complex at C6-7, which he suspected was directly related to the 2008 injury and contributing to some of appellant's pain. He did not explain the basis for his opinion.

Dr. Bisson provided reports dated January 18 to December 26, 2011. He described the 1990 injury and initially reported appellant had a work injury in 2008 when files hit him on the head and exacerbated his condition. Dr. Bisson noted appellant's complaint that his condition had declined since January 2008. He initially diagnosed spastic quadriparesis related to a cervical spinal cord injury in 1990, status post surgery. Dr. Bisson, however, later stated that the January 24, 2008 employment injury exacerbated appellant's medical condition. On December 6, 2011 he corrected the history, stating that appellant reported that he tripped over a file that was on the floor, fell forward, and hit his head on the desk. Dr. Bisson, who did not examine appellant until three years after the slip and fall at work on January 24, 2008, did not explain why he initially found that appellant's condition was due to the 1990 injury. As he did not provide a sufficient explanation regarding the mechanism of how the January 24, 2008 incident caused appellant's condition, his opinion is insufficient to meet appellant's burden of proof.[28]

The reports of Drs. Lamkin, Goodrich, Smith, Gallardo, and Spence are insufficient to meet appellant's burden of proof as none of these physicians provided an opinion on the cause of his condition. As such, their opinions are insufficient to establish causal relationship.[29] Likewise, numerous diagnostic studies are of limited probative value as they do not address whether the 2008 work incident caused any diagnosed conditions.

Consequently, appellant has not met his burden of proof. He may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

[27] *Supra* note 13.

[28] *See T.H.*, 59 ECAB 388 (2008).

[29] *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that a January 24, 2008 slip and fall caused neurological injuries.

ORDER

IT IS HEREBY ORDERED THAT the May 23, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 12, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board