United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 14-255**
	)	**Issued: June 25, 2014**
ENVIRONMENTAL PROTECTION AGENCY, HEADQUARTERS, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Acting Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 8, 2013 appellant filed a timely appeal from the May 15, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied his occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant sustained an injury causally related to his exposure to environmental factors in his employment from December 1991 to July 1995.

FACTUAL HISTORY

On the prior appeal,[2] the Board set forth the relevant facts of this case.[3] On April 25, 1997 appellant, a 54-year-old retired program analyst, filed an occupational disease claim

[1] 5 U.S.C. § 8101 *et seq.*

[2] Docket No. 09-1245 (issued May 24, 2010).

[3] The facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.

alleging that his neurological and respiratory symptoms were a result of his federal employment, primarily a result of his work environment in the Waterside Mall office complex beginning December 1991. He first became aware of a causal relationship to his employment in 1994, after his supervisor told him the Waterside Mall had a history of sick building syndrome.

Initially, appellant's symptoms were apparent only when working in his immediate office space in the West Tower Annex, but they gradually seemed to appear and worsen in adjoining work spaces. Following exposure to smoke and fumes from an electrical fire in May 1994, his symptoms seemed to emerge upon entering the building from any site. From August 1994 to March 1995, appellant was allowed to work primarily from home. Thereafter, appellant worked at an alternative work site, but occasionally visited the Waterside Mall. He stopped work in July 1995 and retired on disability. Appellant identified the nature of his diagnosed disease as occupational asthma/reactive airways disease, migraine headaches, chronic fatigue syndrome, allergic rhinitis and neurocognitive impairment.

On the issue of whether appellant sustained chronic fatigue syndrome in the performance of duty, the Board found that the weight of the medical opinion evidence rested with Dr. Madalene K. Greene, a Board-certified rheumatologist and impartial medical specialist, who observed that chronic fatigue syndrome has no known causative agent and who stated that the current state of standard medical knowledge did not permit a causal link between his chronic fatigue syndrome and his federal workplace. The Board added, however, that she should clarify whether extreme fatigue, weakness, myalgia, arthralgia, headache, dizziness, disruptive sleep and neurocognitive impairment were symptoms of chronic fatigue syndrome and whether her opinion on chronic fatigue syndrome effectively addressed such claimed conditions as dysautonomia, hypotension and ataxia or loss of balance. To the extent that Dr. Greene's opinion did not effectively address these claimed conditions or complaints and to the extent that any remaining nonrespiratory condition constituted a separate medical diagnosis, the Board remanded the case to OWCP to further develop the evidence by obtaining a second opinion on causal relationship.

On the issue of whether appellant sustained a pulmonary or respiratory injury in the performance of duty, the Board found that a conflict in medical opinion remained unresolved between appellant's and OWCP's referral physicians. The Board remanded the case for an impartial medical specialist Board-certified in pulmonary disease. The Board also found that the statement of accepted facts should be revised, primarily to include all relevant reports of environmental data and findings. The facts of this case, as set forth in the Board's prior decision, are hereby incorporated by reference.

Dr. Greene clarified that her opinion addressed appellant's complaints or symptoms of extreme fatigue, weakness, myalgia, arthralgia, headache or migraine, dizziness, disruptive sleep and neurocognitive impairment. She indicated, however, that dysautonomia, hypotension and ataxia/loss of balance were not addressed, as they fell outside the realm of rheumatology.

Following referral to Dr. Ajeet G. Vinayak, Board-certified in pulmonary disease, to resolve whether appellant sustained a pulmonary or respiratory injury in the performance of duty, OWCP accepted his claim for the condition of reactive airways disease.

In a decision dated December 8, 2010, OWCP formally denied appellant's claim for the conditions or symptoms that Dr. Greene confirmed were addressed in her impartial medical evaluation. On June 28, 2011 an OWCP hearing representative affirmed.

Appellant requested reconsideration. It was his understanding that the hearing representative had denied the entirety of his claim. Appellant argued that OWCP was required to develop his claim for eight claimed medical diagnoses[4] and that before doing so OWCP should develop a new statement of accepted facts as directed by the Board.

To support his request, appellant submitted, among other things, a June 19, 2012 report from his family physician, Dr. Ritchie C. Shoemaker,[5] who found that appellant had remained profoundly disabled since 1995 as the result of his occupationally-caused chronic inflammatory response syndrome.

In a decision dated May 15, 2013, OWCP reviewed the merits of appellant's claim and denied modification of OWCP's hearing representative's June 28, 2011 decision. It noted that Dr. Shoemaker had refined appellant's diagnosis from chronic fatigue syndrome to chronic inflammatory response syndrome. "However, other than simply stating that objective medical test results reinforce his diagnosis, he provides no other rationale for his opinion." OWCP noted that Dr. Shoemaker used all of the prior testing and previously submitted medical reports to support his opinion. It found that appellant did not meet his burden of proof to establish that it should accept that he sustained additional conditions causally related to factors of his federal employment.

On appeal, appellant argues that OWCP's decision fails to comply with the Board's prior order; ignores new medical evidence; reaffirms a hearing representative's decision that is based on significant errors; ignores and fails to correct important errors; fails to comply with OWCP's procedures; violates Board precedent and improperly makes medical decisions.

LEGAL PRECEDENT

FECA provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[6] An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim. When an employee claims that he or she sustained an injury in the performance of duty, he or she must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. He or she must also establish that such event, incident or exposure caused an injury.[7]

[4] Appellant listed chronic inflammatory response syndrome (a new diagnosis, replacing chronic fatigue syndrome), dysautonomia, hypotension, sensitization, ataxia, headaches, chronic dizziness and neurocognitive impairment.

