United States Department of Labor
Employees' Compensation Appeals Board

RENATA A. SEALEY, Appellant	)	
and	)	**Docket No. 04-315**
	)	**Issued: August 24, 2004**
U.S. POSTAL SERVICE, MAIN POST OFFICE, Columbus, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant.
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On November 17, 2003 appellant filed a timely appeal of an October 21, 2003 merit decision of the Office of Workers' Compensation Programs. Pursuant to 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 established that her claimed fibromyalgia is causally related to her accepted October 8, 1998 employment injury.

FACTUAL HISTORY

This is appellant's second appeal before the Board. Appellant has an accepted claim for cervical strain, which arose from an October 8, 1998 employment-related traumatic injury. On May 22, 2002 the Board affirmed a March 20, 2001 Office decision which denied appellant's claim for a recurrence of disability for the periods January 2 to 4, February 13 to 26 and

November 26 to December 8, 1999. The Board's May 22, 2002 decision is incorporated herein by reference.[1]

Following the Board's decision, the Office determined that a second opinion medical examination was required and referred appellant, together with a statement of accepted facts and questions to be addressed, to Dr. James H. Rutherford, a Board-certified orthopedic surgeon.

In an August 16, 2002 report, Dr. Rutherford reviewed appellant's factual and medical history, noted that her symptoms did not improve even with rest and physical therapy, and indicated that Dr. Paul C. Kirk, a Board-certified family practitioner and occupational medicine practitioner, had diagnosed fibromyalgia. Dr. Rutherford noted that appellant complained of constant pain in her neck and radiating down her back, causing low back pain, numbness and burning in her left leg and pain radiating into her arms bilaterally. He noted that appellant also complained of frequent headaches and a crunching in her neck when she walked. Dr. Rutherford noted that appellant had undergone physical therapy, aquatic therapy, work hardening, the use of a TENS (transcutaneous electrical nerve stimulator) unit, ultrasound, and massage therapy, and that her symptoms worsened rather than improved. In reviewing appellant's medical records, Dr. Rutherford indicated that her history was significant for fibromyalgia, high blood pressure and obesity. He noted that a negative electromyogram (EMG) and nerve conduction study which confirmed the impression of Dr. Robert Shriber, a Board-certified internist, of fibromyalgia syndrome. He noted that Dr. Deborah A. Venesy, Board-certified in physical medicine and rehabilitation, indicated that appellant had a number of findings that were "persistent" with fibromyalgia and sleep dysfunction. Dr. Rutherford discussed his findings upon examination and noted that appellant used a cane, but had an even gait with her cane. He noted that she could stand on her toes and heels, but that she did poorly when walking in a tandem fashion. Dr. Rutherford noted that on range of motion of her back she had flexion of 40 degrees with 60 degrees being normal, and that she could perform 20 percent of a deep knee bend. He noted that motor function in the lower extremities was intact on manual muscle testing, with straight leg testing positive at 45 degrees on the left and 60 degrees on the right.

Regarding her upper body, Dr. Rutherford found that appellant had chest pain and headaches that began in her neck, which occurred almost daily. He noted that she had tenderness over both trapezius muscles with the right side being more involved than the left, and that she had tenderness over the posterior spinous process of C7 and the posterior neck. Dr. Rutherford noted that, on range of motion of her neck, appellant had flexion to 50 degrees and extension to 10 degrees, with lateral rotation of 45 degrees to the right and 70 degrees to the left. He noted that shoulder range of motion was 140 degrees of active flexion and 140 degrees of abduction, with 80 degrees of internal and external rotation. Appellant's left shoulder showed only 90 degrees of active flexion and 90 degrees of active abduction, with 70 degrees of internal and external rotation. Dr. Rutherford noted that motor function in appellant's upper extremities was intact on manual muscle testing, with sensorum intact, but with unexplained paresthesias in the first and second fingers of both hands and in the tips of her fingers. He found appellant had 11 out of 18 trigger areas for fibromyalgia, which were tender and this would qualify her as having a diagnosis of fibromyalgia. He concurred with the diagnosis of fibromyalgia, noted that she still

[1] Docket No. 01-1340 (issued May 22, 2002).

had residuals from her October 8, 1998 injury, and a limited range of cervical motion which could be accommodated by working six hours per day, part time, with a 10-pound lifting restriction and restrictions on working overhead. Dr. Rutherford indicated that these limitations were related to her cervical strain injury, but noted that restrictions requiring sedentary activity, limited walking and limited standing and no stooping or bending were related to her low back strain and fibromyalgia. He opined that these restrictions were temporary at this point.

