United States Department of Labor
Employees' Compensation Appeals Board

D.N., Appellant	)	
and	)	**Docket No. 09-67**
	)	**Issued: May 22, 2009**
DEPARTMENT OF VETERANS AFFAIRS, LOUIS B. STOKES MEDICAL CENTER, Brecksville, 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, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 9, 2008 appellant, through his representative, filed a timely appeal from the September 19, 2008 merit decision of the Office of Workers' Compensation Programs, which denied compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant's pulmonary condition is causally related to his occupational exposure to mold on March 7, 2006. Appellant argues that the Office's September 19, 2008 decision is "contrary to fact and law."

FACTUAL HISTORY

On the prior appeal of this case,[1] the Board found that appellant met his burden to establish that he experienced a specific event, incident or exposure occurring at the time, place

[1] Docket No. 07-921 (issued July 26, 2007).

and in the manner alleged.[2] The Board found, however, that the medical opinion evidence did not establish the critical element of causal relationship. Dr. Sridhar K. Iyer, a Board-certified internist specializing in pulmonary diseases, did not review the May 23, 2005 mold assessment and did not account for appellant's activity in the room or the duration of his exposure. Further, he did not explain how a lung biopsy suggested an allergic reaction possibly to mold-type exposure. The results of appellant's biopsies were not in the record, so it was unknown whether they supported Dr. Iyer's opinion. The Board emphasized that sound medical reasoning was particularly important where appellant had a history of pneumonia, where everyone at work appeared to have the flu at the time appellant began feeling ill and, where appellant was diagnosed with and aggressively treated for pneumonia. If that diagnosis was wrong, Dr. Iyer did not explain. The Board affirmed the Office decision denying appellant's claim for compensation. The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

On June 25, 2008 appellant, through his representative, requested reconsideration by the Office. He submitted medical records to support his claim. On June 12, 2006 Dr. Sudish C. Murthy, a consulting Board-certified thoracic surgeon, reported that appellant's fairly rapidly advancing interstitial lung disease was of unclear etiology.

On April 28, 2006 Dr. Iyer diagnosed bilateral infiltrate, etiology undetermined. On August 24, 2007 he described appellant's past medical history, including bibasilar pneumonia requiring open lung biopsy. Appellant was determined to have bronchiolitis obliterans. Dr. Iyer stated: "These respiratory events occurred after he was exposed to a place with a lot of mold in the workplace. It seems to have happened secondary to the mold."

On June 16, 2006 Dr. Thomas R. Gildea, a Board-certified specialist in pulmonary disease, noted that appellant was treated in March 2004 for a few months of dry cough, which resolved:

> "No further lung problems until [March] [20]06 when [appellant] went to VA hospital file room in the basement looking for vagrants (he is a detective). There was extensive mold on the walls and he had been in the room with a flashlight for about 15 minutes, before finding the mold. He left immediately.
>
> "About a week and a half later [appellant] developed flu[-]like symptoms and then a week later was short of breath with modest activities."

On October 11, 2006 Dr. Gildea stated: "It is clear that the acute exposure is the proximate source of [appellant's] disease …."

On February 9, 2007 Dr. Jeffrey T. Chapman, a specialist in pulmonary disease and an associate of Dr. Gildea, reported the same history of present illness. He noted no evidence of

[2] On May 17, 2006 appellant, then a 52-year-old criminal investigator, filed a claim alleging that he sustained an injury to his lungs on March 7, 2006 when he was exposed to mold or fungus in the performance of duty. He entered a records room and noticed what appeared to be mold on the files and other surfaces. Appellant remained in the room for about 15 minutes and the following week he was coughing and felt like he had the flu.

systemic disease or exposure other than the mold. Dr. Chapman stated, however: "I doubt the mold is playing a role here." On March 7, 2008 he reported:

> "The cause of [appellant's] organizing pneumonia is unclear. In most cases the cause is either unknown, related to a connective tissue disease, or related to a recent viral infection. Temporally [appellant] notes a relationship to an intense mold exposure which could also be the cause. Given he has no connective tissue disease and did not have an antecedent viral exposure, it is more likely than not that the mold exposure is the proximate cause."

On March 26, 2008 Dr. Alan E. Kravitz, Board-certified in cardiovascular disease, reported to appellant's representative that he had reviewed appellant's voluminous file. He stated that appellant had a bronchoscopy that showed allergic relation secondary to mold exposure, which was his only pulmonary problem. Additionally, Dr. Kravitz stated it was altogether likely that appellant's recurrent episodes of pneumonia were related to the mold damage to his lungs:

> "Mold is one of the causes of allergic bronchitis and obstructive airways disease. It is clear that [appellant] has had recurrent exposure and the physicians treating him discussed this allergic obstructive airways disease reversible by steroids. Accordingly, to a reasonable degree of medical certainty as stated below there is a causal relationship between pulmonary diseases described and various mold described, and it is far more likely than not in this case that the cause of his pulmonary disease is mold exposure."

Indeed, Dr. Kravitz stated that there was absolute medical certainty. He noted: "[Appellant] had no pulmonary problems prior to exposure and had problems after." Dr. Kravitz added that treatment, including steroids, was directed at complications from exposure to mold, whether allergic reaction, allergic bronchitis or obstructive airways disease.