[5] The Board is unable to confirm whether Dr. Shoemaker is Board-certified.

[6] 5 U.S.C. § 8102(a).

[7] *John J. Carlone*, 41 ECAB 354 (1989).

Causal relationship is a medical issue[8] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the claimant,[9] must be one of reasonable medical certainty[10] 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.[11]

If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[12] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[13]

ANALYSIS

On the prior appeal, the Board found that the opinion of Dr. Greene, the Board-certified rheumatologist and impartial medical specialist, represented the weight of the medical evidence on the issue of chronic fatigue syndrome. Dr. Greene had reviewed appellant's extensive medical record; and interviewed and examined him. She noted that his symptoms of extreme fatigue, weakness, myalgia, arthralgia, headache, dizziness, disruptive sleep and neurocognitive impairment had started out with a flu-like syndrome in 1993, which progressively worsened over the ensuing three to four years. Dr. Greene also noted that appellant's occupational exposures were all documented one to three years after the onset of his symptoms. Although it was possible the workplace environment contributed to his condition, she explained that the current state of standard medical knowledge did not permit a causal link. As a Board-certified rheumatologist, Dr. Greene is an expert in the field of inflammatory disease and autoimmune response.

It appeared to the Board that Dr. Greene had addressed more than a single medical condition. Dr. Greene noted that extreme fatigue, weakness, myalgia, arthralgia, headache, dizziness, disruptive sleep and neurocognitive impairment were symptoms of appellant's syndrome. Nonetheless, to directly address appellant's argument that OWCP must adjudicate each of the conditions he had itemized, the Board asked OWCP to obtain clarification from her on the scope of her opinion.

Dr. Greene clarified that her opinion did, indeed, address many of the symptoms identified by appellant, including extreme fatigue, weakness, myalgia, arthralgia, headache or

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

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

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

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

[12] 5 U.S.C. § 8123(a).

[13] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

migraine, dizziness, disruptive sleep and neurocognitive impairment. Accordingly, her opinion continues to represent the weight of the medical evidence with respect to his syndrome.

Dr. Greene also clarified that her opinion did not address dysautonomia, hypotension and ataxia/loss of balance, as those conditions fall outside the realm of her specialty in rheumatology. That being the case and consistent with the Board's prior decision, OWCP shall further develop the evidence with respect to these three conditions, complaints or symptoms by obtaining a second opinion on causal relationship.

To support his reconsideration request, appellant submitted a June 19, 2012 report from a family physician, Dr. Shoemaker, who found that appellant had remained profoundly disabled since 1995 as the result of his occupationally caused chronic inflammatory response syndrome. He argued that OWCP was required to develop his claim with respect to this new diagnosis.

Dr. Shoemaker had reported in 2006 and again in 2010, that appellant's illness was caused by exposure to the indoor air environment at his workplace. He explained that appellant's syndrome was given many names, including sick building syndrome, though he felt a better name was "chronic biotoxin-associated illness caused by exposure to interior environments of water-damaged buildings with resident toxigenic microbes, including, but not limited to, fungi." Dr. Shoemaker stated: "The name of the illness is less important at this time than the reality of the clinical symptoms and signs that create a case definition of the illness."

In his June 9, 2012 report, Dr. Shoemaker named a diagnosis of occupationally-caused chronic inflammatory response syndrome. He provided test results to reinforce the diagnosis and appellant's permanent disability for work.

The Board finds that Dr. Shoemaker's most recent report is cumulative of evidence previously submitted and adjudicated. That the name given to appellant's illness is now chronic inflammatory response syndrome, as opposed to chronic fatigue syndrome or any other syndrome for which his clinical symptoms and signs might meet the case definition criteria, does not place an obligation upon OWCP to again adjudicate the issue of causal relationship. As Dr. Shoemaker (of the Chronic Fatigue Center) explained, the name of the illness is less important. The crux of the matter, appellant's constellation of symptoms and signs, has already been addressed by a Board-certified rheumatologist and impartial medical specialist, who made clear that the current state of standard medical knowledge does not permit a causal link between his syndrome and his federal workplace.

The Board finds that OWCP properly denied modification of its decision to deny appellant's claim for the clinical symptoms or signs Dr. Greene confirmed were addressed in her impartial medical evaluation. The Board will therefore affirm OWCP's May 15, 2013 decision.

Appellant may submit new evidence or argument with a 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.

Appellant correctly argues that OWCP failed to comply with the Board's prior decision insofar as it did not obtain a second opinion on issue of dysautonomia, hypotension and ataxia/loss of balance. The Board will remand the case for further action.

CONCLUSION

The Board finds that OWCP properly denied modification of its decision to deny appellant's claim for the conditions or symptoms Dr. Greene confirmed were addressed in her impartial medical evaluation. The Board will therefore affirm OWCP's May 15, 2013 decision.

The Board finds that the case is not in posture for decision on whether appellant developed dysautonomia, hypotension or ataxia/loss of balance as a result of his occupational exposure to environmental factors from December 1991 to July 1995. Further, development of the medical opinion evidence is warranted on this remaining issue.

ORDER

IT IS HEREBY ORDERED THAT the May 15, 2013 decision of the Office of Workers' Compensation Programs is affirmed in part. The case is remanded for further action.

Issued: June 25, 2014
Washington, DC

Patricia Howard Fitzgerald, Acting Chief Judge
Employees' Compensation Appeals Board

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

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