United States Department of Labor
Employees' Compensation Appeals Board

B.E., Appellant	)	
and	)	**Docket No. 15-0815**
	)	**Issued: October 5, 2015**
DEPARTMENT OF VETERANS AFFAIRS, ATLANTA VETERANS ADMINISTRATION MEDICAL CENTER, Decatur, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On February 26, 2015 appellant timely appealed the December 22, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has met her burden of proof to establish that her respiratory condition is causally related to her federal employment.

FACTUAL HISTORY

On December 6, 2013 appellant, then a 55-year-old medical technician, filed an occupational disease claim (Form CA-2) for a respiratory condition that allegedly arose on or

[1] 5 U.S.C. §§ 8101-8193.

about November 1, 2013. She claimed to have been exposed to mold, mildew, and dust particles when a ceiling collapsed due to rain water damage. Appellant indicated that the workroom ceiling tiles had since been replaced, but nothing was done about the mold, mildew, odor, and dust. The alleged occupational exposure reportedly caused headaches and respiratory problems, which included nasal congestion, chest congestion, and throat irritation. Appellant did not submit any factual or medical evidence with her claim.

In a January 17, 2014 development letter, OWCP outlined the five basic elements to establishing a claim under FECA, and advised appellant that her claim was deficient from both a factual and a medical standpoint. Appellant was afforded at least 30 days to submit the required evidence in support of her claim.

In a March 10, 2014 decision, OWCP denied appellant's occupational disease claim because she had not submitted any factual or medical evidence. It found that she failed to establish that the employment incident(s) occurred as alleged. Appellant also failed to submit medical evidence that contained a diagnosis in connection with her alleged occupational exposure.

Appellant requested reconsideration on March 25, 2014, but again failed to submit any factual or medical evidence. Consequently, OWCP denied reconsideration by decision dated April 7, 2014.

On April 23, 2014 OWCP received another request for reconsideration. Appellant provided factual information regarding her claimed exposure, which included various e-mails about the ceiling in her work area. OWCP also received various treatment records from the employing establishment's occupational health unit. Additionally, it received February to April 2014 treatment records from Kaiser Permanente.

On January 22, 2013, before the current claim, appellant had visited the employee health unit complaining of an upper respiratory infection, with nasal drainage, throat soreness, and a loss of appetite over the past five days. She reported having been exposed to dust and mold. Appellant's self-medication had not improved her symptoms. Dr. Michael B. Miller, Board-certified in family practice, who examined appellant, described her condition as "reaction to environmental allergen." He referenced an unexplained June 4, 2012 incident where the employing establishment's safety team and industrial hygienist had been called to investigate. Dr. Miller recommended that appellant be reassigned to another area until the safety team and industrial hygienist could reassess the situation.

Appellant returned to the employee health unit on April 2, 2013 with continued complaints of upper respiratory symptoms while working. Dr. Miller reported that she attributed her symptoms to exposure to mold in the workplace. Appellant described an incident from May 2012 where an overhead pipe leaked water onto her desk and computer. Dr. Miller noted a prior history of allergies, with continued intermittent upper respiratory exacerbation. He provided a differential diagnosis (rule out) of mold vs. allergies. Appellant was advised to continue taking Claritin.

On December 3, 2013 Dr. Miller saw appellant again for complaints of recurrent respiratory allergy from dust in the work environment. Appellant attributed her condition to a ceiling leak that was awaiting repair and replacement of the ceiling tiles. Her current symptoms reportedly began two weeks prior, with minimal relief from self-management. Appellant indicated that the laboratory area where she worked had been closed the previous evening, and when she returned to work the following day she experienced a runny nose, itchy eyes, sneezing, and headache. Dr. Miller's assessment was respiratory allergy exacerbation secondary to environment. He recommended conservative treatment, which included medication and avoidance of the work area until construction was completed.

