U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BRIAN J. ROBINSON and DEPARTMENT OF THE NAVY, NAVAL SEA SYSTEMS COMMAND, Bremerton, WA

Docket No. 03-175; Submitted on the Record;
Issued January 30, 2004

DECISION and ORDER

Before ALEC J. KOROMILAS, COLLEEN DUFFY KIKO, DAVID S. GERSON

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof in terminating appellant's compensation and medical benefits effective July 13, 1998; (2) whether appellant has met his burden of proof in establishing that he had any disability after July 13, 1998 causally related to the employment injury; and (3) whether appellant met his burden of proof to establish that his neurogenic bladder and esophageal reflux conditions were causally related to the May 24, 1991 employment injury.

On May 24, 1991 appellant, then a 28-year-old temporary fabric worker, sustained an employment-related L3 transverse process fracture when he fell 20 feet at work. Following a release from his attending physician that his L3 transverse process fracture had healed, appellant returned to limited-duty day shift on October 8, 1991 but stopped work on or about October 9, 1991.

In an August 24, 1992 report, Dr. Melvin D. Levine, a Board-certified orthopedic surgeon, and Dr. James M. Burnell, a Board-certified internist, each reviewed appellant's medical records, statement of accepted facts and performed an examination. Dr. Levine opined that, based on his examination and review of history, the fracture of the transverse process had healed and there were no residuals. He also stated that appellant had a number of neurologic complaints of questionable etiology, which included a marked give-away weakness of the entire lower extremity and a somewhat bizarre gait pattern. Dr. Burnell opined that the hiatal hernia was the consequence of the work injury and it should be repaired. He further advised that appellant probably had a urethral stricture and may have some minor sexual function related thereto. Dr. Burnell recommended an urologic evaluation. He also advised that appellant had a foot drop, but it was not clear as to the etiology or the role of the spine injury in its progression. Dr. Burnell opined that there was probable complete recovery of all other aspects of his back injury.

The Office accepted the subsequent condition of a hiatus hernia and appellant underwent an authorized reduction of the hernia on September 17, 1992. A Nissen fundoplication was performed at the same time, although the Office did not authorize this procedure as part of the accepted conditions. The Office did not accept appellant's conditions of neurogenic bladder and esophageal reflux as being causally related to the May 24, 1991 employment injury.

In a December 1, 1992 progress note, Dr. Yuen San Yee, a Board-certified internist and appellant's attending physician, noted that appellant had a history of severe hiatal hernia, probably trauma related with severe reflux requiring surgical repair. A suspected tightening of the wrap from the fundoplication or stricture was noted due to intermittent dysphagia with solid foods. Appellant was also noted to have a recurrent urinary tract infection and neurogenic bladder which required chronic antibiotic therapy and self-catheterization. In a January 18, 1993 report, Dr. Yee commented that appellant had complex neurologic signs and symptoms which included neurogenic bladder, possible fecal incontinence and difficulty walking secondary to a clumsy right leg. Objective testing was essentially normal without evidence of cord involvement. An organic lesion was not identified, but questions were raised as to a possible myelopathy and transverse myelitis.

In a letter dated January 22, 1993, the Office wrote to Dr. David Fryer, a neurologist, who had evaluated appellant for possible pyelonephritis, possibly secondary to a neurogenic bladder, in an effort to determine whether appellant's urological problems were related to his work injury. In a February 4, 1993 report, Dr. Fryer commented that appellant had come in for an evaluation in a wheelchair complaining of loss of sensation and the inability to move his legs, but advised that there was no objective evidence of organic nervous system damage. The inconsistency in the motor power testing suggested a conversion reaction, which Dr. Fryer advised would explain the fact that extensive studies had not led to a definite diagnosis. He noted that urinary retention, intermittent paresis and sensory loss could be on a functional basis.

