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

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| **P.W., Appellant** | ) | |
| **and** | ) | **Docket No. 10-2402** |
| | ) | **Issued: August 5, 2011** |
| **DEPARTMENT OF VETERANS AFFAIRS, HUNTER HOLMES McGUIRE MEDICAL CENTER, Richmond, VA, Employer** | ) | |

*Appearances:*
*Charles W. Jackson*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

### *JURISDICTION*

On September 27, 2010 appellant filed a timely appeal from an August 18, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

### *ISSUE*

The issue is whether appellant met her burden of proof to establish that she sustained an occupational disease in the performance of duty.

### *FACTUAL HISTORY*

On November 23, 2009 appellant, then a 55-year-old rehabilitation technician, filed an occupational disease claim alleging that she sustained a headache, irritated eyes, coughing and burning in her nose and throat due to airborne dust. She became aware of her condition and its relationship to her employment on November 16, 2009. Appellant was last exposed on

[1] 5 U.S.C. § 8101 *et seq.*

November 19, 2009 and stopped work on November 23, 2009.[2] A medical note dated November 23, 2009 from Dr. Richard L. Overmeyer, a Board-certified internist, authorized a December 8, 2009 return to work.

OWCP informed appellant in a December 14, 2010 letter that additional evidence was needed to establish her claim. It gave her 30 days to submit a statement identifying the employment factors that contributed to her condition and medical reports offering a physician's reasoned opinion as to how occupational exposure caused or aggravated the injury.

In a November 30, 2009 statement, appellant noted that an adjacent work area was under construction and a nearby hallway was being painted when she experienced burning in her eyes, nose and throat as well as a headache, coughing and vocal changes during a November 16, 2009 shift. Three days later on November 19, 2009, she reported worsening symptoms to the employing establishment's health clinic. Appellant's blood pressure was 174/104 millimeters of mercury (mmHG) at the time. She denied any history of smoking or hypertension and attributed her condition to construction dust and airborne particle exposure.[3]

A November 24, 2009 attending physician's report from Dr. David Alan Chandler, a Board-certified ophthalmologist, related that appellant sustained ocular irritation from fumes and debris at the worksite on November 16, 2009. Appellant exhibited a corneal breakdown on examination. Dr. Chandler diagnosed punctate keratitis, allergic conjunctivitis and ocular pain. He checked the "yes" box in response to a form question asking whether appellant's condition was caused or aggravated by employment activity and added that "consistent ocular damage follows exposure." In a November 24, 2009 duty status report, Dr. Chandler released her to full-time duty starting December 8, 2009.

In a December 1, 2009 attending physician's report, Dr. Overmeyer noted that appellant was exposed to fumes and dust due to workplace construction on November 16, 2009, resulting in eye irritation and a sudden increase in blood pressure. He diagnosed acute conjunctivitis and possible hypertension. Dr. Overmeyer checked the "yes" box to indicate that appellant's condition was caused by her job and explained that she did not demonstrate hypertension before her exposure.[4] He discharged her to regular work on December 7, 2009.[5]

The employing establishment controverted the claim in a December 22, 2009 letter, pointing out that the construction occurred in another hallway at least 150 feet away from appellant's unit, the designated site was monitored and inaccessible to employees, industrial vacuums and other procedures were utilized to remove dust particles or otherwise contain them

[2] The notice of injury claim showed that appellant filed two previous claims for a similar injury.

[3] In a subsequent December 30, 2009 statement, appellant added that she reported to the employer's health clinic again on December 10 and 14, 2009. She wore a mask to work on or around December 23, 2009, but continued to have symptoms. Appellant recounted that her condition improved when she stayed home.

[4] Dr. Overmeyer essentially repeated his findings in a December 23, 2009 attending physician's report while adding that appellant also had an employment-related allergic reaction.

[5] On the other hand, a December 1, 2009 duty status report from Dr. Overmeyer checked the "no" box in response to a form question asking whether appellant was able to perform regular work.

to the site, and all vents were properly sealed. It also asserted that the safety manager found no evidence of dust migration.

Periodic eye examination records from Dr. Chandler dated November 24, 2009 to January 4, 2010 stated that appellant was allergic to construction dust at work and sustained a headache, irritated and burning eyes and an elevated blood pressure. Appellant's symptoms resurfaced when she returned to work on November 19 and 23 and December 7, 2009. Dr. Chandler diagnosed superficial punctate keratitis and noted a history of cataracts, conjunctivitis and ocular allergies.[6] In December 15, 2009 and January 4, 2010 attending physician's reports, he diagnosed corneal keratitis and allergic conjunctivitis after observing a corneal breakdown and ocular pain on examination. Dr. Chandler stated that appellant's ocular injury was "related to toxicity from airborne debris, as well as allergy" and advised that she be removed from the area of exposure. He released her to regular work on January 11, 2009.

