



## **FACTUAL HISTORY**

This case has previously been before the Board. By decision dated October 4, 2012, and pursuant to a request by the Director of OWCP, the Board remanded appellant's occupational disease claim for OWCP to further address the allegation regarding poor air quality in the workplace.<sup>3</sup> The facts of that decision are incorporated herein and the relevant facts are set forth below.

On July 7, 2011 appellant, then a 57-year-old program analyst, filed an occupational disease claim (Form CA-2) alleging that she sustained asthma attacks and chronic respiratory problems due to exposure to naphthalene. She explained that a coworker was using mothballs in her home and exposed her to the chemical at work. Appellant first became aware of her condition on January 1, 2000 and realized it resulted from her employment on June 28, 2011. She stopped work on August 10, 2011. The employing establishment reported that appellant had been on leave on several occasions for various periods of time. It stated that she would be transferred to the Charlotte, NC district office effective August 28, 2011.

Appellant reported that in 2000 she began to work at the Charlotte, NC district office of the employing establishment and experienced headaches, wheezing, and problems breathing. She attributed her symptoms to poor air quality in the building from constant construction and renovations. Appellant stated that several air quality tests were conducted which were positive for asbestos in her office. In 2011 she transferred to the Washington, DC district office but continued to experience respiratory issues when she was in the presence of her acting supervisor, Mary Burks.

Appellant was treated by Dr. Carl A. Smart, a Board-certified internist specializing in pulmonary disease. In a July 29, 2011 report, Dr. Smart related that she had a history of sinus disease, bronchospasm, and shortness of breath. He stated that appellant was exposed to naphthalene and experienced increased shortness of breath and wheezing. Dr. Smart reported that he was concerned about the environment to which she was constantly exposed.

In a September 15, 2011 report, Dr. Robert E. Harley, a Board-certified otolaryngologist, listed various procedures that had been performed and diagnosed left sinonasal polyposis, chronic pansinusitis, turbinate hypertrophy, asthma, perennial allergic rhinitis, and seasonal allergic rhinitis.

By letter dated September 20, 2011, OWCP advised appellant that the evidence submitted was insufficient to establish the alleged employment factors or that she had sustained a diagnosed condition as a result of the alleged exposure to chemicals at work.

On October 4, 2011 appellant provided a statement explaining that in June 2011 she was informed that her existing condition, which initially occurred in the Charlotte, NC district office, was exacerbated because of mothball vapors. She claimed that these vapors resulted in her surgery in April 2011 and ongoing sinus infections. Appellant stated that her disability was due to poor air quality in the Charlotte, NC and Washington, DC, district offices. She reported that

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<sup>3</sup> Docket No. 12-1071 (issued October 4, 2012).

the medical evidence proved that she experienced a respiratory reaction and complications when in the district office buildings. Appellant explained that her respiratory reactions were witnessed by Ms. Burks, Kendra Duckworth, and numerous coworkers. She claimed that she experienced headaches, sneezing, tightness in her chest, lethargy, and trouble speaking but these conditions went away when she was away from the triggers. Appellant explained that the testing done by the government was based upon a “normal” person and not a person with a compromised immune system.

In a decision dated November 22, 2011, OWCP denied appellant’s occupational disease claim, finding that the evidence was insufficient to establish that she was exposed to a coworker who used mothballs or that exposure to vapors at work caused or contributed to her pulmonary conditions.

Appellant filed an appeal before the Board. The Director of OWCP requested that the case be remanded as OWCP had failed to address appellant’s alleged exposure to poor air quality at work. The Board remanded the claim for OWCP to further develop the evidence as appropriate and adjudicate her claim in its entirety.

By letter dated July 2, 2013, OWCP requested a detailed description from appellant of the employment factors she believed contributed to her injury and a narrative medical report from a physician explaining how she sustained a diagnosed condition as a result of the alleged employment factors.

