

**United States Department of Labor
Employees' Compensation Appeals Board**

A.C., Appellant)

and)

**DEPARTMENT OF HEALTH & HUMAN)
SERVICES, SOCIAL SECURITY)
ADMINISTRATION, Ironton, OH, Employer)**

**Docket No. 11-1502
Issued: February 7, 2012**

Appearances:
Rick W. Hanna, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 10, 2011 appellant filed a timely appeal from a December 28, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied her occupational disease claim and a February 24, 2011 decision, which denied her request for an oral hearing as untimely. Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish that her medical conditions were causally related to mold exposure at work; and (2) whether OWCP properly denied appellant's request for an oral hearing as untimely filed.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 16, 2010 appellant, then a 39-year-old social security insurance specialist, filed an occupational disease claim alleging that she suffered from repeated colds, respiratory and sinus infections, wheezing, headaches, severe fatigue, weight loss, severe bleeding that led to a hysterectomy, drowsiness, loss of hair, skin irritation, chest pain, numbness of extremities and a seizure as a result of exposure to mold at her workplace. She became aware of her conditions on June 15, 2000 and realized her conditions were caused or aggravated by her employment on July 30, 2010.

Appellant stated that she suffered from various illnesses for many years and she attributed that to the fact that she worked and lived around many people. She explained that even though she took many precautions such as washing her hands, wiping her desk with Clorox wipes and using hand sanitizer she suffered from continual sinus and respiratory infections, chronic fatigue, shortness of breath, continual headaches, muscle and joint aches, numbness and tingling of extremities, loss of balance and coordination, memory problems, chronic cough, wheezing and itchy watery eyes. In October 2005, appellant was hospitalized for a few days after suffering a seizure, the first seizure she had ever had. In February 2010, she was admitted to the hospital for chest pain and low blood pressure. In May 2010, appellant had a hysterectomy and was off work due to surgery from May to July 2010. While away from the office for a few weeks she noticed a difference in the way she felt but when she returned to work, her respiratory and sinus infections started all over again. In July 2010, a union representative informed them that allergen testing revealed *Stachybotrys* mold on the walls throughout the office. Appellant had worked in her office since October 1999 for eight and half hours a day, five days a weeks.

In an undated letter, Bette L. Backus, appellant's supervisor, explained that their agency moved into the current building on November 11, 1998 and experienced various problems with the heating, ventilation and air conditioning (HVAC) system and window installation. Around June 2009, mold was found on the exterior facing walls, but tests revealed that the mold was not in sufficient quantities to present health hazards. September 2009 tests revealed mold inside the exterior walls on both the south and west side of the building. It was recommended that the walls be torn down and reconstructed. The landlord did not submit a plan for correction but sent a contractor to talk with Ms. Backus. The contractor told Ms. Backus that he refused to work for the landlord when he saw the extent of the mold. He noted black streaks down the side of the building in several spots that corresponded to the peeling wallpaper inside and had green moss growing on them. Ms. Backus stated that the action taken to contain the mold was the best course of action in the situation, considering all the alternatives and that air testing revealed that mold spores were not present in the HVAC system. Appellant explained that she also had a recurring cough and a rash on her face, but there was no evidence that it was due to the mold.

Appellant submitted a September 25, 2009 mold analysis report which found suspected mold behind the wallpaper at the bottom corners of most of the windows in the south portion of the office, at least one window in the break room, at a wallpaper seam on the south perimeter wall and at a seam on the west perimeter wall. Additional investigation was recommended to determine the extent of mold growth behind wallpaper and within the wall cavities. Carbon dioxide levels did not exceed the American Society of Heating Refrigerating and

Air-conditioning Engineers guideline levels. It was noted that a number of employees had health-related complaints including frequent headaches, sneezing, coughing and sinus infections.

In an October 8, 2010 letter, OWCP advised appellant that the evidence submitted was insufficient to support her claim and requested additional medical evidence to establish that her medical conditions resulted from exposure to mold at work.

Appellant submitted various hospital treatment records, progress notes and diagnostic reports regarding her hospital visit from October 2 to 5, 2005. In an October 2, 2005 report, Dr. Henry C. Goodman, a Board-certified neurologist, examined her for her onset of seizures. He noted that appellant's maternal aunts, uncles and daughter had seizures and that she had a history of fibromyalgia and scoliosis. Dr. Goodman opined that the onset of seizures was "more than likely familial in origin," but the causes still needed to be determined.