On September 19, 2002 the Office requested that Dr. Rutherford explain how appellant's fibromyalgia was related to her October 8, 1998 injury. In a September 30, 2002 supplemental report, Dr. Rutherford noted that the statement of accepted facts noted that appellant's medical history was significant for fibromyalgia, high blood pressure and obesity. Dr. Rutherford stated: "fibromyalgia is not related specifically to the October 8, 1998 injury," noting that no probable causal connection had been made for the diagnosis of generalized fibromyalgia as a result of the October 8, 1998 injury.

Appellant's treating physician, Dr. Alton J. Ball, a Board-certified occupational medicine specialist, referred her to Dr. Steven P. Stanos, a Board-certified osteopath specializing in pain management, for an evaluation and consultation. In a report dated June 25, 2002, Dr. Stanos advised that appellant had "cervical pain extending straight through her spine down to the lumbar region," and that "she was also told since her accident that she had fibromyalgia." Dr. Stanos noted that appellant was quite tearful and reported severe depression related to her ongoing pain, but also noted that her lumbar spine magnetic resonance imaging (MRI) scan was negative. He further noted that her cervical spine MRI scan showed multilevel degenerative disc disease at C2-3 and C5-6 with no spinal stenosis or foraminal narrowing and noted that a previous physician had told her that she had torticollis related to her accident. Appellant ambulated with a cane in her right hand with an inconsistent gait pattern in a crouched posture and unable to stand fully erect, which she claimed was secondary to left hip pain. She reported vague inconsistent paresthesia-like pain in the left arm extending from the shoulder into her hand. He noted that appellant presented with significant pain behaviors including guarding and overreaction, and that her head was tilted to the left with shoulder shrug bilaterally. Appellant complained of diffuse tenderness primarily along the cervical paraspinals, posterior scapular region, but with no trigger points and with diffuse pain along the anterior chest, soft tissue and bony prominences. Dr. Stanos noted that there was inconsistent active proximal strength with at least a 50 percent loss of range of motion with hands over her head. He noted that appellant had give way weakness with proximal and distal upper limb testing and inconsistent tone, which was occasionally normal in both the upper and lower limbs, and that appellant had inconsistent tremor which changed throughout the examination. Dr. Stanos diagnosed chronic pain syndrome with severe depression and affective disorder, and severe myofascial pain of the anterior chest, scapula, and cervical, thoracic and lumbar spines related to bracing and guarding.

Appellant also submitted medical reports from preceding years. In a December 11, 2000 report, Dr. Kirk, a Board-certified family practitioner and occupational medicine practitioner, diagnosed fibromyaglia and noted that appellant had multiple trigger points. This diagnosis was repeated on a form report dated May 23, 2001 and Dr. Kirk checked "yes" to the form question as to whether the condition found was caused or aggravated by an employment activity.

Dr. Ball provided July 1, 2002 narrative and form reports which noted that Dr. Stanos had recommended a multidisciplinary pain program for pain management and rehabilitation. He diagnosed "cervical strain [and] back strain." On a July 1, 2002 Form CA-20 attending physician's report, Dr. Ball diagnosed fibromyalgia and cervical strain and he checked "yes" to the form report question as to whether the condition found was caused or aggravated by an employment activity provided. Dr. Ball indicated that appellant was partially disabled for the period July 1 through 29, 2002.

In a July 29, 2002 report, Dr. Ball diagnosed chronic pain syndrome associated with a cervical strain injury and he noted in a brief narrative that no new findings were made on examination that date. On a form report of that date Dr. Ball diagnosed cervical strain with associated chronic pain syndrome.

Dr. Ball completed an August 20, 2002 form report diagnosing fibromyalgia complicating cervical strain.

