

FACTUAL HISTORY

This case has previously been before the Board. In a decision dated September 25, 2009, the Board affirmed an OWCP hearing representative's August 14, 2008 decision, that denied appellant's claim of vocal chord dysfunction, shortness of breath, allergic rhinitis/hay fever, persistent cough, reactive dysfunction syndrome, sleep apnea with hypersomnia and gastroesophageal reflux disease.² The Board also affirmed an October 15, 2008 OWCP decision denying authorization of a polysomnography test. In a decision of August 11, 2010, the Board reversed a May 20, 2009 hearing representative's decision terminating appellant's medical benefits. The Board found that OWCP failed to establish that she had no residuals of her accepted dysphagia and chronic pharyngitis. The history of the case as provided in the Board's prior decisions is incorporated by reference.³

On September 20, 2010 appellant requested reconsideration of OWCP's denial to expand her claim and requested acceptance of consequential injuries of stress and depression. She submitted a January 18, 2000 copy of a material safety data sheet.

Appellant submitted a June 8, 2009 report by Dr. Michael A. Spandorfer, Board-certified in pulmonary medicine, internal medicine and critical care medicine, who provided physical findings which revealed moderate restriction and reported a history of employment-induced asthma/reactive airway dysfunction syndrome. The diagnoses included occupationally-induced reactive airway dysfunction syndrome/asthma with acute exacerbation, occupationally-induced allergic rhinitis, gastroesophageal reflux disease, lower extremity edema, high blood pressure and obstructive sleep apnea.

In an October 9, 2009 report, Dr. John T. Ramey, a Board-certified allergist and internist, noted that he had treated appellant for occupationally-induced asthma and related symptoms of cough and shortness of breath since May 23, 2006. He attributed these conditions to exposure to paint fumes at work on January 5, 2004, February and December 2005. Dr. Ramey concluded that appellant's exposure to the paint fumes more likely than not was the cause of her occupationally-induced asthma.

On November 13, 2009 Dr. Ramey diagnosed vocal cord dysfunction, reactive airways dysfunction syndrome and gastroesophageal reflux disease. He concluded that appellant was totally disabled due to these conditions.

² Docket Nos. 08-2377 & 09-196 (issued September 25, 2009).

³ On December 1, 2005 appellant, then a 47-year-old computer technician, filed a traumatic injury claim alleging that on that date she had an allergic reaction to smelling paint fumes. OWCP accepted the claim for dysphagia and chronic pharyngitis, which was subsequently expanded to include chronic obstructive asthma. Appellant stopped work on December 1, 2005 and was placed on the periodic rolls for temporary total disability. On December 31, 2007 OWCP combined claim numbers xxxxxx657 and xxxxxx168 with claim number xxxxxx122, the claim number currently on appeal. Under claim number xxxxxx657 appellant alleged that on July 14, 2004 she had an allergic reaction to smelling paint fumes. She, under claim number xxxxxx168, alleged that on February 28, 2005 she had an allergic reaction to smelling paint fumes. In a November 21, 2007 memorandum, OWCP noted that claim numbers xxxxxx657 and xxxxxx168 had been administratively closed with no accepted condition.

In a March 23, 2010 report, Dr. Spandorfer provided physical findings and reported a history of employment-induced asthma/reactive airway dysfunction syndrome. A spirometry test revealed moderate restrictive impairment.

Appellant submitted reports from Dr. Lucinda Halstead, a treating Board-certified otolaryngologist, dated May 21, 2006 through October 1, 2009. Dr. Halstead listed physical findings and the treatment provided for appellant's voice problems. She diagnosed laryngospasm, cough, voice problems, allergies, gastroesophageal reflux disease, hoarseness and right true vocal fold varix. In a September 21, 2006 report, Dr. Halstead related that appellant has had problems with reactive airway disease, asthma, shortness of breath, hoarseness and chest tightness since her December 1, 2005 exposure to paint.

In reports dated May 26, August 16 and October 7, 2010, Dr. Spandorfer noted physical findings and reported a history of employment induced asthma/reactive airway dysfunction syndrome. A review of a spirometry test in the May 26, 2010 report revealed severe restriction. In August 16 and October 7, 2010 reports, Dr. Spandorfer related that review of a spirometry test revealed severe restriction with possible deterioration seen when compared to the prior test. He diagnosed occupationally-induced reactive airway dysfunction syndrome/asthma with acute exacerbation, allergic rhinitis, gastroesophageal reflux disease and obstructive sleep apnea.