In an October 2, 2005 computerized tomography (CT) scan of the head, Dr. Aram Salem, a Board-certified diagnostic radiologist, noted appellant's history of seizures. He did not observe any intracranial hemorrhage, mass effect, midline shift or calvarial lesions and noted that her ventricles were within normal limits.

In an October 3, 2005 magnetic resonance imaging (MRI) scan report, Dr. Daniel L. Hall, a Board-certified gynecologist, noted that appellant underwent a seizure and that coronal thin section images through the temporal lobes showed definite temporal lobe signal abnormality. There were no definite areas of focal restricted diffusion or other definite abnormalities.

In a November 1, 2005 follow-up report, Dr. Goodman examined appellant for the new onset of generalized seizures. He noted that she had familial inherited generalized seizures but was stable.

Appellant provided various diagnostic reports dated from January 6, 2006 to September 16, 2009, which did not reveal any significant abnormalities. She also provided an October 7, 2009 operative report for an endometrial ablation and an October 19, 2009 operative report for coccygeal nerve block, intraspinal myelography and neurography.

In a February 3, 2010 examination report, Dr. Angela Lewis, a Board-certified family practitioner, noted appellant's complaints of chest pain when she drank. She stated that appellant was a heavy smoker, appeared very frail and seemed to have an exaggerated level of pain throughout her body. Upon examination Dr. Lewis observed scattered wheezing bilaterally because she was a heavy smoker and some chronic obstructive pulmonary disease. Appellant's chest wall was tender to palpation and there were no cyanosis, clubbing or edema in her extremities. Dr. Lewis noted that appellant's laboratory and diagnostic data were all within normal limits. She diagnosed chest pain, nicotine dependency and hypokalemia.

In a February 3, 2010 discharge summary, Dr. Lewis stated that appellant was admitted in the emergency room for complaints of chest pain. The examination revealed that the pain was not cardiac related. Dr. Lewis encouraged her to quit smoking and to schedule a follow-up examination with her primary care physician.

In a February 3, 2010 chest examination, Dr. Steven Woolley, a Board-certified diagnostic radiologist, noted appellant's complaints of chest pain. The examination revealed perihilar bronchiolitis and interstitial pneumonitis, but the findings were mild. Dr. Woolley diagnosed a mild bronchitis pattern.

In an April 9, 2010 ultrasound report, Dr. Woolley noted that appellant had an abnormal CT scan of the abdomen and pelvis in March 25, 2010. He observed a left kidney stone measuring approximately 4.7 millimeters present with no hydronephrosis. Dr. Woolley recommended a post contrast CT scan of the abdomen to assess the area better. Appellant's right kidney was unremarkable and the left kidney was within normal limits. Dr. Woolley noted that the findings were most consistent with a small cortical cyst and left renal stone.

Appellant provided additional hospital records from May 25, 2010 regarding her hysterectomy, including a May 27, 2010 operative report.

In an April 7, 2010 ultrasound report, Dr. Woolley observed findings consistent with a small cortical cyst and a left renal stone.

In a November 8, 2010 report, Dr. Lesley P. Abbott, a doctor of osteopathic medicine, noted that appellant had recurrent episodes of allergic rhinitis and acute sinusitis which "could be caused from the exposure of black mold."

Appellant submitted an internet article which explained the various symptoms indicating black mold exposure.

In an undated statement, appellant explained that for several years she experienced constant headaches, sinus infections, fatigue, nasal congestion, irritable bowel syndrome, nose and throat irritation and eye irritation with burning and redness. She took several medications, underwent allergy testing and received shots for over two years without any success. Appellant noted that she had a CT scan for her headaches, but her physician could not find a reason for them. When she was on vacation or had a three-day weekend, she noticed a significant difference in the way she felt. However, after returning to the office appellant started sneezing, rubbing her eyes and getting a headache within an hour. She stated that her symptoms worsened throughout the day and that her coworkers also complained of the same symptoms. Appellant noted that she did not inform her physicians of the recent mold problem because it was just realized, but she planned on having follow-up appointments to address the issue.

In a decision dated December 28, 2010, OWCP denied appellant's occupational disease claim finding that the medical evidence failed to establish that her medical conditions were causally related to exposure to black mold at work.