OWCP also requested additional information from the employing establishment regarding the accuracy of appellant’s statements. It requested a description of the harmful substances to which appellant could have been exposed, including the results of any air samples if available, a description of the circulation and ventilation of her work area, and whether precautions were taken to minimize effects of exposure.

On July 16, 2013 appellant stated that she was forced to return to the Charlotte, NC district office in 2011 because the Washington, DC, district office could not accommodate her disability. Appellant clarified that the exposure to mothballs only caused an exacerbation of her condition from 2000 to 2012. She stated that she was now on retirement disability.

Appellant submitted a January 24, 2012 report by Dr. Smart. Dr. Smart noted that he had treated her for approximately 12 years and that during that period of time she informed him that she had endured adverse work environments in the Washington, DC and Charlotte, NC district offices resulting in continuous treatment for respiratory asthma and lung diseases. He related that appellant remained in the same poor work environment and was restricted to certain areas of the building. Dr. Smart reported that when she returned to the Charlotte, NC district office in September 2011 she was allowed to have an air machine in her office and work from home two days per week. He noted that, since appellant returned to Charlotte, NC, he had treated her for a number of respiratory infections. Dr. Smart recommended that her work environment be changed in order to reduce her risk of recurrent pulmonary disease exacerbations.

In a decision dated August 12, 2013, OWCP denied appellant’s occupational disease claim. It accepted that she was exposed to a coworker who used mothballs and to poor air

quality in the workplace and that she was diagnosed with various pulmonary conditions, but denied her claim finding insufficient medical evidence to establish that her pulmonary conditions were causally related to her employment.

By letter dated August 29, 2013, appellant requested an oral hearing regarding her claim. She questioned why her file did not contain any documents or statements from the Charlotte, NC district office regarding her office work environment. Appellant provided the names of various witnesses who could testify about her problems with poor air quality in the Charlotte, NC and Washington, DC district offices and her need for accommodation.

On March 3, 2014 a telephone hearing was held. Counsel at that time<sup>4</sup> stated that he had never received any information from OWCP regarding the quality of air in the Washington, DC office even though appellant's claim had been remanded to develop the issue of poor air quality. Mr. Harris contended that this information was essential to appellant's claim and that he could not adequately move forward without such information. He also contended that the medical evidence, specifically, Dr. Smart's August 1, 2011 report addressed that exposure in appellant's work office led to her condition.

Appellant testified that she worked in the Charlotte, NC district office until 2000 before she transferred to the Washington, DC, district office where she worked for over 10 years. She explained that the Washington, DC office was an open floor plan divided with cubicles. Appellant stated that it was not the whole building where she experienced these symptoms, but in specific areas, including her area, the supervisor's area, and the disability director's area. She related that she experienced asthma attacks, eyes burning, and headaches. Appellant stated that, although she had an air machine to assist with the open floor plan, it did not help with her symptoms. She received treatment from a variety of doctors from January to March 2011 and underwent surgery in April 2011.

Appellant submitted various medical reports dated from 2008 to 2012. In a November 20, 2008 report, Dr. Richard E. Collins, Board-certified in allergy and immunology, stated that she had a history of chronic rhinitis symptoms and was allergic to dust and mold. He related that she had increasing rhinitis symptoms accompanied by headaches, sinus congestion, and recurrent sinus infections. Dr. Collins reported that appellant had mold and dust exposure at work and related her feelings that her symptoms were perennial in nature and increasing in intensity. He reviewed her history and provided examination findings. Dr. Collins also conducted an allergy skin test and reported that appellant was allergic to dust mites and mold. He diagnosed allergic rhinitis and chronic sinusitis.

In reports dated August 1 to May 31, 2011, Dr. Smart noted that appellant had suffered from sinus and lung disease for many years. He opined that her lung disease had been "exacerbated and worsened, if not caused, by her exposure, primarily at work." Dr. Smart explained that appellant initially worked in the Charlotte, NC district office and subsequently moved to the Washington, DC district office. He noted that she had been exposed to naphthalene which had led to recurrent sinus infections, bronchitis, and asthma exacerbation. Dr. Smart

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<sup>4</sup> The record reflects that on October 27, 2014 Mr. Harris withdrew as counsel for appellant.

recommended that appellant not be in an environment that risked any potential exposure that could be an irritation to the lungs.

