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

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| **R.O., Appellant** | ) | |
| **and** | ) | **Docket No. 09-2241** |
| | ) | **Issued: September 16, 2010** |
| **U.S. POSTAL SERVICE, POST OFFICE, Stockbridge, MI, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### *JURISDICTION*

On September 8, 2009 appellant filed a timely appeal from the August 14, 2009 merit decision of the Office of Workers' Compensation Programs denying his claim for a work-related environmental condition. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

### *ISSUE*

The issue is whether appellant met his burden of proof to establish that he sustained an occupational disease as a result of chemical and other environmental exposures in the performance of duty.

### *FACTUAL HISTORY*

On December 28, 2006 appellant, then a 43-year-old postmaster, filed an occupational disease claim alleging that he sustained various medical conditions, including allergic and

pulmonary conditions, due to exposure to harmful substances at work.[1] He asserted that he was exposed to some unknown harmful substance when contractors dismantled the ceiling and insulation at the employing establishment on October 27 and 28, 2006. Appellant indicated that water from the ceiling dripped on him during these activities.

In a December 29, 2006 statement, appellant noted that on October 27, 2006 the roof at the employing establishment was being repaired due to a history of water leaks. The floor was covered with water when he arrived at work and he encountered leaking water in multiple locations. Appellant attempted to dry and secure the mail in the processing area and box section and placed containers on the casing equipment in the processing area to keep water from splashing on employees. A clerk informed him that construction workers were in the building dismantling and removing the ceiling tiles and insulation and that commercial fans were circulating debris throughout the building without any protective barriers. Appellant felt irritation in his eyes within 15 minutes of arriving at work. When he arrived at work on October 28, 2006 he observed that the protective tarp had given way and the building was flooded again. Appellant decided to suspend operations on October 29, 2006 and spent 11 hours in the building working to move operations to a temporary location. On October 31, 2006 he returned to the employing establishment wearing a respirator mask and a safety officer noticed that his face was getting red. In following days, appellant began to experience swollen neck glands, facial burns, irritated eyes, headaches and pain from both ears down into the neck glands. He first sought medical treatment on November 6, 2006. Environmental testing at the employing establishment was begun in early November 2006 and showed the presence of several molds (Penicillium, Stachybotrys, Aspergillus and Chaetomium) and asbestos fibers.[2]

On November 1, 2006 inspectors from Environmental Testing & Consulting, Inc., performed environmental studies to assess the condition of the work site. In a November 3, 2006 report, the inspectors noted that water damaged ceiling material and insulation had been removed prior to the inspection and observed that there were visible water stains on the exposed roof decking and ceiling joists.[3] Total mold air testing, which measured all spores floating in the air of the building, indicated "no significant amplification of airborne mold spores." The report indicated that the bulk sampling performed showed that a "few spores" of Penicillium and Aspergillus were present on the ceiling joist south of the utility room wall.[4] Based upon the review of the facility and sampling results, it was determined that there was "no evidence of significant mold growth in the building."

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[1] Appellant stated that he developed facial burns, swollen neck glands, headaches and sharp pain in both sides of his face.

[2] Appellant indicated that he was allergic to Penicillin, a medication made from Penicillium.

[3] Moisture readings of the roof decking and joist ranged from 8 to 17 percent and readings of plaster walls ranged from 6 to 8 percent. The report noted that readings below 12 percent were considered to be acceptable, readings between 12 and 17 percent were moderately wet and readings greater than 17 percent were saturated. Relative humidity levels in the building ranged from 33 to 40 percent. Humidity readings exceeding 55 percent were deemed to provide increased chances for mold growth.

[4] Other mold spores, including Basidiospores and Cladosporium, were found in several areas, but the concentration of all spore types did not exceed 80 spores per cubic meter.

A second sampling was performed by Environmental Testing & Consulting, Inc., on November 24, 2006. In a November 29, 2006 report, it was noted that samples for total mold spores and asbestos fibers were taken from the service counter, back and exterior areas. Traces of Stachybotrys and Chaetomium were detected in the sample taken from the front of the restrooms. These results were characterized as representing "very low levels," and recommendations were made for clean-up activities.[5] The report noted that airborne asbestos fiber sampling revealed that all samples collected were below the acceptable average criterion of 70 asbestos structures per square millimeter ($As/mm^2$) as required by the Environmental Protection Agency (EPA) under the Asbestos Hazard Emergency Response Act (AHERA). The highest level noted was 26 $As/mm^2$ which meant that the highest sample was less than 50 percent of the clearance levels established for school buildings.

