United States Department of Labor
Employees' Compensation Appeals Board

D.E., Appellant	)	
and	)	**Docket No. 07-27**
	)	**Issued: April 6, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Albany, NY, Employer	)	

Appearances:
Joseph Hein, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 2, 2006 appellant filed a timely appeal from a June 23, 2006 decision of the Office of Workers' Compensation Programs that denied her request for reconsideration. Appellant also appealed October 6, 2005 and February 23, 2006 Office decisions that denied her claim for compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit and nonmerit decisions.

ISSUES

The issues are: (1) whether appellant met her burden of proof in establishing that she developed an occupational disease in the performance of duty; and (2) whether the Office properly denied appellant's request for reconsideration without conducting a merit review.

FACTUAL HISTORY

On November 14, 2003 appellant, then a 65-year-old stenographer clerk, filed an occupational disease claim stating that she developed asthma due to building ventilation

problems at the employing establishment. She first became aware of her condition and related it to her employment on April 21, 2000. Appellant did not stop work.

On December 29, 2003 the Office requested additional information concerning appellant's claim.

By decision dated March 31, 2004, the Office denied appellant's claim for compensation, finding that she had not sustained an injury as alleged.

Appellant requested reconsideration on April 15, 2004. She submitted a January 12, 2004 statement attributing her asthma to moldy air vents near her desk. Appellant also submitted medical reports from several different physicians. In a May 25, 2000 report, Dr. Eckardt Johanning, a Board-certified occupational medicine specialist, noted that appellant had been newly diagnosed with asthma which she attributed to poor air quality at her workplace. He indicated that a report was pending to determine whether poor air quality caused appellant's asthma. In an October 19, 2001 report, Dr. Carol J. Burgess, a Board-certified internist, diagnosed asthma, dizziness secondary to pain medication and hyperlipidemia. In a January 7, 2002 report, she characterized appellant's condition as "progressive respiratory distress and bronchospasm" and noted that appellant experienced "chest discomfort, cough and shortness of breath ... within 30 to 60 minutes of arrival at work." In an October 23, 2001 report, Dr. Jean McMahon, a Board-certified internist, diagnosed occupational asthma, but focused most of her report addressing appellant's carpal tunnel syndrome.

In a May 17, 2000 report, Dr. Janet Claassen, a Board-certified allergist and immunologist, diagnosed dyspnea which "likely represents asthma triggered by irritant exposure to possible mold at her workplace." She recommended that appellant take various measures to limit her exposure to the "presumed mold." In a June 14, 2000 report, Dr. Claassen indicated that appellant exhibited dyspnea symptoms at work, which worsened when the air vent above her desk was opened. She recommended that appellant undergo a methacholine challenge test "to better establish a diagnosis of asthma." On August 22, 2000 Dr. Claassen again noted that appellant had dyspnea aggravated by her work environment, which appeared to be "secondary to asthma." The report also noted, however, that "increased symptoms experienced at work are of uncertain etiology."

Dr. Lynne I. Portnoy, a Board-certified occupational medicine specialist, provided a January 30, 2002 report. She stated that appellant's asthma was "consistent with poor air quality and irritant chemical exposure as part of her work at the [employing establishment]." Dr. Portnoy noted that Adirondack Environmental Services, Inc., (AES) had recently studied the employing establishment facilities and recommended remedial action but that appellant was concerned that the employing establishment did not timely change air filters. She opined that appellant's asthma was "consistent with poor air quality and irritant chemical exposure as part of her work at the [employing establishment]." Dr. Portnoy noted that the "onset and the recurrence of symptoms at work in conjunction with [appellant's] recorded peak flow monitoring strongly suggests that the quality of air at her workplace is a significant asthmatic trigger." In an April 24, 2002 report, she diagnosed "quiescent occupationally-aggravated asthma." Dr. Portnoy noted that appellant's symptoms improved after she was moved to a desk near a window. In reports from July 25, 2002 to April 24, 2003, she diagnosed employment-related asthma and

noted that appellant's symptoms were relieved when she was able to open a window at work. Dr. Portnoy indicated that appellant's symptoms were exacerbated by inadequate circulation of fresh air at her workplace and that cold air aggravated her breathing difficulties.