In reports dated from November 7, 2011 to October 16, 2013, Dr. Smart noted that appellant had moved back to Charlotte, NC from Washington, DC because her health accommodations were not being met. Appellant claimed that she was still being exposed to dust. Dr. Smart continued to examine her for complaints of sinus infection, wheezing, and postnasal drip. In a May 3, 2012 report, he noted that appellant was now out of work due to disability. Dr. Smart reported that there was some improvement with her sinus symptoms but she still experienced coughing and some shortness of breath. He opined that there was clearly an issue with exposure to environmental exposures. In a September 13, 2012 report, Dr. Smart reported that appellant still experienced increased shortness of breath, cough, and nasal drainage but that she has improved over the past several months since being removed from her work environment. In an April 9, 2013 progress note, he related her continued symptoms. Dr. Smart diagnosed acute bronchospasm, sinusitis, shortness of breath, asthma, and cough. He noted that appellant's condition had been a long-standing issue and that her work environment had contributed to the condition.

Appellant was also treated by Dr. Harley, who provided reports dated April 25, 2011 to May 21, 2013. Dr. Harley related that she experienced chronic sinus problems for the past five years. He reviewed appellant's history and provided findings on examination. Dr. Harley diagnosed acute sinusitis, left nasal polyposis, chronic pansinusitis, turbinate hypertrophy, asthma, and perennial allergic rhinitis.

In progress notes dated January 28, 2011 to October 10, 2013, Dr. Latimer A. Taylor, an internist, examined appellant for complaints of sore throat, loss of appetite, diffuse arthralgia, and ear discomfort. He related that she believed her work environment was causing breathing difficulties and stated that her work environment had not changed for the better. In a December 9, 2012 report, Dr. Taylor reported that appellant's condition had improved since quitting her job in Washington, DC. Upon examination, he observed unlabored breathing and wheeziness in the lungs. Dr. Taylor diagnosed asthma, rectal bleeding, and unspecified menopausal and postmenopausal disorder.

On November 26, 2012 appellant underwent an x-ray examination, which found no evidence of pulmonary disease and an April 4, 2011 computerized tomography (CT) report which found severe pansinusitis, postoperative changes, and questionable rounded masa in the apex of the left maxillary sinus.

In a July 7, 2013 urgent care record, Dr. Ajsa Nikolic, a Board-certified family practitioner, examined appellant for complaints of dizziness, nausea, and vomiting. He reviewed her history and conducted an examination. Dr. Nikolic observed that appellant's chest and lungs were within normal limits and found no wheezing, rhonchi, or auscultation. He reported that she had likely benign positional vertigo, but dizziness from hypertension was possible. Dr. Nikolic recommended that appellant follow up with her primary care physician that same week.

On December 12, 2013 appellant underwent pulmonary function testing which revealed reduced forced expiratory volume/volume capacity, but normal volume capacity and total lung capacity, therefore, indicating asthma or chronic bronchitis.

In a decision dated April 17, 2014, an OWCP hearing representative affirmed the denial of appellant's claim. She noted that the employing establishment had not responded to the request for further information regarding appellant's alleged exposures. The hearing representative, therefore, denied the claim on relationship, finding that the evidence was insufficient to establish how the alleged exposures caused appellant's sinus and lung conditions.

On October 15, 2014 OWCP received appellant's reconsideration request. Appellant alleged that it had failed to acknowledge that her claim had been remanded by the Board to investigate claims of contaminants in the Washington, DC district office.

Appellant provided a February 16, 2014 Environmental Studies report of the Charlotte, NC district office. The results demonstrated very low levels of asbestos and a very light covering of settled dust. The report concluded that routine building maintenance and custodial activities produced significantly elevated airborne asbestos exposures when surfaces were in excess of 100,000.00 square centimeters.