On April 9, 1993 the Office referred appellant for a second opinion evaluation with a panel of specialists to determine whether the accepted conditions had resolved and whether appellant's neurological complaints and urological conditions and difficulties were related to the work injury of May 24, 1991. On May 21, 1993 appellant was examined by Dr. Phillip L. Grisham, a Board-certified neurologist, Dr. Loy E. Cramer, a Board-certified orthopedist, Dr. Kenneth N. Anderson, a Board-certified urologist, and Dr. John E. Hamm, a Board-certified psychiatrist. In a report dated May 21, 1993, Drs. Grisham, Cramer and Anderson concluded that the accepted L3 transverse process fracture had resolved and that, from a neuromuscular point of view, appellant was not totally disabled. They opined, however, that appellant's neurological complaints and "findings" defied a specific diagnosis. Positive features were noted which suggested nonorganic components. The physicians noted that, although appellant claimed to have no motor use of the lower extremities, motor activity was demonstrated. Problems with the bladder were noted to have begun in 1988. The physicians noted that, although Dr. John C. Hedges, a urologist, had noted a urethral stricture in his report of August 24, 1992, his evaluation evidenced a normal lower tract uninjured by the 1991 fall. Accordingly, the physicians stated a neurologic condition that was not identified and they opined that a resolution of appellant's neurologic symptoms was more likely to parallel resolution of his emotional problems. The physicians further felt that appellant did not need to use his wheelchair. In the same report,

Dr. Hamm diagnosed a probable hysterical conversion reaction involving appellant's lower extremities which appeared to be related to psychodynamic causes unrelated to his work injury. Dr. Hamm opined that further investigation was needed to determine the psychological dynamics of this case.

By letter dated June 11, 1993, the Office requested clarification from Drs. Anderson, Grisham and Hamm. In a June 14, 1993 report, Dr. Grisham stated that it was better to phrase appellant's neuromuscular status as complaints rather than a condition, noting that he had ongoing neuromuscular complaints both before and after the May 24, 1991 injury, with the complaints being more widespread and intense after the injury. Dr. Grishman explained that, as a specific organic neuromuscular condition could not be identified for appellant's complaints both before and after his work accident, his condition was "undiagnosable." In a June 21, 1993 report, Dr. Hamm advised that appellant's impotence could be part of his hysterical conversion reaction, but he could not offer such an opinion on a more probable than not basis. In a June 30, 1993 report, Dr. Anderson opined that appellant's urologic problems were, more probable than not, related to his work injury, but, as discussed by Dr. Hamm, could relate to a conversion disorder.

Because of the deficiencies in the reports of Drs. Hamm and Anderson, the Office referred appellant for another second opinion panel evaluation with Dr. William Dean, a Board-certified urologist, and Dr. Robert H. Fortiner, a psychiatrist.[1] On November 9, 1993 appellant underwent a panel evaluation with the above physicians. In a November 9, 1993 report, Dr. Dean explained that the lack of neurologic consistency and lack of objective evidence by imagining studies suggested that appellant's inability to urinate was factitious as the studies were not consistent with hypotonia. Further, the history of apparent pyelonephritis was not substantiated by the record. Dr. Dean noted that, although appellant claimed problems voiding, he did not actually seek urologic attention until mid-1992, approximately 13 to 14 months post-injury in 1991. He further noted that, although appellant stated that here was a problem with bladder function, this was not documented in the records. Dr. Dean diagnosed probable factitious neurologic deficit, apparent history of difficulty voiding, without strong documented evidence by urodynamics, doubt diagnosis of pyelonephritis in January 1993, status post Nissen fundoplication and impotence, probably psychogenic. A nonbiased urodynamics study was recommended with respect to the urologic deficit. In the same November 9, 1993 report, Dr. Fortiner diagnosed a factitious disorder with physical symptoms. He noted that appellant's described absence of muscle strength involving the lower extremities was voluntarily produced and not related to the 1991 work injury. Dr. Fortiner stated that, as a lay person, appellant could not authentically present the complete picture of a hemiparetic patient and his sensory loss from the umbilicus distally failed to conform to any known anatomic pattern. He opined that appellant had a preexisting passive-aggressive personality disorder which was not aggravated by the injury of 1991. Dr. Fortiner stated that, because appellant had concealed so much of his past history, presenting everything as super normal, it was impossible to determine the earlier manifestations of his personality disorder. He opined that appellant's impotence was likely psychogenic in light of appellant's other multitudinous psychological symptoms.

[1] By decision dated September 28, 1993, the Office suspended appellant's compensation benefits effective September 19, 1993 until he complied with the Office's second opinion examinations.

The Office forwarded copies of Drs. Dean's and Fortiner's report to Dr. Yee for review. In a response dated January 12, 1994, Dr. Yee advised that it was still his impression that appellant had an episode of pyelonephritis when he was hospitalized on January 18 through 25, 1993. He noted that he was forwarding the report of Drs. Dean and Fortiner to Dr. Hedges, the urologist involved in appellant's care, for his review and comments.