In a September 23, 2010 letter, Brian Otero, a physician specialty accounts coordinator, requested that the diagnoses of achalasia and cariospasm, cough, unspecified asthma with acute exacerbation and asthma be accepted. He related that Dr. Spandorfer provided treatment for these conditions which were a direct result of appellant's employment injury.

On December 13, 2010 OWCP received a June 17, 2010 report from Dr. Spandorfer, who found that appellant was totally disabled and developed additional conditions. Dr. Spandorfer attributed her significant cough, shortness of breath, dysphonia, sinusitis, dysphagia and severe lung restriction to her paint exposure.

On December 20, 2010 OWCP received reports dated October 28 and November 29, 2010 report from Dr. Spandorfer, who reviewed a spirometry test which revealed moderate restriction and that the study was limited as a result of appellant's effort and reproducibility. A review of a spirometry test on November 9, 2010 revealed severe restrictive impairment, which was limited as a result of her effort and reproducibility. Dr. Spandorfer diagnosed occupationally-induced asthma and reactive airway dysfunction syndrome with acute exacerbation, allergic rhinitis, hoarseness, thrush, gastroesophageal reflux disease and obstructive sleep apnea.

By decision dated December 22, 2010, OWCP denied modification of the prior decisions.⁴ It found that the medical evidence contained insufficient rationale to establish the causal relationship between appellant's vocal chord dysfunction, shortness of breath, allergic

⁴ The Board notes that, following the December 22, 2010 decision, OWCP received additional evidence. However, the Board may only review evidence that was in the record at the time OWCP issued its final decision. See 20 C.F.R. §§ 501.2(c)(1); *M.B.*, Docket No. 09-176 (issued September 23, 2009); *J.T.*, 59 ECAB 293 (2008); *G.G.*, 58 ECAB 389 (2007); *Donald R. Gervasi*, 57 ECAB 281 (2005); *Rosemary A. Kayes*, 54 ECAB 373 (2003).

rhinitis/hay fever, persistent cough, reactive dysfunction syndrome, sleep apnea with hypersomnia and gastroesophageal reflux disease and her accepted employment injury.⁵

LEGAL PRECEDENT

Where an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury.⁶ To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting such a casual relationship.⁷ Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.⁸ Rationalized medical evidence is evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁹ 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.¹⁰

ANALYSIS

OWCP accepted that appellant's employment caused the conditions of dysphagia and chronic pharyngitis, which was subsequently expanded to include chronic obstructive asthma. It denied her request to expand her claim to include the conditions of achalasia and cariospasm, cough, unspecified asthma with acute exacerbation and Asthma NOS. The issue is whether appellant has met her burden of proof to establish that those conditions were causally related to her accepted injury. The Board finds that she has not met her burden of proof.

In support of her request to expand her claim to include additional conditions, appellant submitted reports from Drs. Halstead, Spandorfer and Ramey. In his June 8, 2009 report, Dr. Spandorfer reported diagnoses of occupationally-induced reactive airway dysfunction syndrome/asthma with acute exacerbation, occupationally-induced allergic rhinitis, gastroesophageal reflux disease, lower extremity edema, high blood pressure and obstructive sleep apnea. In subsequent reports, he provided physical findings, spirometry test findings and diagnoses of employment-related asthma and reactive airways dysfunction syndrome. On June 17, 2010 Dr. Spandorfer attributed shortness of breath, sinusitis, dysphagia, significant cough and severe lung exposure to appellant's paint exposure. However, he offered no medical

⁵ *Id.*

⁶ See *Jaja K. Asaramo*, 55 ECAB 200 (2004).

⁷ See *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

⁸ See *D.E.*, 58 ECAB 448 (2007); *Mary J. Summers*, 55 ECAB 730 (2004).

⁹ See *Phillip L. Barnes* 55 ECAB 426 (2004); *Leslie C. Moore*, 52 ECAB 132 (2000).

¹⁰ See *V.W.*, 58 ECAB 428 (2007); *Ernest St. Pierre*, 51 ECAB 623 (2000).

reasoning in support of his stated conclusion. Dr. Spandorfer merely offered a conclusion that appellant's conditions were due to her pain exposure with no supporting rationale or explanation. A mere conclusion without the necessary medical rationale explaining how and why Dr. Spandorfer believes that her accepted chemical exposure could result in a diagnosed condition is not sufficient to meet her burden of proof.¹¹ The medical evidence must also include rationale explaining how he reached the conclusion he or appellant is supporting. Dr. Spandorfer did not provide such an explanation. Due to the foregoing deficiencies these reports are insufficient to establish appellant's claim.