In an August 26, 2002 narrative report, Dr. Ball noted that appellant was being followed for "cervical strain with back pain and fibromyalgia complicating." He indicated that appellant's symptoms were generally mildly improved, and that she was currently being followed for pain by Dr. Stanos. Dr. Ball indicated that appellant still had some numbness in her hands occasionally.

In a September 24, 2002 narrative report, Dr. Ball noted that appellant now had symptoms that were certainly not related to her cervical strain. He opined that her chronic pain persisted, and that she needed a multidisciplinary pain control program. Dr. Ball indicated on a September 27, 2002 attending physician's report that there were no changes in appellant's examination and he diagnosed fibromyalgia complicating cervical strain. Dr. Ball opined that appellant remained partially disabled.

On October 14, 2002 Dr. Ball noted that there was no change in appellant's physical examination, he diagnosed fibromyalgia complicating back/neck strain and referred appellant for pain management. Dr. Ball checked "yes" to the question of whether the condition found was caused or aggravated by an employment activity.

By letter dated October 28, 2002, the Office requested that Dr. Ball discuss appellant's current findings and diagnosis, and opine whether she could work and with what restrictions.

In a response dated October 31, 2002, Dr. Ball noted that appellant had chronic cervical and thoracic area pain associated with the October 8, 1998 work incident and that fibromyalgia was an important component of her chronic pain. Dr. Ball recommended further work-up with a pain management specialist and agreed with Dr. Rutherford's expressed work restrictions.

By decision dated November 26, 2002, the Office rejected appellant's claim for fibromyalgia finding that Dr. Rutherford, the second opinion specialist, had found that there was no causal connection between the diagnosed fibromyalgia and appellant's October 8, 1998 cervical sprain injury.

By letter dated December 15, 2002, appellant, through her representative, requested an oral hearing. A hearing was held on August 13, 2003 at which appellant testified.

Appellant submitted additional evidence, which included a report dated December 16, 2002 Dr. Wanda McEntyre, a clinical psychologist, who noted that she was seen for pain complaints and was significantly depressed by testing. Dr. McEntyre noted that appellant was experiencing a significant amount of emotional distress related to her work injury and coping with her ongoing pain.

In a December 9, 2002 form report, Dr. Ball indicated that appellant's neck pain got worse with cold weather and he diagnosed neck and back sprain with chronic pain. On December 12, 2002 he noted that appellant's chronic pain was exacerbated by activity, and that some days she could work only four hours per day. He also recommended that appellant not work a changing shift. On December 19, 2002 Dr. Ball recommended that appellant work only four to six hours on the morning shift. Dr. Ball reiterated his opinions, diagnosed tight cervical and trapezius musculature and left shoulder sprain and recommended the interdisciplinary pain management program.

In a February 12, 2003 report, Dr. Gladstone C. McDowell, II, an anesthesiologist, examined appellant and diagnosed lumbar degenerative disc disease with facet arthropathy which was a significant component to her pain, fibromyalgia, mechanical neck pain, rule out cervical degenerative disc disease and morbid obesity. He discussed appellant's need for multidisciplinary pain management.

On April 2, 2003 Dr. Ball provided a medical narrative report on appellant in which he reviewed her history of injury after lifting a tub of mail, stated that she developed significant pain and stiffness, and noted that since that time she had not progressed in terms of duration of work or of physical limitations and capabilities. He noted that there was no documentation of progressive improvements, and he indicated that the cause of appellant's pain was multifactorial, as it could not be attributed to one specific cause. He stated that appellant's multiple musculoskeletal symptoms and diagnoses were part of her syndrome including a "concern about fibromyalgia and lumbar musculoskeletal disease." Dr. Ball noted that appellant's significant depression adversely affected and presented a barrier to her recovery, and he diagnosed depression and potentially fibromyalgia as complicating factors. He noted that he saw appellant monthly to monitor her OxyContin usage and he recommended a multidisciplinary pain management program to wean her off the OxyContin.