On January 10, 2007 Dr. Amy L. Dean, an attending osteopath and Board-certified internist, stated that she first saw appellant on December 6, 2006 for a rash on his face and hands. Appellant reported being exposed to mold while working at the employing establishment and experiencing a burning sensation, skin outbreaks, headaches and difficulty breathing. Dr. Dean stated that November 1, 2006 testing showed that he was exposed to Stachybotrys, Cladosporium, Chaetomium, Penicillium and Aspergillus. She noted that exposure to indoor airborne mold could lead to multiple medical conditions affecting the dermatological, immune, respiratory and nervous systems and recommended that appellant be evaluated by Dr. William J. Rea, a physician Board-certified in several surgery specialties who was a member of the American Academy of Environmental Medicine.[6]

In a February 1, 2007 letter, the Office asked appellant to submit additional factual and medical evidence in support of his claim.

In a February 1, 2007 report, Dr. Rodney H. Poling, an attending osteopath and Board-certified family practitioner, advised that appellant presented on November 6, 2006 with a history of being exposed to toxic chemicals at work. Appellant indicated that on October 27, 2006 roofers repaired the leaking roof of his workplace and he subsequently experienced respiratory difficulty, tightness in his neck and in the skin around his eyes, headache and a rash on his face, ears and hands. On physical examination, there was an erythematous rash on his forehead, periorbital areas, ears and a fullness of his cervical area compatible with "lymphatic congestion secondary to the dermatological conditions." Dr. Poling stated that these conditions were exacerbated by two subsequent 45-minute exposures to mold in the same building. A preliminary examination revealed that appellant had toxic exposure to chemicals and molds including Penicillium and that he had a confirmed history of a Penicillin allergy. Dr. Poling concluded that appellant was exposed to various toxic chemicals while working which required "extensive toxicological evaluation and treatment."

[5] Other mold spores, including Basidiospores, Chaetomium and Cladosporium, were found in several areas, but the concentration of all spore types did not exceed 80 spores per cubic meter. Wall material had been removed in the bathrooms and utility room, but no evidence of mold impact was observed in the exposed cavities.

[6] On April 2, 2007 Dr. Dean stated that, while appellant's exposure to "incitants" at the employing establishment exacerbated his condition, additional evaluation was needed by Dr. Rea.

On February 17, 2007 Dr. Richard Schultz, an attending Board-certified dermatologist, noted appellant's complaints of persistent rash with a burning sensation on his face. Examination revealed erythematous dermatitis on his medial cheeks and mid forehead which was most consistent with eczema or contact dermatitis. Dr. Schultz reviewed numerous documents and photographs of appellant's face and stated, "I can find no connection to an infectious etiology. There is a possibility that [appellant] may have developed an irritant dermatitis from some of the roofing material."

In a March 22, 2007 report, Dr. Rea noted that appellant underwent initial testing that "revealed significant sensitivity with work-related symptoms provoked when skin tested to several molds and to formaldehyde found in fiberglass." He diagnosed autonomic nervous system dysfunction documented by abnormal heart rate variability test and pupillography and opined that this condition was related to mold and chemical exposure at work.

In an April 26, 2007 report, Dr. Rea stated that appellant developed a rash and burning sensation on his face, headaches and difficulty breathing due to exposure to molds, airborne asbestos fibers and chemicals while working at the employing establishment. Appellant also experienced symptoms of itching, dry eyes, blurred vision, heart murmur and dysphagia. Neurological examination revealed that he was unable to maintain balance while performing tandem gait test and while walking on his toes with his eyes closed. Clinical examination showed swollen nasal passages, white tongue, regular heart rate with no murmur, clear breathing sounds without rales or wheezing and slight erythema of the face. Dr. Rea indicated that mycotoxin testing showed a significantly elevated level at 12.51 parts per billion (ppb) and that pupillography testing, which was developed to evaluate the autonomic nervous system, was abnormal with nonspecific changes. The heart rate variability test, designed to detect early signs of functional disorder, revealed that the parasympathetic system had decreased significantly while the sympathetic system had increased with activity. Appellant had a physical fitness level of 10.5. The results of the skin testing demonstrated significant sensitivities to Stachybotrys, formaldehyde and benzene, which produced symptoms of tension, temple pressure and burning sensation.