In a February 8, 1994 report, Dr. Hedges noted his review of the reports of Drs. Dean and Fortiner, in addition to previous evaluations by Dr. Anderson, Dr. Jane Miller and Dr. Tamara Bavendam and his initial evaluation. Dr. Hedges stated that a great deal of appellant's complaints could not be explained. He opined that appellant had, on several occasions, been noted to have a massive bladder distension to as high as 1200 cc which, combined with urodynamic testing, suggested that appellant had a degree of hypotonia. Dr. Hedges felt that further evaluation was necessary as there was a division of opinion between the urologists, Dr. Bavendam, Dr. Miller, Dr. Anderson and himself as to whether appellant had a neurogenic bladder. Dr. Hedges further noted that Dr. Dean questioned the finding of pyelonephritis because of the presentation of anterior left chest wall pain. He advised that appellant had severe reflux esophagitis as well as dysphia for solid foods and had a Nissan fundoplication. Dr. Hedges further noted that Dr. Yee was concerned that the wrap may have been too tight, leading to obstruction or a stricture. In addition to the anterior chest pain, Dr. Hedges noted that appellant had also complained of bilateral flank pain and was found to have a temperature of 101 degrees with a positive urine culture. He opined that appellant's anterior left chest wall pain was more likely related to his esophageal dysfunction. Dr. Hedges could not say with certainty that appellant had pyelonephritis, but had definitely a febrile urinary tract infection with bilateral flank and abdominal pain.

In view of the reports from Drs. Lee and Hedges, in a March 4, 1993 letter, the Office requested clarification from Dr. Dean. In a March 31, 1994 response, Dr. Dean advised that he was not aware that there had been "urodynamic testing on several occasions," as his records only showed one study. He further noted that there were circumstances in which detrusor hypotonia does not have to exist with neurogenic disease and, in fact, could be associated with psychiatric disease. Accordingly, Dr. Dean amended his previous statement, that appellant's lack of ability to urinate could be factitious and not consistent with hypotonia, to say that appellant's condition of hypotonia was more probably related to some unknown neurological cause as there can be other explanations for his hypotonia. He further stated that, with regard to the diagnosis of pyelonephritis, appellant had developed a febrile urinary tract infection five days after the urodynamic study. Dr. Dean opined that the urinary tract infection was secondary to the instrumentation as it occurred five days after the urodynamic study and appellant probably did not empty his bladder, which increased his chance for a post-instrumentation infection.

On May 3, 1994 the Office posed additional questions to Drs. Yee and Hedges. In a May 10, 1994 report, Dr. Yee advised that, as appellant had instrumentation of the urinary tract prior to the onset of acute febrile infection, it was difficult to say with certainty whether the febrile illness was related to the instrumentation process or poor drainage from a neurogenic bladder. He noted that appellant had an urodynamic study the week prior to his admission and was doing self-catherization four times a day. Dr. Yee opined that, if it was an instrumentation-related phenomena, he would have expected the febrile illness to occur within 24 to 48 hours

after the event, rather than 5 days later. He further noted that appellant was not presently confined to his wheelchair, but had a significant handicap in terms of his requirement for self-catherization and had significant trouble with his gait and weakness in his lower limbs. Dr. Yee opined that, until appellant can be rehabilitated, his outlook for employment remained limited. In a Form OWCP-5c report dated September 1, 1994, Dr. Yee opined that appellant was capable of working 20 hours per week with restrictions.

As no additional reports were received from Dr. Hedges, the Office referred appellant for another second opinion examination with Dr. Robert Modarelli, a Board-certified urologist, and Dr. Patrick Hogan, a Board-certified neurologist. In a report dated February 1, 1995, Dr. Modarelli reviewed the referral package and set forth his examination findings. He stated that, inasmuch as appellant's urologic condition did not occur at the time of the May 24, 1991, injury but some six to eight months later, he did not believe that the urologic condition was due to the May 24, 1991 injury. Dr. Modarelli opined, however, that appellant could have a hypotonic bladder which could be controlled with medications or intermittent catherization. He opined that, from a urologic standpoint, appellant was capable of working. Dr. Modarelli noted that there was good range of motion of appellant's knees with good muscular development of the quadriceps and biceps and opined that a wheelchair was not necessary for appellant's urologic condition. He further noted that, although appellant said he could walk, he was reluctant to walk. Dr. Modarelli concluded that he did not see how appellant's injury and evaluation of the same could result in his bladder difficulties, concluding that there were other noninjury related causes.