In an April 24, 2003 narrative report, Dr. Ball noted that appellant was experiencing increased pain which she related to a later work shift. Dr. Ball noted that appellant claimed that the late shift caused her to miss taking her medication and he recommended the morning shift. On a form report of that date Dr. Ball reiterated his earlier form reports dated April 14 and February 10, 2003. He continued to check "yes" to the question of employment relationship; he diagnosed "cervical left shoulder strain/sprain," and noted findings as "tight cervical/trapezius musculature." In an April 24, 2003 medical narrative, Dr. Ball opined that appellant should not start work at a later shift because it increased her pain as she was unable to take her pain medication. He recommended that she work a morning shift only. In an April 24, 2003 emergency room report, the treating physician diagnosed cephalgia, chronic neck pain and

sinusitis, and noted that appellant was discharged with antibiotics, to follow up with her private physician.

By decision dated October 21, 2003, the Office hearing representative affirmed the November 26, 2002 decision. The hearing representative found that none of the physicians who treated appellant provided a rationalized medical opinion supporting a causal relationship between the diagnosed fibromyalgia and her employment injury.

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence, including that any specific condition or disability for work for which she claims compensation is causally related to the employment injury.[3] Causal relationship is a medical question that can generally be resolved only by rationalized medical opinion evidence.[4]

Where appellant claims that a condition not accepted or approved by the Office was due to her employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury.[5] It is an accepted principle of workers' compensation law that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause attributable to the employee's own intentional conduct.[6]

ANALYSIS

In this case, appellant contends that she developed fibromyalgia as a result of her October 8, 1998 employment injury, which was accepted for cervical soft tissue muscle strain injury. In addition to the cervical muscular strain injury, appellant claimed that on October 8, 1998 she injured her shoulder and trapezius muscles, and her thoracic and upper lumbar spinal muscles. The contemporaneous medical evidence at that time, however, supported that appellant sustained only cervical muscular strain, which was the condition accepted by the Office.

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[2] 5 U.S.C. §§ 8101-8193.

[3] *Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[4] *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors must be based on a complete factual and medical background of the claimant. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, in order to be considered rationalized, the opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

[5] *Jacquelyn L. Oliver*, *supra* note 3.

[6] *Carlos A. Marrero*, 50 ECAB 117, 119-20 (1998); *Clement Jay After Buffalo*, 45 ECAB 707, 715 (1994).

In December 1998, Dr. Venesy opined that appellant did have a number of findings that were consistent with fibromyalgia, but she did not provide any opinion on causal relationship. Therefore, this report does not support appellant's claim that she sustained fibromyalgia as a result of her October 8, 1998 employment injury.

In December 1998, Dr. Kirk noted that appellant had cervical and upper back strain, noted that she had multiple trigger points and diagnosed fibromyalgia. However, he merely checked "yes" to the form question as to whether the condition found was caused or aggravated by an employment factor, without any medical explanation or rationale. Therefore, Dr. Kirk failed to provide any opinion as to the causal relationship of the diagnosis with the October 8, 1998 employment injury. Therefore, his report does not support appellant's claim.[7]

In March 1999, Dr. James Fulop, a Board-certified neurologist, diagnosed fibromyalgia, but he did not address causal relationship. Therefore, this report does not support causal relationship.

In December 2000, Dr. Kirk again opined that based on clinical findings appellant had fibromyalgia, and indicated again by checking "yes" to a form question regarding causal relationship, that he believed the condition found was caused or aggravated by appellant's employment. However, no further explanation was provided. Dr. Kirk noted that it was known that trauma could trigger an episode of fibromyalgia, but that, in this case, the condition was probably present prior to the trauma. This opinion therefore does not support causal relation with employment factors.

Appellant's treating physicians diagnosed fibromyalgia, or noted that appellant claimed to have fibromyalgia, but they did not provide sufficient medical rationale to support that this condition was causally related to her October 8, 1998 employment injury.

Dr. Kirk was found to have a conflict in medical opinion with Dr. Marvin Thomas, a Board-certified neurologist, and the case was referred to an impartial medical specialist for resolution. The referee physician, Dr. Shriber, opined after examination that there was insufficient medical evidence relating appellant's fibromyalgia to her accepted cervical strain injury, such that there was no explanation of how the cervical strain may have expanded into fibromyalgia as a natural consequence.

Thereafter, Dr. Stanos noted that, in addition to chronic pain syndrome with severe depression and affective distress, severe myofascial pain of the anterior chest, scapula, cervical, thoracic and lumbar spine, appellant stated that she had fibromyalgia, but he did not address causal relationship.

