U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of VALERIE F. DOWNEY and U.S. POSTAL SERVICE,
POST OFFICE, Long Beach, Calif.

Docket No. 97-1371; Submitted on the Record;
Issued July 7, 1998

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether appellant has established that she developed an upper respiratory condition or injury and a severe migraine headache in the performance of duty, causally related to factors of her federal employment.

On August 5, 1996 appellant, then a 48-year-old personnel clerk, filed a claim alleging that she developed chest pain, difficulty breathing, a severe migraine headache, a burning nose and throat, and aggravation of her asthma on July 25, 1996, causally related to new carpet and modular furniture being installed in her workplace. Appellant alleged that she had chest pain and had to use her inhaler, that she was unable to work, that her difficulty continued through the weekend when she was at home, that the employing establishment placed her in a small office across the hall, but that she was still on the same floor and was exposed to the same air.

The employing establishment controverted appellant's claim for continuation of pay, noting that her claim was for an occupational injury, that although she claimed the exposure took place July 25, 1996 she did not seek medical treatment until August 6, 1996, that she had filed a claim for similar symptoms on June 5, 1994, and that she had alleged having these conditions for the previous two years with or without the presence of new carpets and furniture.

In support of her claim, appellant submitted an August 6, 1996 disability certificate stating that she would be disabled until approximately August 12, 1996. No diagnosis was given and no reason for the disability was stated. Appellant also submitted a July 8, 1996 report, predating her claimed employment injury by 17 days, from Dr. Eric D. Feldman, a Board-certified rehabilitation medicine specialist, which diagnosed bilateral carpal tunnel syndrome.

In an August 12, 1996 report, Dr. Feldman reviewed appellant's history of employment exposure to new carpeting and new modular furniture, noted that she claimed to have experienced breathing difficulty "such as she has had before with fumes and environs at work," and noted her complaints of chest pain. Dr. Feldman found that appellant's lungs were clear to

auscultation and without rales or ronchi, but noted that she had costochondral tenderness to direct palpation. He diagnosed "myofascial pain syndrome, chronic costochondritis, [and] exacerbation of restrictive lung disease by history, environmental fumes." Dr. Feldman indicated that appellant could return to work as long as she was away from new carpet smell or modular furniture. He recommended work-up by a pulmonologist.

In an August 12, 1996 report, Dr. Jeffrey B. Riker, a Board-certified pulmonologist, reviewed appellant's history of being first exposed to new modular furniture and carpet on July 25, 1996, noted that she also implicated painting in the halls as causing her problems, noted that she was off and on work for the next week and one half with symptoms both at work and at home, and indicated that from August 5, 1996 on appellant remained off work. Dr. Riker noted that appellant had experienced similar symptoms in June 1994 when the employing establishment was tarring the roof and she became weak and dizzy. Dr. Riker noted that at that time appellant was diagnosed as having hyperventilation syndrome, but that she differentiated this occurrence as having more shortness of breath and cough. He also noted that appellant claimed her nose and mouth felt like they were burning when she was exposed, but not at other times. Dr. Riker examined appellant, finding her comfortable and without coughing, with regular respirations and without redness or edema of the nasal or oral mucosa or ear canals, he found no lypmhadenopathy and a clear chest to percussion and ascultation. He did note a wheeze on forced expiration only, and noted that on touching her chest anteriorly she grimaced and whinced and complained of severe pain. Dr. Riker diagnosed an episode of irritation of the nasal and oral mucosa and a burning sensation in the chest associated with inhalation of fumes at work in relationship to new carpet and furniture. He found no evidence of bronchial asthma or any other lung disease, and completely normal x-rays. Dr. Riker opined: "I cannot exclude the possibility of upper airway irritation related to chemical fumes but her symptoms seem way out of proportion to the objective findings since there is no redness or swelling of the mucosa noted." He recommended that she be removed from the area where fumes were present until it had been thoroughly ventilated. Dr. Riker opined that he would not expect any permanent effect since there was absolutely no evidence of physiologic abnormality at that time. He recommended no other treatment. In an August 13, 1996 follow-up note, Dr. Riker indicated that appellant's pulmonary function testing had been normal, and he reiterated his previous recommendations. On September 5, 1996 Dr. Riker noted that air sampling at the employing establishment had revealed no volatile organic compounds or formaldehyde levels above-established threshold limits, and he opined that appellant could return to work.