On January 28, 2011 appellant, through her representative, requested an oral hearing. She alleged that the evidence indicated that she experienced an ongoing pattern of sinus problems, breathing problems, swallowing issues, fatigue, skin irritations, nausea, recurring colds and flu and that the medical information submitted revealed that this "could be related" to the mold in the building.

By decision dated February 24, 2011, OWCP denied appellant's request for an oral hearing as untimely filed. It found that her request for an oral hearing was postmarked on January 28, 2011, which was not within the 30-day time limitation. OWCP exercised its discretion and determined that the issue in appellant's case could equally well be addressed by requesting reconsideration from the district OWCP and submitting evidence not previously considered.

LEGAL PRECEDENT -- ISSUE 1

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of her claim by the weight of the reliable, probative and substantial evidence² including that she sustained an injury in the performance of duty and that any specific condition or disability for work for which she claims compensation is causally related to that employment injury.³ In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.⁴

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.⁵ Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the specified employment factors or incident.⁶ The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.⁷ The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and

² *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

³ *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *M.M.*, Docket No. 08-1510 (issued November 25, 2010).

⁴ *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000); *D.U.*, Docket No. 10-144 (issued July 27, 2010).

⁵ *D.I.*, 59 ECAB 158 (2007); *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

⁶ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁷ *Solomon Polen*, 51 ECAB 341 (2000); *B.B.*, 59 ECAB 234 (2007); *D.S.*, Docket No. 09-860 (issued November 2, 2009).

accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.⁸

ANALYSIS -- ISSUE 1

Appellant alleged that she suffered from various medical conditions such as sinus infections, repeated colds, headaches, weight loss, chest pain and skin irritation as a result of exposure to black mold at her workplace. OWCP accepted that she was exposed to mold at her workplace but denied her claim finding insufficient evidence to establish causal relationship between her multiple medical conditions and her mold exposure at work. The Board finds that appellant has failed to meet her burden of proof to establish that she developed an occupational disease in the performance of duty.

Appellant provided a November 8, 2010 report by Dr. Abbott who stated that her recurrent episodes of allergic rhinitis and acute sinusitis “could be caused” from the exposure of black mold. Dr. Abbott’s opinion that her medical conditions “could be caused” by black mold are speculative in nature. The Board has held that medical opinions that are speculative or equivocal in character are of diminished probative value.⁹ Dr. Abbott did not provide a rationalized medical explanation as to why physiologically appellant’s mold exposure would have caused any medical condition. An award of compensation may not be based on surmise, conjecture, speculation or upon her own belief that there is a causal relationship between her claimed condition and her employment.¹⁰ Thus, Dr. Abbott’s report is insufficient to meet appellant’s burden of proof.

Appellant also provided medical reports by Dr. Goodman and Dr. Lewis. In an October 2, 2005 report, Dr. Goodman examined her for her onset of seizures and opined that the seizures were “more than likely familial in origin.” He attributed appellant’s seizures to her familial history and fails to mention the exposure to mold at work or any other employment factors. Similarly, in Dr. Lewis’ February 3, 2010 report, she diagnosed chest pain, nicotine dependence and hypokalemia and indicated that appellant’s chest pain was because she was a heavy smoker. Both Dr. Goodman and Dr. Lewis fail to explain how appellant’s medical conditions resulted from exposure to black mold at her workplace and instead attribute them to other factors. These reports also fail to establish causal relationship.

Appellant submitted numerous diagnostic reports, such as CT scans and MRI scan reports by Drs. Salem, Hall, and Woolley and hospital treatment records. While these reports noted her various medical conditions, they did not address the cause of these conditions or provide a rationalized medical opinion explaining how factors of her employment, such as exposure to mold, caused or aggravated her medical conditions. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee’s condition is of limited

⁸ *Patricia J. Bolleter*, 40 ECAB 373 (1988).

⁹ *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley*, 55 ECAB 206 (2004).

¹⁰ *Robert A. Boyle*, 54 ECAB 381 (2003); *Patricia J. Glenn*, 53 ECAB 159 (2001).

probative value on the issue of causal relationship.¹¹ Because these reports fail to explain how exposure to black mold caused or aggravated appellant's conditions, they are insufficient to support her claim.