Joyce Thompson, a doctor of nursing practice and family nurse practitioner, submitted a February 6, 2014 "report of employee's emergency treatment."[2] She noted that appellant visited employee health earlier that day complaining of a sore throat, cough, sinus headache, watery eyes, night cough, and sweats. Appellant also reported that her other acute illness was exacerbated with chest heaviness.[3] Ms. Thompson noted a February 4, 2014 onset of recurrent upper respiratory infection due to work environment construction. Appellant reported there was a dark stain on the ceiling near the sprinkler and a smell of mildew and that the safety team reportedly had visited the area earlier that day and an air quality assessment had been completed the day before. She reported that the staff was instructed to move until further notice. Ms. Thompson noted that appellant's respiratory history was compromised with this environmental exposure. She recommended conservative treatment, which included medication and a humidifier. Ms. Thompson further advised that appellant should be removed from the area or taken off work for the remainder of the day if her condition did not improve.

Appellant returned to the employee health unit on February 11, 2014 and Ms. Thompson submitted another "report of employee's emergency treatment." Ms. Thompson noted that appellant was seen for follow up of her respiratory illness after environmental exposure on February 4, 2014. Appellant reported some relief with medication, but her symptoms flared up earlier that morning while she continued to work at her current workstation. Ms. Thompson recommended that appellant be removed from her current work area until construction was completed.

Dr. Neena D. Ghose, a Board-certified family practitioner, examined appellant on February 20, 2014 and diagnosed acute upper respiratory infection. The Kaiser Permanente treatment records noted a prior history of chronic type 2 diabetes (uncontrolled), screening for diabetic retinopathy, chronic hypertension, sciatica, and fibromyalgia.

In a February 24, 2014 "report of employee's emergency treatment," Dr. Miller noted that he had a discussion with an industrial hygienist who recommended that appellant relocate while construction continued.

Appellant returned to Kaiser Permanente on April 9, 2014, where she was seen by Dr. Marion E. Howard, a Board-certified internist with a subspecialty in geriatric medicine. She

[2] Ms. Thompson previously treated appellant on January 22, April 2, and December 3, 2013.

[3] Appellant's prior medical history included chronic hypertension and type 2 diabetes.

received a diagnosis of allergic rhinitis (nose congestion), seasonal. Dr. Howard prescribed a nasal spray (Fluticasone) and referred appellant to an allergy clinic.

With respect to her alleged occupational exposure, appellant identified several dates in November and December 2013 when the ceiling in her work area leaked. She also provided photographs. Additionally, appellant identified several other dates in March 2014 when the ceiling continued to leak and when ceiling tiles were replaced. She also submitted an April 2, 2014 work completion report, which indicated that a ceiling light panel had been cleaned.

In a February 5, 2014 note to appellant, the employing establishment advised her that engineering, infection control, and safety were all in the labs that morning to evaluate the water leak and ceiling conditions.[4] It further noted that they were currently working to control/stop the leak and also to ensure that the areas were dry.

The record also includes a February 6, 2014 e-mail exchange between Ms. Thompson and Jeffery Jones, the employing establishment's industrial hygiene program manager. The e-mail subject line was "environmental exposure." Ms. Thompson advised that she had seen a total of four employees that day for respiratory complaints as a result of the February 4, 2014 roof leakage and construction work in the laboratory area. She further noted that it was her understanding that safety visited the area to replace the wet ceiling tile. Ms. Thompson noted that one employee was still experiencing breathing difficulty and another employee experienced further complications from a prior medical history.

In a separate February 6, 2014 e-mail to Mr. Jones, Ms. Thompson indicated that an employee reported to occupational health that day with complaints of an upper respiratory infection and headache due to construction on the roof that caused ceiling damage, such as leaking with moisture and mildew odor. She also noted that industrial hygiene and safety had reportedly visited the area. Ms. Thompson further indicated that other staff members were experiencing similar signs and symptoms. She commented that there was no current treatment for the location other than plastic to cover the ceilings. Ms. Thompson advised that the employee was treated with antibiotics, and due to the headache and difficulty breathing, she needed to relocate or take the day off. She asked for an evaluation of the air quality and requested that air purifiers be provided to improve ventilation.