Appellant submitted various documents from 2002 and 2003 regarding a grievance she filed against her employing establishment for failing to accommodate her disability of asthma. She also provided various letters and e-mails dated June to August 2011 regarding her request to transfer back to the Charlotte, NC district office because they could better accommodate her disability.

In an undated statement, appellant's son related appellant's problems with asthma and difficulty breathing for over 10 years. He noted that despite her various requests and efforts to obtain an office at work because of her sinus and lung conditions, the employing establishment did not assist appellant. Appellant's son stated that appellant also informed him of the negative attitude that appellant's supervisor had towards her due to her disability, which added stress to appellant's condition. He reported that she had sinus surgery in April 2011 and had to return to the Charlotte, NC district office in August 2011. Appellant's son requested a resolution of appellant's claim.

By decision dated December 3, 2014, OWCP denied modification of the April 17, 2014 decision, finding that specific details of exposure to allergens at work had not been documented and the medical evidence of record had not established that the diagnosed conditions were causally related to specific employment factors.

### **LEGAL PRECEDENT**

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence<sup>5</sup> including that he or she sustained an injury in the performance of duty and that any

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<sup>5</sup> *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

specific condition or disability for work for which she claims compensation is causally related to that employment injury.<sup>6</sup> 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.<sup>7</sup>

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.<sup>8</sup> 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.<sup>9</sup>

### ANALYSIS

This case was previously remanded by the Board, upon a motion from the Director of OWCP, for remand to address appellant's allegation of poor air quality which it had failed to do in its earlier decision. Upon remand,<sup>10</sup> on July 2, 2013 OWCP requested additional information from the employing establishment and appellant regarding the air quality of the workplace, including results of air studies, and a description of circulation and ventilation in appellant's work area, if available. Neither appellant nor the employing establishment responded to this request.

Based upon appellant's allegations, OWCP accepted that appellant was exposed to a coworker who used mothballs and to general poor air quality in the workplace, and, that she was diagnosed with various pulmonary conditions.<sup>11</sup> The Board finds, however, that the medical evidence of record is insufficient to establish that appellant's pulmonary conditions were caused or aggravated by factors of appellant's federal employment.

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<sup>6</sup> *M.M.*, Docket No. 08-1510 (issued November 25, 2010); *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

<sup>7</sup> *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

<sup>8</sup> *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

<sup>9</sup> *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

<sup>10</sup> See *Donald L. Strain*, Docket No. 94-2607 (issued January 14, 1997); *Robert A. Redmond*, 40 ECAB 800 (1989). See also *K.H.*, Docket No. 14-968 (issued July 6, 2015).

<sup>11</sup> In the absence of any response from the employing establishment, OWCP may accept appellant's version of events as established. See *W.M.*, Docket No. 07-1223 (issued September 10, 2007). See also *T.C.*, Docket No 08-1497 (issued December 1, 2005). Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Development of Claims*, Chapter 2.800.5(d)(1) (June 2011). In this case, appellant has not specified the implicated employment factors with detail such as extent or duration. See generally *Tracey P. Spillane*, 54 ECAB 608 (2003).

Appellant submitted various reports by Dr. Smart dated July 29, 2011 to October 16, 2013. Dr. Smart related that she had a history of sinus disease, bronchospasm, and asthma. He reported that appellant was exposed to naphthalene at work. In a May 31, 2011 report, Dr. Smart opined that her lung disease had been “exacerbated and worsened, if not caused, by her exposure, primarily at work.” In a January 24, 2012 report, he explained that appellant worked in adverse environments in Charlotte, NC and Washington, DC, which resulted in continuous treatment for respiratory, asthma, and lung disease. Dr. Smart recommended a change in her work environment to reduce her risk of recurrent pulmonary disease exacerbations. In an April 9, 2013 report, he provided findings on examination and diagnosed acute bronchospasm, sinusitis, shortness of breath, asthma, and cough. Dr. Smart found that appellant’s condition had been a long-standing issue and that her “work environment had contributed to the significant degree to such.”