On appeal, appellant relates that she suffered respiratory problems, continuing sinus problems, breathing problems and various other health conditions as a result of continued and prolonged exposure to a large amount of mold at her workplace. She contends that because multiple air quality reports verified the continuing high levels of mold at her workplace, her symptoms subsided when she was away from work and she had no other exposures that would cause these problems the Board should find that exposure to mold caused or aggravated her conditions. Causal relationship, however, is a medical question that can generally be resolved only by rationalized medical opinion evidence.¹² Appellant's assertions do not constitute medical evidence as she is a lay person and is not competent to render medical opinion.¹³ The Board finds that the medical evidence submitted failed to establish that she sustained an injury causally related to her employment.

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.

LEGAL PRECEDENT -- ISSUE 2

Section 8124(b)(1) of FECA provides that a claimant for compensation who is not satisfied with a decision of the Secretary is entitled, on request made within 30 days after the date of the issuance of the decision and before review under section 8128(a), to a hearing on her claim before a representative of the Secretary.¹⁴

OWCP regulations further provide that a claimant can choose between two types of hearings: an oral hearing or a review of the written record.¹⁵ The hearing request must be sent within 30 days (as determined by postmark or other carrier's date marking) of the date of the decision for which a hearing is sought.¹⁶ The Board has held that section 8124(b)(1) is unequivocal in setting forth the time limitation for requesting hearings or reviews of the written record.¹⁷ A claimant is entitled to a hearing or review of the written record as a matter of right only if the request is filed within the requisite 30 days and before the claimant has requested

¹¹ See *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009); see also *A.C.*, Docket No. 11-549 (issued December 14, 2011).

¹² *Steven S. Saleh*, 55 ECAB 169 (2003); *Robert G. Morris*, 48 ECAB 238 (1996).

¹³ *James A. Long*, 40 ECAB 538, 542 (1989).

¹⁴ 5 U.S.C. § 8124(b)(1).

¹⁵ 20 C.F.R. § 10.615.

¹⁶ *Id.* at § 10.616(a).

¹⁷ *Claudio Vazquez*, 52 ECAB 496, 499 (2001).

reconsideration.¹⁸ However, if the request is not timely filed or when reconsideration has previously been requested, OWCP must exercise its discretion to grant or deny a request that is made after this 30-day period.¹⁹ In such a case, it will determine whether to grant a discretionary hearing and, if not, will so advise the claimant with reasons.²⁰

ANALYSIS -- ISSUE 2

OWCP denied appellant's occupational disease claim on December 28, 2010. Appellant's request for an oral hearing before OWCP's hearing representative was postmarked on January 28, 2011. The date of her hearing request is determined by the date of the postmark.²¹ As appellant's January 28, 2011 hearing request was made more than 30 days after the date of OWCP's December 28, 2010 decision, she was not entitled to a hearing as a matter of right.

OWCP, however, has the discretionary authority to grant a hearing if the request was not timely filed. In its February 24, 2011 decision, it considered the issue involved and properly exercised its discretion when it denied appellant's hearing request and determined that she could equally well address the issue of causal relationship by requesting reconsideration and submitting new evidence. The Board has held that the only limitation on OWCP's authority is reasonableness. Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable deduction from established facts.²² In the present case, OWCP did not abuse its discretion in denying a discretionary hearing and properly denied appellant's request for an oral hearing under section 8124 of FECA.²³

CONCLUSION

The Board finds that appellant failed to meet her burden of proof to establish that she developed her medical conditions in the performance of duty as a result of her employment. The Board also finds that OWCP properly denied her request for an oral hearing as untimely.

¹⁸ *Martha A. McConnell*, 50 ECAB 129, 130 (1998).

¹⁹ *G.W.*, Docket No. 10-782 (issued April 23, 2010). See also *Herbert C. Holley*, 33 ECAB 140 (1981).

²⁰ *Id.* See also *Rudolph Bermann*, 26 ECAB 354 (1975).

²¹ 20 C.F.R. § 10.616(a); *N.M.*, 59 ECAB 511 (2008).

²² *Teresa M. Valle*, 57 ECAB 542 (2006); *Daniel J. Perea*, 42 ECAB 214 (1990).

²³ See *Hubert Jones, Jr.*, 57 ECAB 467 (2006); *D.F.*, Docket No. 11-42 (issued August 1, 2011).

ORDER

IT IS HEREBY ORDERED THAT the February 24, 2011 and December 28, 2010 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: February 7, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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