In a September 11, 1996 report, Dr. Riker noted that appellant had returned to see him after going back to work on September 9, 1996, that at work she again smelled an odor which she believed was from the carpeting and furniture, that she again noticed chest, nose and throat symptomatology, but that on physical examination he found no abnormalities. Dr. Riker found no objective evidence of lung disease or upper respiratory inflammation, and he opined that some people were sensitive to odors but that there was no way to measure that. He concluded that there was no objective information he could give which would confirm appellant's subjective symptoms.

By decision dated September 20, 1996, the Office rejected appellant's claim finding that she had failed to establish fact of injury. The Office found that the medical evidence only

documented complaints and appellant's beliefs and failed to document that an injury or condition was sustained as alleged.

On October 21, 1996 appellant requested reconsideration, and in support she submitted a September 21, 1996 report from Dr. Vaughn Nixon, a Board-certified otolaryngologist. Dr. Nixon stated that appellant was examined September 12, 1996 with complaints of nasal congestion, nose irritation, and headaches; he indicated that examination revealed some edema of the nasal mucosa, and he recommended over-the-counter antihistamine decongestants. Dr. Nixon repeated appellant's allegations and he recommended that she avoid toxic chemicals in the workplace. Appellant also submitted some records from 1983 and 1994.

By decision dated October 30, 1996, the Office denied modification of the September 20, 1996 decision finding that the evidence submitted was not sufficient to warrant modification. The Office advised that Dr. Nixon's report did not provide a clear diagnosis or history of injury, that it lacked objective testing results, and that it was speculative, did not establish a work-related pulmonary condition, and did not explain how appellant's condition was causally related to her federal employment.

By letter dated November 6, 1996, appellant again requested reconsideration. In support she restated her previous allegations.

By decision dated November 20, 1996, the Office denied appellant's request for reconsideration finding that the evidence submitted in support was immaterial and cumulative in nature, and was not sufficient to warrant a merit review.

By letter dated January 1, 1997, appellant again requested reconsideration. In support of her request, appellant submitted material safety data sheets on the glue used to install the carpet, several 1994 medical reports regarding dizziness, hearing loss and tinnitus problems, a 1995 medical report regarding fibromyalgia and myofascial pain syndrome, chronic low back pain and degenerative disc disease, a January 1996 report regarding chronic costochondritis, a March 1996 and an April 1996 report regarding a chronic pain disorder, an April 1996 report regarding fibromyalgia, myofascial pain, and degenerative disc disease, and a December 4, 1996 report from Dr. Arthur F. Gelb, a Board-certified internist, which stated that on September 26, 1988 a methacholine challenge test was positive, indicating that appellant had bronchoreactive airways at that time.

By decision dated February 12, 1997, the Office denied modification of the prior decisions finding that the evidence submitted failed to address whether appellant actually sustained an employment illness or condition or whether these conditions were causally related to her exposure to furniture and carpets installed in July 1996.

The Board finds that appellant has failed to establish that she developed an upper respiratory condition or injury and severe migraines in the performance of duty, causally related to factors of her federal employment.

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his or her claim, including that he or she sustained an injury in the performance of duty as alleged.[2] In cases of occupational disease or illness, an employee must establish fact of injury by submitting medical evidence establishing that conditions or factors of employment caused an "injury" as defined in the Act and its regulations.[3]

Further, to establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying the specific employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed, or stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[4] The medical evidence required to establish causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 claimant.[5] Causal relationship is a medical issue that can be established only by medical evidence.[6] The Board notes that the fact that a condition manifests itself or worsens during a period of employment does not raise an inference of an employment relationship.[7]

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[1] 5 U.S.C. §§ 8101-8193.

[2] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[3] *Cf. Frederick H. Coward, Jr.*, 41 ECAB 843 (1990); *Victor J. Woodhams*, 41 ECAB 345 (1989) (the employee must submit, among other things, medical evidence establishing that the employment factors identified by the employee proximately caused the condition for which compensation is claimed). 5 U.S.C. § 8101(1)(5) defines "injury" in relevant part as follows: "'injury' includes, in addition to injury by accident, a disease proximately caused by employment...." 20 C.F.R. § 10.5(a)(16) defines "occupational disease or illness" as follows: "[A] condition produced in the work environment over a period longer than a single workday or shift by such factors as systemic infection; continued or repeated stress or strain; or exposure to hazardous elements such as, but not limited to, toxins, poisons, fumes, noise, particulates, or radiation, or other continued or repeated conditions or factors of the work environment."

[4] *See Victor J. Woodhams, supra* note 3.