Although he provided an opinion on causal relationship, the Board finds that Dr. Smart’s conclusion is unsupported by medical rationale demonstrating how appellant’s work environment caused or exacerbated her pulmonary condition.<sup>12</sup> Dr. Smart fails to explain how any specific exposure to naphthalene at appellant’s workplace or any other exposure to poor air quality contributed to her recurrent pulmonary conditions. A physician’s 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 the claimant’s specific employment factors.<sup>13</sup> Dr. Smart did not relate specific exposures at appellant’s employment or explain how they caused her condition. The Board has found that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.<sup>14</sup> For these reasons, Dr. Smart’s opinion is insufficient to establish appellant’s claim.

Appellant was also treated by Dr. Harley from April 25, 2011 to May 21, 2013. Dr. Harley noted that she experienced chronic sinus problems for the past five years and conducted an examination. He diagnosed left sinonasal polyposis, chronic pansinusitis, turbinate hypertrophy, asthma, perennial allergic rhinitis, and seasonal allergic rhinitis. Dr. Harley does not, however, provide any opinion on the cause of appellant’s various pulmonary 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 probative value on the issue of causal relationship.<sup>15</sup> Likewise, Dr. Nikolic’s July 7, 2013 hospital record is also of limited value on the issue of causal relationship as he does not provide any opinion on the cause of appellant’s symptoms.

In progress notes dated January 28 to October 10, 2011, Dr. Latimer examined appellant for complaints of sore throat, loss of appetite, diffuse arthralgia, and ear discomfort. He related that she believed her work environment was causing breathing difficulties and pointed out that

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<sup>12</sup> *D.R.*, Docket No. 12-478 (issued July 23, 2012).

<sup>13</sup> See *Victor J. Woodhams*, *supra* note 9; see also *S.D.*, 58 ECAB 713 (2007).

<sup>14</sup> *T.M.*, Docket No. 08-975 (February 6, 2009); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

<sup>15</sup> *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

her condition improved since leaving her job in Washington, DC. Dr. Taylor diagnosed asthma, rectal bleeding, and unspecified menopausal and postmenopausal disorder. The Board notes that he does not opine on the cause of appellant's conditions but merely communicated her belief that her work environment caused her pulmonary conditions.<sup>16</sup> Dr. Taylor's reports, therefore, are insufficient to establish appellant's claim.

The additional medical evidence including the November 26, 2012 x-ray examination, December 12, 2013 pulmonary function testing, and the July 7, 2013 hospital record are likewise insufficient as there is no opinion on whether appellant's employment caused or contributed to her pulmonary conditions.

The Board finds that there is insufficient medical evidence to establish that appellant sustained a pulmonary condition causally related to her work environment. Accordingly, appellant did not meet her burden of proof to establish her claim.

On appeal, appellant alleges that OWCP refused to consider the evidence she provided and had a bias against the evidence she submitted. She specifically stated that it overlooked the contradictions of the agency and failed to provide any evidence to show that they provided appellant with a safe work environment. The Board notes that appellant has the burden of proof to establish that her pulmonary conditions were causally related to exposures at work. Although appellant submitted medical evidence, none of the reports on the record were sufficiently rationalized to establish that any specific exposure to a coworker who used mothballs and any specific lack of air quality at work caused or contributed to her pulmonary conditions.

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 has not met her burden of proof to establish that she sustained a pulmonary condition causally related to factors of her federal employment.

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<sup>16</sup> See *P.K.*, Docket No. 08-2551 (issued June 2, 2009) (an award of compensation may not be based on a claimant's belief of causal relationship).

**ORDER**

**IT IS HEREBY ORDERED THAT** the December 3, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 16, 2015  
Washington, DC

Christopher J. Godfrey, Chief Judge  
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge  
Employees' Compensation Appeals Board