Based upon his examination and the results of diagnostic testing, Dr. Rea opined that appellant suffered from toxic effect of mycotoxin, toxic encephalalopathy, dermatitis, mold sensitivity, chemical sensitivity and autonomic nervous system dysfunction. He stated that it was clear that appellant suffered from multi-organ system dysfunction based on the elevated tricothecene mycotoxin in his urine and posited that the immune system dysfunction was demonstrated by the skin testing results and the reproduction of his primary chief complaints. The finding that appellant had nervous system dysfunction was based upon the results of the pupillography and the heart rate variability testing. Dr. Rea stated that appellant was in a hypermetabolic and hyperreactive state, which often tended to deplete appellant's nutrient pools, impaired detoxification and resulted in his susceptibility to accumulation of chemical and mycotoxins. Appellant had suffered a significant exposure to mold, as documented by the environmental studies and the skin testing demonstrated his sensitivity to mold which in turn provoked the majority of his presenting symptoms. Dr. Rea discussed the effects mold toxins can have on the development of cancer and other serious medical conditions. He concluded that appellant's diagnoses were related to his chronic and cumulative exposure to chemicals, molds and mycotoxins while at work.

In a June 26, 2007 decision, the Office denied appellant's claim on the grounds that he did not submit sufficient medical evidence to establish that he sustained an occupational disease in the performance of duty. It accepted that he was exposed to minimal levels of molds and asbestos from October 27 to 31, 2006, which were well within EPA standards. The Office found, however, that none of the physicians of record provided a rationalized medical opinion relating appellant's claimed conditions to the accepted work factors.

Appellant requested a hearing before an Office hearing representative.[7] In a September 27, 2007 decision, an Office hearing representative set aside the June 26, 2007 decision and remanded the case for further development. She found that, while the reports of the attending physicians were not completely rationalized, they generally supported that appellant sustained a reaction to the exposures at work. The hearing representative directed the Office to refer him for a second opinion examination with an appropriate Board-certified medical toxicologist or environmental medicine specialist.

The Office referred appellant for evaluation by Dr. Ernest Chiodo, Board-certified in internal, public health, preventive and occupational medicine. In a December 3, 2007 report, Dr. Chiodo discussed appellant's factual and medical history, including the findings on examination and diagnostic testing. He found that appellant did not have any active injury or illness arising from his exposures at the employing establishment. While there was evidence of some mold amplification within the building at the time of testing, the reports that Dr. Chiodo reviewed did not establish any significant or substantial contamination of the building with mold species and appellant did not exhibit any evidence of toxic chemical exposure. Appellant's neck lymphadenopathy and facial pain might have been related to some allergic response to mold, but these conditions resolved shortly after he left the work premises. Dr. Chiodo advised that the facial rash he observed on examination was not consistent with any disease from mold exposure and appeared to have a telangiectasia character that was atypical of a rash that one would experience with mold exposure. He stated:

> "In conclusion, it is my opinion that [appellant] does not currently have any injury or illness arising from exposure to any contaminants or toxicologic agent in his workplace. [Appellant] may have had some mild allergic response to mold exposure while working in the building manifested in the form of bilateral lateral facial pain and neck lymphadenopathy, however, if these conditions did occur, they resolved shortly after his having left the building."

In a January 25, 2008 decision, the Office denied appellant's occupational disease claim. It found that the weight of the medical evidence rested with the well-rationalized medical opinion of Dr. Chiodo.

In an August 14, 2008 report, Dr. Rea reiterated appellant's factual and medical history and diagnosed a toxic effect of mycotoxin, toxic encephalopathy, dermatitis, mold sensitivity, chemical sensitivity and autonomic nervous system dysfunction. He provided an extensive discussion of the medical conditions caused by exposure mycotoxin and chemicals and stated

[7] In a July 25, 2007 letter, appellant provided additional argument in support of his claim. He alleged that environmental studies that were undertaken were incomplete.

that appellant's diagnoses were related to chronic and cumulative exposure to chemicals, molds and mycotoxins while at work. Dr. Rea stated:

> "[Appellant's] history clearly shows a significant mold and chemical exposures. Mold studies revealed elevated levels in the [his] workplace.... The Urine Mycotoxin (Trichothecene) documented [that appellant's] personal intake of molds and mold toxins and documented a history of mold and mold toxin exposure. It has been in my medical experience that toxic chemical and mycotoxin exposures will affect many organ systems and produce a complex medical condition. [Appellant's] immune system was dysfunctional which was evident with the skin testing results, which show sensitivities to several Stachybotrys, Formaldehyde and Benzene. More significantly, [his] primary chief complaint symptoms were reproduced. It is well known in the profession, [appellant] who has a strong sensitivity to a particular substance will cross react with other antigens. Pupillography through an iriscorder and the heart rate variability test reveals autonomic nervous system dysfunction. [Appellant] exists in a hypermetabolic and hyperreactive state. This state has a tendency to deplete [his] nutrient pools, consequently impairing detoxification and resulting in [his] susceptibility to accumulation of chemicals and mycotoxins."

In an October 6, 2008 decision, an Office hearing representative set aside the January 25, 2008 decision and remanded the case to the Office for further development of the medical evidence. He directed the Office to prepare a statement of accepted facts that further detailed the nature and extent of appellant's work exposure and to obtain a supplemental report from Dr. Chiodo to clarify whether appellant suffered facial pain, neck lymphadenopathy or any medical condition due to the accepted work factors.[8] Dr. Chiodo was asked to address whether he agreed with the diagnoses and opinion on causal relationship by Dr. Rea.

In a February 10, 2009 report, Dr. Chiodo stated that he did not see documentation of bilateral facial pain or neck lymphadenopathy, noting that the April 26, 2007 and August 14, 2008 reports of Dr. Rea found that appellant's neck was supple with no lymphadenopathy or carotid bruits. He explained that lymphadenopathy is a nonspecific sign that can occur for any number of reasons, including minor head and neck infections, tooth infections, toothaches and mild viral infections. Dr. Chiodo disagreed with Dr. Rea that appellant had any work-related disease or specifically any disease due to mold exposure (including myocotoxins). He stated that the mycotoxin test used by Dr. Rea was not well recognized and it had not been accepted that the mere presence of any mold mycotoxins upon urine testing was indicative of toxicity as there was no existing standardization of toxicity levels. Moreover, the fact that mycotoxins were found in urine would not tell one how they were contracted or ingested. Dr. Chiodo stated that there was no indication that appellant was exposed to chemicals or substances other than mold in that he was not suffering from any disease due to any such exposure, nor was he currently suffering from any disease due to exposure to mold. He stated, "In conclusion, my opinion remains the

[8] If it was determined that appellant had bilateral facial pain or neck lymphadenopathy, Dr. Chiodo was to indicate whether these symptoms were associated with specific diagnosed medical conditions.

same, that [appellant] is not suffering from any disease due to any exposure in his workplace and in specific that he is not suffering from any chemical or mold mediated disease."

In a March 12, 2009 decision, the Office denied appellant's claim that he sustained an occupational disease in the performance of duty.

Appellant requested a hearing before an Office hearing representative. At the hearing held on June 9, 2009, he testified that he had no dermatological condition prior to exposure to harmful substances at work on October 27, 2006. Appellant contented that the medical evidence of record, particularly the reports of Dr. Rea, established his claim.

In an August 14, 2009 decision, the Office hearing representative affirmed the March 12, 2009 decision.

## ***LEGAL PRECEDENT***

An employee seeking benefits under the Federal Employees' Compensation Act[9] has the burden of establishing the essential elements of his 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 for which compensation is claimed are causally related to the employment injury.[10] These are the essential elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[11]

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 a causal relationship 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.[12]

Section 8123(a) of the Act provides in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee,

[9] 5 U.S.C. §§ 8101-8193.

[10] *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[11] *See Delores C. Ellyett*, 41 ECAB 992, 994 (1990); *Ruthie M. Evans*, 41 ECAB 416, 423-25 (1990).