In a decision dated September 19, 2008, the Office reviewed the merits of appellant's claim and denied modification of its prior decision. It found that appellant failed to submit a comprehensive, probative medical opinion based on an accurate history of injury and fully providing a well-rationalized medical explanation of whether and how the March 7, 2006 work exposure directly led to his lung condition.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[3] An employee seeking compensation under the Act has the burden of proof to establish the essential elements of his claim. When an employee claims that he sustained an injury in the performance of duty, he must submit sufficient evidence to establish that he experienced a specific event,

[3] 5 U.S.C. § 8102(a).

incident or exposure occurring at the time, place and in the manner alleged. He must also establish that such event, incident or exposure caused an injury.[4]

Causal relationship is a medical issue[5] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[6] must be one of reasonable medical certainty[7] and, must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[8]

ANALYSIS

In its July 26, 2007 decision, the Board explained what was missing from the medical evidence submitted. The Board noted no review of the May 23, 2005 mold assessment, which was the best evidence of the nature of appellant's exposure. The Board noted no account of appellant's activity in the room or the duration of his exposure. Further, the Board noted no explanation of how a lung biopsy suggested an allergic reaction possibly to mold-type exposure. The Board emphasized that sound medical reasoning was particularly important where appellant had a history of pneumonia, where everyone at work appeared to have the flu at the time appellant began feeling ill and where he was diagnosed with and aggressively treated for pneumonia.

After the Board's decision, appellant, through his representative, submitted over 700 pages of medical documents to the case record. These documents were unresponsive to the Board's decision.

Dr. Murthy, the consulting Board-certified thoracic surgeon, reported that appellant's lung disease was of unclear etiology. That does not help appellant's case. Dr. Iyer, a Board-certified internist specializing in pulmonary diseases, also reported that appellant's condition was of undetermined etiology. On August 24, 2007 after noting that appellant's respiratory events occurred after exposure to a lot of mold in the workplace, Dr. Iyer stated that these events seemed to have happened secondary to the mold exposure. But a mere temporal relationship is not enough to establish cause.[9] Dr. Iyer failed to explain how appellant's specific exposure on

[4] *See Walter D. Morehead*, 31 ECAB 188, 194 (1979) (occupational disease or illness); *Max Haber*, 19 ECAB 243, 247 (1967) (traumatic injury). *See generally John J. Carlone*, 41 ECAB 354 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] *Mary J. Briggs*, 37 ECAB 578 (1986).

[6] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[7] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[8] *See William E. Enright*, 31 ECAB 426, 430 (1980).

[9] *Thomas D. Petrylak*, 39 ECAB 276 (1987).

March 7, 2006 caused his subsequently diagnosed pulmonary condition. He stated only that it seemed to have happened secondary to the mold. Such uncertain and unrationalized opinions carry little weight.

Dr. Gildea, a Board-certified specialist in pulmonary disease, briefly described appellant's exposure and on October 11, 2006 he stated: "It is clear that the acute exposure is the proximate source of [appellant's] disease …." He offered no medical rationale. Dr. Gildea did not explain what evidence made the causal connection clear.

Dr. Jeffrey T. Chapman, a specialist in pulmonary disease and an associate of Dr. Gildea, did not think the causal connection was clear. On February 9, 2007 he stated: "I doubt the mold is playing a role here." The following month appellant became equivocal. Dr. Chapman reported that the cause of appellant's organizing pneumonia was unclear, but given no connective tissue disease and no antecedent viral exposure, it was more likely than not that the mold exposure was the proximate cause. Although the medical 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 opinion be speculative or equivocal.[10] Dr. Chapman appears to be providing two different opinions, first that the cause remains unclear, second that the cause is more likely than not appellant's mold exposure. The lack of internal consistency diminishes the value of his opinion. However, it is not clear whether his history of no antecedent viral exposure is accurate. Appellant reported that everyone at work appeared to have the flu at the time he began feeling ill.

The only medical opinion evidence developed after the Board's July 26, 2007 decision is the March 26, 2008 report from Dr. Kravitz, a cardiologist, who does not specialize in pulmonary diseases, so his opinion on the cause of appellant's bronchiolitis obliterans with organizing pneumonia, or BOOP, is not persuasive. Dr. Kravitz alleged, without explanation, that a bronchoscopy showed an allergic reaction secondary to mold exposure. He alleged, without supporting factual evidence, that appellant had recurrent exposure. The only issue is whether appellant's 15 minutes in a records room on March 7, 2006 caused an injury to his lungs. Dr. Kravitz pointed to a temporal relationship between appellant's exposure and his subsequent lung problems, but causal relationship requires much more than a sequence of events. It requires a soundly reasoned medical explanation. Dr. Kravitz stated that appellant's treatment was directed at complications from exposure to mold, but he did not explain.

The Board finds that the certainty and unequivocal character of Dr. Kravitz's opinion is not enough to overcome his lack of expertise, the lack of convincing medical reasoning and his inaccurate history of recurrent exposure.

The Board reiterates what it stated on the last appeal. Sound medical reasoning is particularly important where appellant had a history of pneumonia, where everyone at work appeared to have the flu at the time appellant began feeling ill and where appellant was diagnosed with and aggressively treated for pneumonia. To discharge his burden of proof, appellant must submit a medical opinion from a specialist in pulmonary diseases addressing these matters. The specialist must review the May 23, 2005 mold assessment in Room H27 and

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

must account for appellant's activity in the room and the duration of his exposure. The specialist must soundly explain, with medical reasoning sufficient to convince a lay adjudicator, that appellant's 15 minutes in Room H27 on May 7, 2006 caused an injury to his lungs. He must explain the nature of that injury and must cite the factual and medical evidence that logically supports causal relationship. Without this evidence, appellant has not met his burden of proof. The Board will therefore affirm the Office's September 19, 2008 decision denying his claim for benefits.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that his diagnosed pulmonary condition is causally related to his occupational exposure to mold on March 7, 2006. The medical opinion evidence does not establish causal relationship.

ORDER

IT IS HEREBY ORDERED THAT the September 19, 2008 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 22, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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