In an October 9, 2009 report, Dr. Ramey, a treating Board-certified allergist and internist, attributed appellant's occupationally-induced asthma and related symptoms of cough and shortness of breath to exposure to paint fumes at work on January 5, 2004, February and December 2005. In support of this conclusion, he stated that this exposure more likely than not was the cause of her occupational-induced asthma. The Board finds that this report is speculative or equivocal as Dr. Ramey concludes that appellant's condition is more likely than not to be due to her pain exposure. In order to be of probative value, medical opinions should be expressed in terms of a reasonable degree of medical certainty.¹² Furthermore, the Board has held that medical opinions which are speculative or equivocal are of diminished probative value.¹³ Dr. Ramey did not explain how the inhalation of paint fumes at work resulted in additional respiratory problems. For these reasons, the report is insufficient to meet appellant's burden to establish that additional conditions were caused by her employment-related paint exposure. Similarly, Dr. Ramey's November 13, 2009 report is also insufficient to support her request to expand her claim to include additional conditions. While he provided diagnoses of vocal cord dysfunction, reactive airways dysfunction syndrome and gastroesophageal reflux disease, he offered no opinion as to the cause of these conditions. Medical evidence offering no opinion as to the cause of an employee's condition is of limited probative value on the issue of causal relationship.¹⁴ Thus, this report is also insufficient to support appellant's burden to expand her claim to include additional conditions.

Appellant also submitted reports from Dr. Halstead for the period May 1, 2006 through October 1, 2009, in which she noted treatment for appellant's voice problems and physical findings. She diagnosed laryngospasm, cough, voice problems, allergies, gastroesophageal reflux disease, hoarseness and right true vocal fold varix. On September 21, 2006 Dr. Halstead stated that appellant's reactive airway disease, asthma, shortness of breath, hoarseness and chest tightness had been present since her paint exposure on December 1, 2005. She offered no

¹¹ See *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Albert C. Brown*, 52 ECAB 152 (2000) (a medical conclusion unsupported by medical rationale is of diminished probative value).

¹² See *Roy L. Humphrey*, 57 ECAB 238 (2005) (to be probative, the medical opinion must be of reasonable medical certainty and supported by medical rationale).

¹³ See *S.E.*, Docket No. 08-2214 (issued May 6, 2009) (The Board has generally held that opinions such as the condition is "probably" related, "most likely" related or "could be" related are speculative and diminish the probative value of the medical opinion); *Cecelia M. Corley*, 56 ECAB 662 Docket No. 05-324 (issued August 16, 2005) (medical opinions which are speculative or equivocal are of diminished probative value).

¹⁴ See *S.E., id.; J.M.*, 58 ECAB 303 (2007); *Ellen L. Noble*, 55 ECAB 530 (2004).

opinion explaining why appellant's condition was caused by her paint exposure other than noting that the conditions occurred following her paint exposure on December 1, 2005. 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 that the conditions are due to her paint exposure.¹⁵ As noted above, in order to support her claim appellant must submit a physician's report, in which Dr. Halstead reviews the employment factors identified by appellant as causing her condition and, taking these factors into consideration as well as findings upon examination and the medical history, state whether the employment injury caused or aggravated the diagnosed conditions and present medical rationale in support of the opinion.¹⁶ None of the reports submitted by Dr. Halstead contain any medical rationale supporting the conclusion that the conditions she diagnosed were caused by appellant's paint exposure at work. Thus, her reports are insufficient to support an expansion of appellant's claim to include additional conditions.

Appellant also submitted a letter from Mr. Otero, a physician specialty accounts coordinator, who requested OWCP expand her claim to include the conditions of diagnoses of achalasia and cariospasm, cough, unspecified asthma with acute exacerbation and Asthma NOS. As a lay person, Mr. Otero does not qualify as a physician under FECA. Therefore, his opinion has no probative value.¹⁷

Appellant 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.

CONCLUSION

The Board finds that appellant failed to meet her burden of proof to expand her claim to include additional conditions.

¹⁵ See *Phillip L. Barnes*, 55 ECAB 426 (2004).

¹⁶ See *Robert Broome*, 55 ECAB 339 (2004).

¹⁷ 5 U.S.C. § 8101(2); see also *Desiderio Martinez*, 55 ECAB 245 (2004); *Robert G. Morris*, 48 ECAB 238 (1996); *James A. Long*, 40 ECAB 538 (1989).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated December 22, 2010 is affirmed.

Issued: November 22, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board