In a report of February 1, 1995, Dr. Hogan reviewed the referral package and set forth his examination findings. He diagnosed status post L3 vertebra transverse process fracture and status post soft tissue injuries to the low back region and the probable perineum (saddle injury) as being resolved. Dr. Hogan further diagnosed portrayal of extremity altered movements ability and sensory alteration of psychogenic etiology, possible right lower extremity peripheral nerve or nerve root injury suggested by a previous electromyographic (EMG) study and neurogenic bladder. He noted that appellant had complained of progressive right lower extremity weakness before the work injury of May 24, 1991 and opined that this condition defied definitive diagnosis, noting that there was no evidence that appellant had a demyelinating process, such as myltiple sclerosis or degenerative nerve system disorder. Dr. Hogan advised that it was possible that appellant had a preexisting peripheral nerve injury related to his motorcycle accident, that occurred in 1983 and the right distal lower extremity burn but that would not cause appellant's lower extremity to give way on him. He noted that, even before the work injury of May 24, 1991, appellant was very disgruntled toward his employer and stated that it is possible that psychogenic factors were in play at that time. Dr. Hogan opined that appellant did not have a neurologic disease of an organic etiology which was producing his lower extremity weakness and altered sensory perception. He stated that appellant could have a conversion reaction, which would be appellant's psychogenic response to the work injury based on a very large array of secondary gain factors. Based on objective findings alone, Dr. Hogan opined that the effects of appellant's injury were medically fixed and stable and appellant was capable of employment with no formal restrictions. Dr. Hogan noted that, although multiple attempts had been made for an EMG study, this has not been successful. He opined that, based on the objective findings on

examination, appellant did not meet the criteria for any ratable permanent partial impairment related to the May 24, 1991 injury.

By letter dated June 10, 1998, the Office advised appellant that it proposed to terminate his compensation and medical benefits on the grounds that the weight of the medical evidence established that he had no remaining disability or medical condition causally related to his May 24, 1991 employment injury. The Office further found that the diagnosed conditions of neurogenic bladder and esophageal reflux were not causally related to the May 24, 1991 employment injury.

By decision dated July 13, 1998, the Office terminated appellant's compensation on the grounds that the weight of the medical evidence established that appellant had no disability or medical condition causally related to his May 24, 1991 employment injury. The diagnosed conditions of neurogenic bladder and esophageal reflux were found not to be causally related to the May 24, 1991 employment injury. The Office noted that appellant did not reply to its proposed action to terminate within the 30 days alloted.

Following the July 13, 1998 termination decision, appellant submitted additional evidence. In a January 27, 2000 report, Dr. James T. Clemen, a Board-certified general surgeon, noted that appellant had a history of traumatic injury to the diaphragm in 1991 from a fall, along with a neurogenic bladder and ruptured diaphragm. He noted that appellant had undergone a hiatal hernia repair and had an incisional hernia. In a July 19, 2000 report, Dr. Clemen reported that appellant's work-related accident caused bladder problems, pyelonephritis, neurogenic bladder and a large hiatal hernia with reflux. He further reported that appellant's accident also caused problems with loss of sensation in the right arm, loss of mobility and strength in the right leg, further problems with reflux, gastrointestinal disturbance, neurogenic bladder and pyelonephritis. An assessment of gastroesophageal reflux disease, vomiting, neurologic problems secondary to the fall at the shipyard, status post Nissen fundoplication, incisional hernia in the epigastric area, neurological deficit in the right hand and right leg and neurogenic bladder with pyelonephritis were provided. In a July 25, 2000 report, Dr. Clemen reported that appellant suffered a brain injury with altered mental status secondary to the May 1991 fall. In a January 28, 2000 report, Dr. Hedges continued to report that appellant has a noncompliant neurogenic bladder secondary to blunt back trauma, in 1991. Erectile dysfunction was also noted.