[5] *Id.*

[6] *Mary J. Briggs*, 37 ECAB 578 (1986); *Ausberto Guzman*, 25 ECAB 362 (1974).

[7] *Paul D. Weiss*, 36 ECAB 720 (1985); *Hugh C. Dalton*, 36 ECAB 462 (1985).

In the instant case, none of the medical evidence submitted establishes that appellant had an identifiable employment-related condition. Much of the medical evidence is not contemporaneous with the alleged occupational injury or illness, and the most contemporaneous evidence, the August 6, 1996 disability certificate, failed to state a diagnosis or give a reason for appellant's disability. On August 12, 1996 Dr. Feldman noted that appellant's lungs were clear and without rales or ronchi, and he diagnosed two muscular conditions which he did not relate to anything in particular. He did not give any diagnosis with respect to appellant's complaints of severe migraine headache, nose or throat irritation, or aggravation of asthma. Dr. Feldman also gave a speculative historical diagnosis of "exacerbation of restrictive lung disease by history, environmental fumes," but he failed to identify any current objective findings to support that diagnosis. As this report is speculative and not one of reasonable medical certainty, is unrationalized and is couched in terms of an historical diagnosis, it is of diminished probative value. Consequently this report is not sufficient to establish that appellant sustained an occupational injury or illness on or around July 25, 1996.

On August 12, 1996 Dr. Riker examined appellant and found her comfortable and without coughing, with regular respirations and without redness or edema of the nasal or oral mucosa or ear canals, without lymphadenopathy and with a clear chest to percussion and to ascultation. Dr. Riker found no evidence of bronchial asthma or any other lung disease, and noted appellant had completely normal x-rays and no evidence of physiologic abnormality at that time. In a follow-up report the next day he further indicated that appellant's pulmonary function tests were normal. Dr. Riker did find a wheeze on forced expiration only, and noted that on touching appellant's chest anteriorly she grimaced and whinced and complained of severe pain. He opined: "I cannot exclude the possibility of upper airway irritation related to chemical fumes but her symptoms seem way out of proportion to the objective findings since there is no redness or swelling of the mucosa noted." Dr. Riker proposed a diagnosis of an "episode of irritation of the nasal and oral mucosa and a burning sensation in the chest associated with inhalation of fumes at work in relationship to new carpet and furniture," but he identified no objective evidence to support this proposed diagnosis, and he explained that he could not "exclude the possibility of upper airway irritation …," which is a speculative comment on its face. As this report is unrationalized, offers a speculative diagnosis, is not one of reasonable medical certainty, and is unsupported by objective findings, it is of diminished probative value in establishing an occupational injury or illness. Consequently, this report is insufficient to establish appellant's claim.

In a September 11, 1996 report, Dr. Riker again found no abnormalities and no objective evidence of lung disease or upper respiratory inflammation. He opined that there was no objective information he could give which would confirm appellant's subjective symptoms. As this report did not offer any supportable diagnosis or identify any objective signs of illness or injury, it is also insufficient to establish appellant's claim.

Thereafter, appellant submitted a September 21, 1996 report from Dr. Nixon which did not offer any specific employment-related diagnosis. He indicated that examination revealed "some edema of the nasal mucosa" but he failed to explain how this was related to appellant's alleged workplace exposure two months earlier on or around July 25, 1996. Dr. Nixon merely

recounts appellant's allegations, and he offers no explanation of causal relationship. Consequently, this report is also unrationalized and is insufficient to establish appellant's claim.

Appellant also submitted multiple medical records and reports dating from before the alleged July 25, 1996 occupational exposure, which have no probative value on her condition on and after that date. Consequently, none of these records or reports establish appellant's claim.

Finally, appellant submitted a December 4, 1996 report from Dr. Gelb which stated merely that a methacholine challenge test was positive on September 26, 1988 indicating that appellant had bronchoreactive airways at that time. The Board notes, however, that this 1988 positive test has no bearing on appellant's condition on or around July 25, 1996, and hence has no probative value in establishing her claim.

As no further rationalized medical evidence of reasonable medical certainty and containing a definitive medical diagnosis of appellant's condition on or around July 25, 1996 has been submitted, the Board finds that appellant has failed to establish her occupational injury or illness claim.

Accordingly, the decisions of the Office of Workers' Compensation Programs dated September 20, October 20 and November 20, 1996 and February 12, 1997 are hereby affirmed.

Dated, Washington, D.C.
July 7, 1998

George E. Rivers
Member

David S. Gerson
Member

Michael E. Groom
Alternate Member