On June 30, 2004 the Office requested that appellant provide an environmental study of the employing establishment workplace.

Appellant submitted a June 21, 2000 environmental report prepared by AES and a June 28, 2000 appendix. The report noted that air filters showed "black staining" and that Penicillium spores constituted 77 percent of the mold found on the filing cabinet adjacent to appellant's desk. The black staining in the air vent above appellant's desk was also found to contain Penicillium. The report stated:

> "Microbial surveys of this type are intended to identify areas within buildings that may have unusual concentrations and varieties of fungi. When these growth areas occur, sensitized individuals working in these areas may experience allergic reactions ranging from rashes and sore throats, to headaches and nausea. An indicator of poor workplace indoor air quality might also be expressed as a lack of these symptoms once the individual leaves the area. However, there are many other potential causes of symptomatic reactions to perceived indoor air quality problems, including lack of fresh air, trace chemical contaminants and comfort parameters, such as temperature and relative humidity."

The report indicated that Penicillium spores were the most prevalent of fungi in the samples collected but concluded that "it is difficult to determine if the presence of Penicillium species. detected inside is from growth within the building or just a result of spores entering the building from outside sources."

By decision dated July 16, 2004, the Office modified its March 31, 2004 decision, finding that the environmental study documented substances in appellant's workplace. It denied the claim because the medical evidence did not establish a causal relationship between appellant's medical condition and any employment exposure.

On July 11, 2005 appellant requested reconsideration of the July 16, 2004 decision. She submitted a June 9, 2005 report from Dr. McMahon, who reviewed the AES environmental study and concluded that there was "fungal amplification" within the employing establishment facilities. Dr. McMahon pointed out that the study found a concentration of 77 percent of Penicillium inside the employing establishment, in the area near appellant's desk, while the study yielded less than 1 percent concentration of Penicillium outdoors. She calculated:

> "An air sample obtained near the filing cabinet adjacent to [appellant's] desk yielded 480 fungal CFUs/m3. Of these, 77 percent were Penicillium species. A quick calculation reveals that this air sample contained 370 CFU/m3 of Penicillium species.
>
> "In contrast, outdoor air samples yielded 2500 fungal CFU/m3 and less than 1 percent of these colonies were identified as Penicillium species. Again, the same

> quick calculation yields the fact that less than 25 CFU/m3 in the outdoor air consisted of Penicillium.
>
> "These calculations thus yield evidence that there was fungal amplification indoors. The concentration of Penicillium in the indoor air adjacent to [appellant's] desk was 15 times the concentration of Penicillium in outdoor air."

Dr. McMahon also noted that when a specific species of fungus is disproportionately more prevalent indoors than outdoors, "an indoor source of the species is more probable." She concluded that there was amplification of the Penicillium mold within the employing establishment facilities.

Appellant, through her attorney, submitted legal arguments on July 11, 2005. She cited several of the medical reports attributing her breathing difficulties to the claimed mold and air quality issues at her workplace. Counsel stated that "common sense as well as medical assessments point to this exposure" as the cause of appellant's condition. Appellant stated that a "summary medical report" would be forthcoming. She also submitted an academic article linking Penicillium to asthma.

By decision dated October 6, 2005, the Office denied modification of the July 16, 2004 decision.

On November 16, 2005 appellant requested reconsideration. She argued that a new report from Dr. McMahon was "critical" in establishing her claim. Appellant stated that the report was enclosed. The report does not appear in the case record.

By decision dated February 23, 2006, the Office denied modification of its October 6, 2005 decision.

Appellant again requested reconsideration on March 24, 2006. She noted that Dr. McMahon's "critical" new report, dated July 22, 2005, was attached, along with printouts establishing appellant's physicians' Board certification status. No July 22, 2005 report from Dr. McMahon appears in the record.