In a February 16, 2000 report, Dr. Donna E. Moore, Board-certified in physical medicine and rehabilitation, examined appellant for right leg and ankle contracture, right hand weakness of undetermined etiology and for severe depression. In a follow-up report of June 7, 2000, she noted that appellant was a poor historian and opined that the majority of his functional impairment was due to probable psychiatric abnormality. A history of a previous brain injury was noted. A July 31, 2000 report noted that appellant's statements and performance were inconsistent. Dr. Moore opined that appellant had a lot of functional overlay.

In an October 17, 2000 report, Dr. Lynn L. Staker, an orthopedic surgeon, advised that she reviewed almost 10 years of medical history and advised that appellant had recurrent bladder infections and self-catheterized with some bladder dysfunction, chronic dysphagia and pain. She noted that appellant seemed to have difficulties in remembering things with probable psychiatric

problems and that most examiners had felt that there was some sort of conversion and psychomatic aspect to his situation. Dr. Staker advised that, as recently as March 2000, appellant exhibited minimal to no use of his right shoulder, elbow or hand, with tightly clenched fists and no active motion of his hip, knee or ankle and no sensation in his upper extremity or lower extremity. She opined that a lot of this seemed to be nonanatomic and could not say exactly what was going on. In a follow-up report dated November 8, 2000, Dr. Staker advised that appellant developed a claw hand and had problems with dizziness, headaches, decreased memory and prolonged weakness, etc. Dr. Staker opined that, while she would concur that there may well be a lot of somatoform problems, there were a lot of physical problems which she thought might be directly attributed to that fall.

By decision dated October 29, 2001, the Office denied modification of its July 13, 1998 decision terminating benefits.[2]

The Board finds that the Office met its burden of proof in terminating appellant's compensation and medical benefits for the accepted conditions of L3 transverse process fracture and the hiatal hernia.

It is well established that once the Office accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to his employment, the Office may not terminate compensation without establishing that the disability had ceased or that it is no longer related to the employment.[3] The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that a claimant no longer has residuals of an employment-related condition that would require further medical treatment.[4]

The Office found that the weight of the medical evidence of record, with regard to the accepted condition of L3 transverse process fracture, rested with the opinions expressed by Drs. Grisham and Cramer on May 21, 1993. The physicians concluded that the accepted condition was resolved given the amount of time which had past and the fact that there was no tenderness or symptoms referable to that condition. Accordingly, they found that, from a neuromuscular point of view, appellant was not totally disabled. They further found that no diagnosable neuromuscular condition could be identified and opined that the positive findings suggested that a nonorganic component, as opposed to an underlying neurologic process, was at work.

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[2] The Board notes that, in a letter dated July 29, 1998, the Office advised appellant that, although the June 10, 1998 notice had been returned to the post office, both it and the final decision dated July 13, 1998 were remailed to his new address and no further action would be taken. The Board finds that as appellant did not take issue with this letter and the Office had properly mailed both the letter proposing termination and the actual termination decision to appellant's last known address, the Office properly issued its termination decision. Accordingly, the Board will proceed to address the merits of the Office's termination decision.

[3] *See Alfonso G. Montoya*, 44 ECAB 193, 198 (1992); *Gail D. Painton*, 41 ECAB 492, 498 (1990).

[4] *See Wiley Richey,* 49 ECAB 166, 168 (1997).

It is well established that a termination or modification of benefits must be based on a reasonably current medical evaluation.[5] In this case, although the Office relied on the May 21, 1993 reports of Drs. Grisham and Cramer in terminating appellant's compensation in July 1998, the Board finds that the physician's findings have not been contested or argued by any of the physicians of record, both attending and Office referral physicians.[6] The records indicate that x-ray evidence as early as October 7, 1991 showed a well-healed transverse process fracture and Dr. Levine, in his report of August 24, 1992, found that the L3 fracture had healed with no residuals. This supports the conclusions of Drs. Grisham and Cramer that the L3 transverse fracture had resolved. Additionally, the opinions of Drs. Fortiner and Hogan support that there are no residuals remaining from the L3 transverse fracture. In his November 9, 1993 report, Dr. Fortiner noted that appellant's variable, but currently described absence of muscle strength involving the lower extremities was voluntarily produced and was a factitious problem with physical symptoms. Appellant's sensory loss from the umbilicus distally failed to conform to any known anatomic patterns. Dr. Fortiner also noted that, as a lay person, appellant could not authentically present the complete picture of a hemiparetic patient. He further noted that appellant had a preexisting passive-aggressive personality disorder which was not aggravated by the 1991 injury. In his February 1, 1995 report, Dr. Hogan also found that the L3 vertebra transverse process fracture, soft tissue injuries to the low back region and the probable perineum (saddle injury) had resolved. Dr. Hogan further found that, although appellant had complained of progressive right lower extremity weakness prior to the work injury of May 24, 1991, this condition defied definitive diagnosis. He opined that appellant did not have a neurologic disease of an organic etiology which was producing his lower extremity weakness and altered sensory perception. As the record in this case is devoid of any medical evidence following Dr. Hogan's 1995 opinion, the Board finds that the 1993 medical opinions of Drs. Grisham and Cramer carry the weight of the medical evidence in this case as their findings that the accepted L3 fracture had resolved with no residuals has not been contested or argued by the attending physicians. The Board notes that Dr. Hedges, in his February 8, 1994 report, commented that a great deal of appellant's complaints could not be explained.

