United States Department of Labor
Employees' Compensation Appeals Board

D.N., Appellant **and** **DEPARTMENT OF VETERANS AFFAIRS, LOUIS B. STOKES MEDICAL CENTER, Brecksville, OH, Employer**	)))))))))	**Docket No. 07-921** **Issued: July 26, 2007**

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 20, 2007 appellant filed a timely appeal from the July 20, 2006 merit decision of the Office of Workers' Compensation Programs and the January 16, 2007 decision of the Office hearing representative, which denied his claim for compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of his claim.

ISSUE

The issue is whether appellant sustained a pulmonary injury in the performance of duty on March 7, 2006.

FACTUAL HISTORY

On May 17, 2006 appellant, then a 52-year-old criminal investigator, filed a claim alleging that he sustained an injury to his lungs on March 7, 2006 when he was exposed to mold or fungus in the performance of duty. He entered the Wade Park Records Room (Room H27) in the course of his employment and noticed what appeared to be mold on the files and other

surfaces. Appellant remained in the room for approximately 15 minutes, and the following week he was coughing and felt like he had the flu. He stated that everyone had what appeared to be the flu, so he thought he had picked it up from a coworker. It became increasingly difficult for appellant to breathe and he was diagnosed with double pneumonia, but antibiotics did not make him better. When he told a doctor that he had found mold in the records room, the doctor told him that might be what was causing his problem. Appellant stated that he never had a problem with his lungs, but his past medical history included pneumonia in 1983.

The employing establishment acknowledged that the Room H27 was a respiratory hazard and that appellant was exposed to mold contamination on March 7, 2006. There was flooding in the room early in 2005 with subsequent mold growth on the records and walls. A mold assessment conducted on May 23, 2005 found visible mold contamination on the medical files in the room. Surface sample results collected on the medical files indicated numerous counts of aspergillus/penicillium, Botrytis and hyphal fragments. Air samples indicated elevated levels of aspergillus/penicillium and Stachybotrys. A contract for remediation was being awarded at the time of appellant's exposure.

On June 15, 2006 Dr. Sridhar K. Iyer, a Board-certified internist specializing in pulmonary diseases, addressed the relationship between appellant's occupational exposure to mold and his respiratory condition:

> "[Appellant] has been seen by me since March 17, 2006, when he was hospitalized. [He] was exposed to a moldy area at workplace on March 7, 2006. A few days later, [appellant] started getting congested and started coughing a lot. He also had difficulty breathing and this got progressively worse. [Appellant] was treated initially as an outpatient and he failed on this and hence, had to come to the hospital and was hospitalized. He was treated vigorously with intravenous antibiotics, etc. [Appellant's] improvement was suboptimal. He was initially discharged and later had to come back in with worsening respiratory status. [Appellant] has had persistent symptoms. His oxygen level is low in his blood. [Appellant] is constantly short of breath with minimal activity. [He] had a bronchoscopy done with a biopsy from the bronchoscope, which suggested an allergic reaction in the lung possibly secondary to mold-type exposure. [Appellant] is requiring very aggressive therapy with high-dose steroid therapy with marginal response. He has been referred to the Cleveland Clinic Foundation for larger lung biopsy. [Appellant's] clinical status has not been stabilized yet. This condition is most likely secondary to his exposure to the mold at this workplace."

Dr. Iyer performed the biopsy in March 2006. He stated that one of the cultures would be sent for culture and sensitivity and gram stain. No pneumothorax was noted when surveyed under fluoroscopy. Dr. Iyer's postoperative diagnosis was bilateral infiltrates, etiology undetermined, question community acquired pneumonia, question interstitial lung disease, question noninfectious etiology.

In a decision dated July 20, 2006, the Office denied appellant's claim. The Office found that he failed to establish that the claimed medical condition was related to the established work-related event.

On November 7, 2006 appellant testified at an oral hearing before an Office hearing representative. In a decision dated January 16, 2007, the hearing representative affirmed the Office's denial of compensation. He found that appellant's exposure to mold on March 7, 2006 was well established, but the medical evidence was insufficient to prove that the exposure caused or contributed to his pulmonary condition. The hearing representative noted that he did not submit all medical records of the examination and testing for his pulmonary condition. Also, he did not submit a nonspeculative reasoned medical opinion based on a complete factual and medical background explaining how and why the pulmonary condition was causally related to the work exposure. The hearing representative found that Dr. Iyer's June 15, 2006 report was speculative in tone, not clearly based on a complete factual background of appellant's exposure, and was not medically rationalized.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of duty.[1] An employee seeking benefits under the Act has the burden of proof to establish the essential elements of his claim. When an employee claims that he sustained an injury in the performance of duty, he must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. He must also establish that such event, incident or exposure caused an injury.[2]

Causal relationship is a medical issue,[3] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[4] must be one of reasonable medical certainty,[5] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[6]

[1] 5 U.S.C. § 8102(a).

[2] *See generally John J. Carlone*, 41 ECAB 354 (1989); *Abe E. Scott*, 45 ECAB 164 (1993).

[3] *Mary J. Briggs*, 37 ECAB 578 (1986).

[4] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[5] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[6] *See William E. Enright*, 31 ECAB 426, 430 (1980).

ANALYSIS

There is no dispute that appellant was exposed to mold on March 7, 2006 in the course of his employment. He has met his burden to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The question that remains is whether this exposure caused an injury to his lungs.

The June 15, 2006 report of Dr. Iyer, the internist specializing in pulmonary diseases, lends some support to appellant's claim, but it is not sufficient to establish the critical element of causal relationship. Dr. Iyer correctly noted that appellant was exposed to a moldy area at work on March 7, 2006, but he did not review the May 23, 2005 mold assessment in Room H27, which stands as the best evidence of the nature of appellant's exposure, and he did not account for appellant's activity in the room or the duration of his exposure. This diminishes the probative or evidentiary value of his opinion. Medical conclusions based on inaccurate or incomplete histories are of little probative value.[7]

Dr. Iyer reported that a biopsy suggested an allergic reaction in the lung possibly secondary to mold-type exposure, but he did not explain. His operative report indicated that the biopsy would be sent for culture and sensitivity and gram stain, but there is no report of the results. Dr. Iyer noted that appellant was referred to the Cleveland Clinic Foundation for a larger lung biopsy, but the results of that biopsy are also not in the record. It is unknown whether the larger biopsy supported Dr. Iyer's opinion or contraindicated the suggestion of an allergic reaction to mold. Without a fuller explanation of the medical basis for his conclusion, Dr. Iyer's opinion, while generally supportive of appellant's claim, is insufficient to establish the element of causal relationship.[8]

Sound medical reasoning is particularly important in this case, where appellant had a history of pneumonia, where everyone at work appeared to have the flu at the time appellant began feeling ill, and where appellant was diagnosed with and aggressively treated for pneumonia. If this diagnosis was wrong, Dr. Iyer did not explain. The Board will affirm the Office's decisions denying appellant's claim for compensation.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained a pulmonary injury in the performance of duty on March 7, 2006. The factual evidence sufficiently establishes his exposure to mold in the course of employment, but the medical evidence fails to show how this exposure caused an injury to his lungs.

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[7] *James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete). *See generally Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

[8] *See Connie Johns*, 44 ECAB 560 (1993) (holding that a physician's opinion on causal relationship must be one of reasonable medical certainty, supported with affirmative evidence, explained by medical rationale and based on a complete and accurate medical and factual background).

ORDER

IT IS HEREBY ORDERED THAT the January 16, 2007 and July 20, 2006 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: July 26, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

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