By decision dated June 23, 2006, the Office denied appellant's request for reconsideration without conducting a merit review of the claim.

LEGAL PRECEDENT -- ISSUE 1

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 the fact that the individual is an "employee of the United States" within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition

[1] 5 U.S.C. §§ 8101-8193.

for which compensation is claimed are causally related to the employment injury.[2] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[3]

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 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. 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.[4]

An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there is a causal relationship between her claimed injury and her employment.[5] To establish a causal relationship, appellant must submit a physician's report, in which the physician reviews the employment factors identified by appellant as causing her condition and, taking these factors into consideration as well as findings upon examination of appellant and her medical history, state whether the employment injury caused or aggravated appellant's diagnosed conditions and present medical rationale in support of his or her opinion.[6]

ANALYSIS -- ISSUE 1

The Board finds that appellant has failed to meet her burden of proof in establishing that she developed an occupational disease in the performance of duty. The record reflects that appellant has asthma and that there is evidence of Penicillium mold within the employing establishment's air circulation system. However, appellant has not established that her asthma is causally related to this exposure in her employment.

[2] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[3] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[4] *Id.*

[5] *Donald W. Long*, 41 ECAB 142 (1989).

[6] *Id.*

In support of her claim, appellant submitted various medical reports tracing the progression of her asthmatic symptoms. These reports, however, did not explain which factors of appellant's employment caused or aggravated her asthma, or how appellant's condition arose. Dr. Claassen's May 17, 2000 report is speculative in nature,[7] diagnosing "dyspnea most likely represent[ing] asthma triggered by irritant exposure to possible mold at her workplace." As it is speculative and equivocal in nature, her report is not sufficient to establish appellant's claim. This is especially so in light of her later August 22, 2000 report noting that appellant's symptoms at work were of an "uncertain etiology." Dr. Johanning's May 25, 2000 report also provided speculative support for causal relationship as he noted that appellant's breathing problems were "possibly related to some indoor air quality problems." Dr. Burgess' January 7, 2002 report noted that appellant developed symptoms within an hour after arriving at work. However, she did not otherwise address causal relationship. The Board has held that the mere fact that appellant's symptoms arise during a period of employment or produce symptoms revelatory of an underlying condition does not establish a causal relationship between appellant's condition and her employment factors.[8]

Dr. Portnoy, in several reports, referred to appellant's condition as work related, but did not offer further explanation to support her opinion. In a January 30, 2002 report, Dr. Portnoy attributed appellant's asthma to poor air quality at work and noted that the "onset and recurrence" of appellant's symptoms while at work suggested a relationship. As noted above, however, the mere fact that a disease or condition manifests itself or worsens during a period of employment or that work activities produce symptoms revelatory of an underlying condition does not raise an inference of causal relationship between the condition and the employment factors.[9] Neither the fact that a condition became apparent during a period of employment nor the belief that the condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[10] In subsequent reports, Dr. Portnoy supported causal relationship but only offered a conclusory opinion and did provide medical rationale to explain how or why the air in appellant's workplace caused or aggravated her diagnosed condition. The Board finds that Dr. Portnoy's reports are insufficient to establish a causal relationship between appellant's diagnosed condition and employment factors, as Dr. Portnoy did not provide sufficient explanation or rationale to fortify her conclusions.[11]

Furthermore, Dr. McMahon's reports do not establish causal relationship. Her October 23, 2001 report diagnosed "occupational asthma" and noted that there were some air quality issues associated with the diagnosis, but she provided no medical reasoning to support her opinion. Dr. McMahon's June 9, 2005 report primarily addressed the finding of the AES report. She noted that there was fungal amplification within the employing establishment

[7] *See Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions which are speculative or equivocal in character have little probative value).

[8] *See Richard B. Cissel*, 32 ECAB 1910, 1917 (1981); *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[9] *See id.*

[10] *Roy L. Humphrey*, 57 ECAB ___ (Docket No. 05-1928, issued November 23, 2005).