With regard to the accepted condition of the hiatal hernia and subsequent surgical repair of September 7, 1992, the Office properly found that the evidence of record failed to note any comment or discussion with regard to this condition until January 16, 1995. The chart note on that date reflects that Dr. Yee had directed appellant to go to the emergency room three weeks previously for his complaints of nausea, vomiting and hematemesis, but appellant did not go. Dr. Yee diagnosed recurrent nausea, vomiting and hiatal hernia. A recurrence of heartburn was also noted. A January 18, 1995 esophagram and upper gastrointestional x-ray revealed an intact Nissen fundoplication; decreased esophageal motility with poor stripping and early breakup of the primary peristaltic wave; and normal appearance of the stomach and duodenum. There was no evidence of protrusion of the stomach or visualized opacified loops of bowel into the ventral hernia. Accordingly, there is no medical evidence documenting the need for continued medical care with regard to the accepted condition of the hiatal hernia.

[5] *See generally Carl C. Green, Jr.*, 47 ECAB 737 (1996) (this refers to a wage-earning capacity determination).

[6] *See Keith Hanselman*, 42 ECAB 680 (1991); *Ellen G. Trimmer*, 32 ECAB 1878 (1981).

Thus, the Office properly terminated appellant's compensation benefits on the grounds that his employment-related disability due to the accepted conditions had resolved.

The Board further finds that, as the Office met its burden of proof to terminate appellant's compensation benefits, the burden shifted to appellant to establish that he had disability causally related to his accepted employment injury.[7] To establish a causal relationship between the condition, as well as any disability claimed and the employment injury, the employee must submit rationalized medical opinion evidence, based on a complete factual background, supporting such a causal relationship. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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 claimant. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[8]

Following the July 13, 1998 termination decision, appellant submitted additional medical evidence. Appellant submitted numerous reports from Dr. Clemen who attributed several conditions to appellant's work-related fall. However, many of appellant's problems, which Dr. Clemen's attributed to the May 1991 fall, failed to take into account the exact history of the injury and the objective evidence prior to and subsequent to the injury. For example, Dr. Clemen reported that appellant suffered a brain injury with altered mental status but the May 25, 1991 computerized tomography (CT) scan of the brain was noted as being normal. Dr. Clemen's opinion is based upon an inaccurate and incomplete history and, therefore, is without probative value.[9] The Board finds that Dr. Clemen did not provide a reasoned medical opinion based on a complete background and his reports are therefore of diminished probative value to the issues presented.

In her report of November 8, 2000, Dr. Staker advised that she thought a lot of how appellant's physical problems could be directly attributed to the work-related fall. Dr. Staker, however, did not provide any medical opinion between what physical problems she thought could be directly attributed to the fall with medical rationale explaining how she reached that conclusion. The Board finds her opinion to be equivocal in nature. Although the opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute medical certainty, neither can such an opinion be speculative or equivocal.[10] The Board finds that Dr. Staker's opinion is equivocal, lacks reasonable medical

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[7] *George Servetas*, 43 ECAB 424, 430 (1992).

[8] *James Mack,* 43 ECAB 321 (1991).

[9] *See Patricia M. Mitchell,* 48 ECAB 371 (1997); *Cleopatra McDougal-Saddler,* 47 ECAB 480 (1996).