In a January 7, 2010 attending physician's report, Dr. Elaine S. Turner, a Board-certified allergist, immunologist and internist, diagnosed nonallergic rhinitis and an irritant reaction based on a negative skin test result. She checked the "yes" box in response to a form question asking whether appellant's condition was employment related.

By decision dated April 21, 2010, OWCP denied appellant's claim, finding the evidence insufficient to demonstrate that her occupational exposure occurred as alleged.

Appellant requested reconsideration on May 26, 2010 and provided additional evidence. Reports from Dr. Overmeyer dated November 23 and December 7, 2009 assessed possible hypertension, rashes and ocular issues related to occupational exposure to construction dust. His December 15, 2009 report added that appellant exhibited a scratchy throat, elevated blood pressure and rhinorrhea after returning to work on December 7, 2009.

In eye examination reports dated May 1, 2008 to April 22, 2010, Dr. Chandler noted appellant's ocular symptoms due to exposure to airborne dust and debris at work. Appellant experienced flare-ups whenever she returned from leave. Dr. Chandler recommended eye protection and immediate relocation to another worksite. His April 5, 2010 attending physician's report also related a history of recurring ocular irritation as a result of airborne debris at work. On examination, Dr. Chandler observed a corneal breakdown and conjunctival reactions. He diagnosed corneal punctate keratitis, allergic conjunctivitis and ocular pain. Dr. Chandler checked the "yes" box to indicate that appellant's condition was caused by her employment, pointing out that it was "repeatedly worse with work exposure."

In a January 7, 2010 report from Dr. Turner, appellant complained of headaches, burning eyes, hoarseness and hypertension during intermittent periods of construction at her workplace since 2008. These symptoms resolved whenever she took time off work and reemerged when she returned. On examination, appellant exhibited mild nasal congestion. Prick and intradermal skin tests were negative. Dr. Turner diagnosed nonallergic rhinitis with an irritant reaction due to the construction and opined that appellant's hypertension stemmed from the irritant reaction.[7]

[6] Dr. Chandler's June 24, July 17 and 23, 2009 records noted previous exposures to dust and debris particles.

[7] Dr. Turner reiterated her findings in January 22 and April 22, 2010 progress notes.

Employer health records from April 15, 2008 to April 13, 2010 related that appellant complained of headaches, nasal irritation, allergic reactions and ocular pain due to construction dust and fumes since April 11, 2008. In particular, November 19, December 10 and 14, 2009 notes stated that she presented similar symptoms on and after November 16, 2009, possibly due to an allergic reaction to paint and construction in the area.[8]

In an August 18, 2010 decision, OWCP denied modification of the April 21, 2010 decision.

## ***LEGAL PRECEDENT***

An employee seeking benefits under FECA 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 FECA, that the claim was timely filed within the applicable time limitation period, that an injury was sustained in the performance of duty as alleged and that any disabilities and/or specific conditions for which compensation is claimed are causally related to the employment injury.[9] 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.[10]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[11] To establish fact of injury in an occupational disease claim, an employee must submit: (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.[12]

An employee's statement that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence.[13] Moreover, an injury does not have to be confirmed by eyewitnesses. The employee's statement, however, must be consistent with the surrounding facts and circumstances and her subsequent course of action. An employee has not met his or her burden in establishing the occurrence of an injury when there are such inconsistencies in the evidence as to cast serious doubt upon the validity of the claim. Circumstances such as late notification of injury, lack of confirmation of injury, continuing to work without apparent difficulty following the alleged injury and failure to

[8] No legible physician's signature was on these records.

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

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

[11] *See S.P.*, 59 ECAB 184, 188 (2007).

[12] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *R.R.*, Docket No. 08-2010 (issued April 3, 2009).

[13] *Gregory J. Reser*, 57 ECAB 277 (2005); *R.T.*, Docket No. 08-408 (issued December 16, 2008).

obtain medical treatment may, if otherwise unexplained, cast doubt on an employee's statement in determining whether a *prima facie* case has been established.[14]

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is evidence which includes a physician's 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, 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.[15]

## ***ANALYSIS***

OWCP found insufficient, conflicting and inconsistent evidence as to whether an occupational exposure occurred at the time, place and in the manner alleged. Specifically, while appellant claimed that she sustained various symptoms such as headaches, irritated eyes, coughing and burning in her nose and throat starting on November 16, 2009 due to airborne construction dust, debris and fumes, OWCP found persuasive the employer's December 22, 2009 letter of controversion, which detailed that construction occurred at least 150 feet away from appellant's work area, the site was monitored and inaccessible to all employees, industrial vacuums and other procedures either removed dust particles or contained them to the site, vents were properly sealed and the safety manager found no evidence of dust migration.