[11] *See supra* note 9.

facilities based on the presence of Penicillium colonies. She discussed the environmental report and concluded, based on mathematical calculations, that there was fungal amplification. Dr. McMahon did not, however, explain how the fungal amplification in the workplace caused or contributed to appellant's asthma condition. She did not state that appellant was allergic to Penicillium mold or offer sufficient explanation of the relationship between the findings of the environmental study and appellant's condition. Accordingly, the Board finds that Dr. McMahon's reports are insufficient to establish a causal relationship between appellant's diagnosed condition and employment factors.[12]

Other medical reports submitted by appellant, did not specifically address causal relationship between her diagnosed condition and her employment.

Appellant contends that, because medical studies have shown that Penicillium could cause asthma and because environmental studies established the presence of Penicillium at her workplace, "common sense" dictates that her asthma was caused by the Penicillium mold in her work space. However, causal relationship is a medical question that can generally be resolved only by rationalized medical opinion evidence.[13] As noted, the medical evidence is insufficient to establish the claim. Similarly, appellant's submission of a medical periodical discussing Penicillium allergies is insufficient to establish causal relationship. The Board has held that newspaper clippings, medical texts and excerpts from publications are of no evidentiary value in establishing the causal relationship between a claimed condition and an employee's federal employment as such materials are of general application and are not determinative of whether the specific condition claimed is related to the particular employment factors alleged by the employee.[14]

For these reasons, appellant has not met her burden of proof in establishing her occupational disease claim.

LEGAL PRECEDENT -- ISSUE 2

Under section 8128 of the Act, the Office has discretion to grant a claimant's request for reconsideration and reopen a case for merit review. Section 10.606(b)(2) of the implementing federal regulation provides guidance for the Office in using this discretion. The regulations provide that the Office should grant a claimant merit review when the claimant's request for reconsideration and all documents in support thereof:

> "(i) Shows that [the Office] erroneously applied or interpreted a specific point of law; or

[12] On appeal, appellant submitted additional medical evidence from Dr. McMahon. The Board, however, notes that it cannot consider this evidence for the first time on appeal because the Office did not consider this evidence in reaching its final decision. The Board's review is limited to the evidence in the case record at the time the Office made its final decision. 20 C.F.R. § 501.2(c).

[13] *See Steven S. Saleh*, 55 ECAB 169 (2003); *Robert G. Morris*, 48 ECAB 238 (1996).

[14] *William C. Bush*, 40 ECAB 1064 (1989).

"(ii) Advances a relevant legal argument not previously considered by [the Office]; or

"(iii) Constitutes relevant and pertinent new evidence not previously considered by [the Office]."[15]

A claimant's application for reconsideration on the merits must meet at least one of the above-listed criteria or the Office will deny the request without reopening the case for a review on the merits.[16]

ANALYSIS -- ISSUE 2

The Board finds that the Office properly denied appellant's request for reconsideration without further merit review. Appellant neither argued that the Office erroneously interpreted a point of fact nor advanced a new and relevant legal argument. Rather, appellant based her reconsideration request upon a July 22, 2005 report from Dr. McMahon. The record reflects, however, that the report was not submitted to the file at the time appellant requested reconsideration and that the Office did not receive it at any time before issuing the June 23, 2006 decision. The record does not reflect that appellant submitted any other pertinent new and relevant evidence in support of her reconsideration request. Accordingly, the Office properly denied appellant's reconsideration request without reaching the merits of the claim, as she failed to meet any of the above-listed criteria.

CONCLUSION

The Board finds that appellant failed to meet her burden of proof in establishing that she developed an occupational disease over the course of her employment and that the Office properly denied appellant's request for reconsideration without conducting a merit review.

[15] 20 C.F.R. § 10.606(b).

[16] 20 C.F.R. § 10.608; *see Annette Louise*, 54 ECAB 783 (2003).

ORDER

IT IS HEREBY ORDERED THAT the June 23 and February 23, 2006 and October 6, 2005 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: April 6, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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