[10] *Philip J. Deroo*, 39 ECAB 1294 (1988).

certainty and, is, therefore, of diminished probative value.[11] Accordingly, Dr. Staker's reports are not sufficient to meet appellant's burden of proof. Although, in his February 8, 1994 report, Dr. Hedges opined that appellant had a febrile urinary tract infection with bilateral flank and abdominal pain, he never responded to the Office's request for additional information. Thus, his report fails to offer a well-rationalized medical opinion on causal relationship. Additionally, the February 16 and July 31, 2000 reports from Dr. Moore opined that the majority of appellant's functional impairment was due to probable psychiatric abnormality and that appellant had a lot of functional overlay. Without any explanation or rationale for the conclusion reached, such reports are insufficient to establish causal relationship.[12]

The Board further finds that the Office properly found that the nonaccepted conditions of neurogenic bladder and esophageal reflux condition with subsequent Nissen's fundoplication on September 17, 1992 were not causally related to the work injury of May 24, 1991.

As previously stated, appellant bears the burden of proof to establish that those conditions and any other disabilities are causally related to his accepted employment injury.[13]

The Board notes that, although appellant underwent a Nissen fundoplication on September 17, 1992 for his esophageal reflux, the Office had not accepted the esophageal reflux condition as being causally related to the work injury of May 24, 1991. Although, in his report of August 8, 1991, Dr. Yee stated that he had suspected that appellant may have torn or ruptured the esophagus and had the formation of scar tissue secondary to healing post injury, his opinion is equivocal and, thus, is of no probative value in establishing causal relationship.[14] There is no other medical evidence in the record that establishes a causal connection between appellant's esophageal reflux condition and his work injury of May 24, 1991. Accordingly, appellant has not met his burden of proof to establish that his Nissen fundoplication procedure or esophageal reflux condition are causally related to the employment injury.

The Board further finds that appellant has not established that his hypotonic or neurogenic bladder condition is causally related to the work injury of May 24, 1991.

The Board notes that the Office, in developing the medical evidence pertaining to the urologic and psychiatric issues raised in this case, had referred appellant out for three second opinion evaluations. The Office properly referred appellant out for a "second" opinion evaluation to Drs. Dean and Fortiner as the initial group of Office referral physicians, which

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[11] *Jennifer Beville*, 33 ECAB 1970 (1982) (statement of a Board-certified internist that the employee's complaints "could have been" related to her work injury was speculative and of limited probative value).

[12] *Lucrecia M. Nielson,* 42 ECAB 583, 594 (1991).

[13] *George Servetas*, *supra* note 7.

[14] *See Wendell D. Harrell*, 49 ECAB 289, 291 (1998).

consisted of Drs. Hamm and Anderson, failed to provide the clarification requested by the Office and dispose of the issue to be resolved.[15] In his June 21, 1993 report, Dr. Hamm specifically advised that he was unable to answer the questions requested by the Office with regard to why it took so long after the work injury for appellant's urologic systems to appear and how appellant's impotence could be related to any psychiatric condition appellant might have. Although, in his June 30, 1993 report, Dr. Anderson opined that appellant's urologic problems were causally related to the work injury, Dr. Anderson's opinion is not probative as the opinion was equivocal in nature as Dr. Anderson noted that both the urologic and neurologic problems may also relate to a conversion disorder and no rationale was offered for his opinion.[16]

Dr. Modarelli, who provided a second opinion for the Office in February 1995, opined that appellant's urologic condition was not causally related to the work injury as the condition arose six to eight months post-injury and there were other noninjury-related causes which could have caused appellant's hypotonic or central neurogenic bladder. This is consistent with the March 31, 1994 opinion of Dr. Dean, who advised that there were other explanations for appellant's hypotonia condition which were not neurological. Moreover, in his February 1, 1995 report, Dr. Hogan opined that, based on the objective findings on the neurological examination, appellant's conditions defied definitive diagnosis and might represent a conversion reaction.

As appellant has not presented a medical opinion which contains a well-rationalized explanation to support a causal relation between his urological conditions and the May 24, 1991 employment injury, he has not discharged his burden of proof.

[15] *Cf. Walter A. Fundinger, Jr.,* 37 ECAB 200, 205 (1985) (Office referral physician's reports were insufficient to dispose of the issue to be resolved; therefore, the Office had an obligation to go further in developing the medical evidence).

[16] *See Wendell D. Harrell*, *supra* note 14.

The October 29, 2001 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
January 30, 2004

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member