On 2001 and 2002 form reports, Drs. Ball and Kirk both checked "yes" to the form question regarding any causal relationship with appellant's employment, without any further

[7] When a physician's opinion on causal relationship consists only of checking "yes" to a form question about causation or aggravation, unaccompanied by medical explanation, that opinion has little probative value and is insufficient to establish a causal relationship. *Gary J. Watling*, 52 ECAB 278 (2001); *Ruth S. Johnson*, 46 ECAB 237 (1994); *William C. Thomas*, 45 ECAB 591 (1994).

explanation or rationale. They opined that appellant had chronic pain syndrome and "work-related fibromyalgia," but neither of them provided any rationalized medical explanation as to how this fibromyalgia was causally related to the October 8, 1998 employment injury. Therefore, these form reports are of diminished probative value and are insufficient to establish appellant's claim.[8]

Thereafter, the Office referred appellant to Dr. Rutherford for a second opinion on the issue of whether or not appellant had developed work-related fibromyalgia. Dr. Rutherford noted appellant's current complaints, reviewed her treatment modalities and her reactions to them, noted that her symptoms did not improve even with rest and physical therapy, aquatic therapy, work hardening, the use of a TENS unit, ultrasound, or massage therapy, and noted that her symptoms worsened rather than improved. In reviewing appellant's medical records, Dr. Rutherford indicated that appellant's history was significant for fibromyalgia, high blood pressure and obesity, and he noted that a negative EMG and nerve conduction study ruled out other pathologies.

Following a detailed review of appellant's factual and medical history and her presenting complaints, he conducted a complete physical examination of both appellant's musculature function and her neurological presentation. Dr. Rutherford discussed his findings upon examination, noted appellant's effective ambulation with a cane, measured her restricted ranges of motion of her back and neck, and noted the motor function of her lower extremities which was intact on manual muscle testing.

Regarding her upper body, Dr. Rutherford found that appellant had chest pain and headaches that began in her neck, which occurred almost daily, and had tenderness over both trapezius muscles, the posterior spinous process of C7 and the posterior neck. He measured appellant's range of neck, shoulder and upper extremity motion, and noted that motor function in appellant's upper extremities was intact on manual muscle testing, with sensorum intact, but noted that she had unexplained paresthesias in the first and second fingers of both hands. He established appellant's diagnosis by determining that she had 11 out of 18 trigger areas for fibromyalgia, which were tender, and he explained that this would qualify her as having a diagnosis of fibromyalgia. He concurred with the diagnosis of fibromyalgia, noted that she still had residuals from her October 8, 1998 injury, and noted that she had a limited range of cervical motion which could be accommodated by work restrictions.

Dr. Rutherford indicated that these limitations were related to her cervical strain injury, but noted that restrictions requiring sedentary activity, limited walking and limited standing and no stooping or bending were related to her low back strain and fibromyalgia.

In response to Office questioning, Dr. Rutherford explained that fibromyalgia was not related specifically to the October 8, 1998 injury, and noted that no probable causal connection had been made for the diagnosis of generalized fibromyalgia as a result of the October 8, 1998 injury. He therefore concluded that appellant's fibromyalgia was not work related, either as a

[8] *Id.*

direct result of the October 8, 1998 traumatic incidents or as a consequential condition to her accepted cervical strain injury.

As none of appellant's treating physicians provided any reports containing medical rationale for their conclusions regarding causal relation, they are insufficient to establish a causal relationship with her employment. Appellant has, therefore, failed to meet her burden of proof to establish her claim that she developed fibromyalgia, causally related to factors of her employment or to her employment-related muscle strain injury.

In contrast, as noted above, Dr. Rutherford provided a thorough and detailed medical report based upon physical examination and testing, and determined that no causal connection with appellant's employment had been made, and that, therefore, her fibromyalgia was not work related or not consequential to her accepted cervical strain condition. His report, therefore, constitutes the weight of the medical evidence of record and negates her causal relationship claim.[9]

CONCLUSION

Appellant failed to establish that her claimed fibromyalgia is causally related to her October 8, 1998 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the October 21, 2003 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 24, 2004
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

[9] *Anna C. Leanza*, 48 ECAB 115 (1996).