[12] *Victor J. Woodhams,* 41 ECAB 345, 351-52 (1989).

the Secretary shall appoint a third physician who shall make an examination."[13] When there are opposing reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist, pursuant to section 8123(a) of the Act, to resolve the conflict in the medical evidence.[14]

## *ANALYSIS*

Appellant claimed occupational disease due to exposure to certain substances after roof and ceiling repairs were performed in his workplace in late October 2006. The Office accepted that he was exposed to mold (including Stachybotrys and Chaetomium) and asbestos from October 27 to 31, 2006. The environmental testing revealed levels of mold that were described as not being significant and levels of asbestos that were within the accepted standards set forth by the EPA. The Board finds that there is a conflict in the medical evidence regarding whether appellant sustained an occupational disease as a result of chemical or other environmental exposures in the performance of duty.

Dr. Rea, an attending physician Board-certified in several surgery specialties and a member of the American Academy of Environmental Medicine, determined that appellant's exposure to harmful substances at work caused him to sustain various conditions affecting his lungs and skin. He noted that clinical examination revealed swollen nasal passages, white tongue and slight erythema of the face. Based upon his examination and the results of diagnostic testing, Dr. Rea opined that appellant suffered from toxic effect of mycotoxin, toxic encephalalopathy, dermatitis, mold sensitivity, chemical sensitivity and autonomic nervous system dysfunction. He stated that it was clear that appellant suffered from multi-organ system dysfunction based on the elevated tricothecene mycotoxin 12.51 ppb in his urine. Immune system dysfunction was demonstrated by the skin testing showing significant sensitivity to Stachybotrys, formaldehyde and benzene and the reproduction of his primary chief complaints. The finding that appellant had nervous system dysfunction was based upon the results of the pupillography and the heart rate variability testing.[15] Dr. Rea stated that appellant was in a hypermetabolic and hyperreactive state, which often tended to deplete his nutrient pools, impaired detoxification and resulted in his susceptibility to accumulation of chemical and mycotoxins. Appellant had suffered a significant exposure to mold, as documented by the environmental studies and his sensitivity to mold provoked the majority of his presenting symptoms. Dr. Rea discussed the effects of mold toxins on the development of serious medical conditions and concluded that appellant's diagnoses were related to his chronic and cumulative exposure to chemicals, molds and mycotoxins while at work.

In contrast, Dr. Chiodo, an Office referral physician Board-certified in internal, public health, preventive and occupational medicine, found that appellant did not sustain any work-

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[13] 5 U.S.C. § 8123(a).

[14] *William C. Bush*, 40 ECAB 1064, 1975 (1989).

[15] In a March 22, 2007 report, Dr. Rea noted that appellant underwent had significant sensitivity to several molds and formaldehyde upon spin testing. He diagnosed autonomic nervous system dysfunction documented by abnormal heart rate variability test and pupillography and opined that this condition was related to mold and chemical exposure at work.

related occupational disease. He noted the limited nature of appellant's exposure to substances in the workplace and indicated that the findings on examination and diagnostic testing did not show the existence of a specific diagnosed environmental condition. Dr. Chiodo indicated that the facial rash evidence he observed in December 2007 was not consistent with any disease to mold exposure and appeared to have a telangiectasia character that was atypical of a rash that one would experience with mold exposure. He stated that he did not see documentation of facial pain and neck lymphadenopathy noting that the April 26, 2007 and August 14, 2008 reports of Dr. Rea indicated that appellant's neck was supple with no lymphadenopathy or carotid bruits. Dr. Chiodo explained that lymphadenopathy is a nonspecific sign that can occur for any number of reasons including minor head and neck infections, tooth infections, toothaches and mild viral infections. He disagreed with Dr. Rea that appellant had any work-related disease and specifically any disease due to mold exposure, including myocotoxins. Dr. Chiodo noted that it had not been accepted that the mere presence of any mold mycotoxins upon urine testing was indicative of toxicity as there was no existing standardization of toxicity levels and indicated that the fact that mycotoxins were found in urine would not tell one how they were contracted or ingested.

The case will be remanded to refer appellant to an impartial medical specialist to resolve the conflict in the medical opinion evidence between Dr. Rea and Dr. Chiodo regarding whether appellant sustained an occupational disease as a result of chemical or other environmental exposures. After such further development as the Office deems necessary, it shall issue an appropriate decision regarding appellant's claim.

## ***CONCLUSION***

The Board finds that the case is not in posture for decision regarding whether appellant sustained an occupational disease as a result of chemical on other environmental exposures in his federal employment.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 14, 2009 decision of the Office of Workers' Compensation Programs be set aside. The case is remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: September 16, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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