The Board finds that appellant provided sufficient evidence to establish that the described employment exposure occurred as alleged. As noted, an employee's statement alleging that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence. Here, the record shows that appellant received initial medical treatment on November 19, 2009, three days after her symptoms arose. She promptly filed an occupational disease claim on November 23, 2009. The history of injury obtained by Drs. Chandler, Overmeyer and Turner and the employing establishment's health clinic were consistent with appellant's factual statements.[16] On the other hand, the employing establishment's December 22, 2009 letter conflicted with its own health records, which indicated that she had some exposure to construction dust and fumes on and after November 16, 2009. The fact that the employer took steps to minimize migration of dust and fumes is insufficient to show that appellant had no exposure at work. In view of the totality of the evidence, the Board finds that she sufficiently established that she was exposed to construction dust, debris and fumes on the job.

The Board finds that appellant did not provide sufficiently-rationalized medical opinion evidence to establish that her condition was causally related to the accepted exposure. The periodic eye examination and attending physician's reports from Dr. Chandler diagnosed

[14] *Betty J. Smith*, 54 ECAB 174 (2002).

[15] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[16] *See Caroline Thomas*, 51 ECAB 451 ("[a] consistent history of the injury as reported on medical reports, to the claimant's supervisor and on the notice of injury can also be evidence of the occurrence of the incident").

appellant with punctate keratitis, allergic conjunctivitis and ocular pain due to construction dust, debris and fume exposure at the workplace. They further noted that appellant experienced flare-ups whenever she returned from leave. In addition, November 24, 2009 and April 5, 2010 attending physician's reports marked the "yes" box in response to the form question asking whether appellant's condition was caused by employment activity. However, these records did not furnish adequate medical rationale explaining how occupational exposure to dust, debris and fumes pathophysiologically caused appellant's diagnosed conditions.[17] Neither Dr. Chandler's observation that appellant was symptomatic at the workplace and asymptomatic on leave[18] nor his affirmative checkbox responses,[19] without supporting rationale, was sufficient to establish causal relationship.

Reports from Dr. Overmeyer from November 23 to December 23, 2009 assessed possible hypertension, rashes, rhinorrhea and acute conjunctivitis in connection with occupational exposure to construction dust and fumes. In particular, a December 1, 2009 attending physician's report contained an affirmative checkmark response regarding causal relationship. Nonetheless, Dr. Overmeyer's opinion has limited probative value on the issue of causal relationship as it lacked fortifying medical rationale.[20]

Similarly, Dr. Turner's January 7 and 22 and April 22 2010 reports are of diminished probative value. While she diagnosed nonallergic rhinitis, hypertension and an irritant reaction related to workplace construction and pointed out that appellant's symptoms only manifested during her employment shifts, she did not provide fortifying medical rationale explaining causal relationship. Also, Dr. Turner's affirmative checkmark response in a January 7, 2010 attending physician's report indicating that appellant's condition was employment related, without supporting rationale, was insufficient to establish the claim. Finally, the remaining medical evidence of record is of limited probative value as none offered an opinion regarding the cause of appellant's injuries.[21]

Employing establishment health unit records, while noting appellant's symptoms and condition after workplace exposure, cannot be considered probative medical evidence as there is no indication that these records were signed by a physician.[22] There is no other medical evidence in which a physician explains the reasons why fumes, debris and dust from construction would cause or aggravate particular diagnosed conditions.

[17] *See Joan R. Donovan*, 54 ECAB 615, 621 (2003); *Ern Reynolds*, 45 ECAB 690, 696 (1994).

[18] *See D.I.*, 59 ECAB 158 (2007) (fact that a condition manifests itself during a period of employment does not raise an inference of causal relationship); *T.M.*, Docket No. 08-975 (issued February 6, 2009).

[19] *See Alberta S. Williamson*, 47 ECAB 569 (1996).

[20] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (a medical opinion not fortified by medical rationale is of little probative value).

[21] *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[22] *R.M.*, 59 ECAB 690 (2008) (a medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a "physician" as defined in 5 U.S.C. § 8102(2)).

Appellant's representative contends on appeal that the August 18, 2010 decision was erroneously based on the employing establishment's December 22, 2009 letter and that the medical evidence demonstrated that appellant was extremely sensitive to her work environment. As noted above, while appellant established that she was exposed to airborne construction dust, debris and fumes at work, the medical evidence did not sufficiently explain how this occupational exposure caused or aggravated her condition. In the absence of well-reasoned medical opinion explaining this relationship, she failed to meet her burden.

The Board points out that appellant submitted new evidence on appeal. The Board lacks jurisdiction to review evidence for the first time on appeal.[23] However, appellant may submit new evidence or argument as part of a formal 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 did not establish that she sustained an occupational disease in the performance of duty.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 18, 2010 merit decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: August 5, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[23] 20 C.F.R. § 501.2(c).