In his February 6, 2014 reply, Mr. Jones noted that an indoor air quality (IAQ) survey had been performed the day before. He further noted that the vendor who performed the IAQ survey did not indicate that there was "anything major going on." Mr. Jones stated that, while the odor was unpleasant, it was not hazardous. He explained that the odor was created by the rain water passing through the roofing material and ceiling tiles, neither of which caused a hazardous fume or odor. Lastly, Mr. Jones advised Ms. Thompson that he would provide the IAQ survey results so that she could include this information in the employees' medical folders.

In a July 3, 2014 merit decision, OWCP found that, while appellant established that she was exposed to "mold or construction" in the workplace, she failed to establish a link between her breathing or upper respiratory condition and the work exposure. It noted that no physician of

[4] In at least one report, Dr. Miller identified Mr. Ugbo as appellant's supervisor.

record explained how "wet ceiling tiles in the workplace" led to the development of a medical condition. Consequently, OWCP continued to deny appellant's occupational disease claim, albeit for a different reason.

On September 17, 2014 appellant again requested reconsideration. She submitted September 8, 2014 treatment records from the Atlanta Allergy and Asthma Clinic. Dr. Na Kyoung Judy Nam, a Board-certified internist, noted that appellant's list of active problems included chronic rhinitis, wheezing, type 2 diabetes mellitus, and unspecified essential hypertension.[5] Aeroallergen testing was negative. Appellant's spirometry revealed a mild restriction, but the results were noted to be limited by technique. The treatment records also noted possible persistent asthma vs. nasal symptoms. Additionally, Dr. Nam considered a possible cardiac etiology, and noted that appellant was scheduled to see a cardiologist in October 2014.

Appellant also submitted a September 16, 2014 "Report of Employee's Emergency Treatment" from Dr. Miller. Dr. Miller noted she was formally diagnosed with asthma and was on multiple medications to control her symptoms. He noted that appellant's condition was aggravated by fumes, chemicals, perfumes, and particulate matter present in her workspace. Dr. Miller further noted that her workplace had been aggravating her condition since 2010, when she began treatment for recurrent respiratory problems. Although appellant was able to work and perform her duties, he recommended that she be relocated in order to minimize contact with airborne irritants.

By decision dated December 22, 2014, OWCP found that, while the medical evidence revealed a history of asthma and chronic rhinitis, the record was insufficient to establish a causal relationship between the diagnosed conditions and appellant's exposure to "mold and construction" in the workplace.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[6]

To establish that an injury was sustained in the performance of duty, a claimant must submit: (1) medical evidence establishing the presence or existence of the disease or condition

[5] Dr. Nam is also certified by the American Board of Allergy and Immunology.

[6] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

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 diagnosed condition is causally related to the identified employment factors.[7]

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[8] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[9] A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician.[10]

ANALYSIS

OWCP has accepted that appellant was exposed to wet ceiling tiles, mold, and construction while performing her duties as a medical technician. Appellant's employee health records reveal a history of allergies and recurrent upper respiratory infections. Her Kaiser Permanente treatment records similarly include a diagnosis of acute upper respiratory infection, as well as allergic rhinitis. Additionally, Dr. Nam noted that appellant's active problems included chronic rhinitis and wheezing. While she also mentioned the possibility of persistent asthma, she did not provide a definitive diagnosis of asthma. Lastly, Dr. Miller recently reported that appellant had been formally diagnosed with asthma, which he believed was aggravated by her workplace exposure.

The issue currently before the Board is whether any of the above-noted conditions have been proven to be causally related to appellant's accepted occupational exposure. As a preliminary matter, the Board finds that Ms. Thompson's February 6 and 11, 2014 reports will not suffice for purposes of establishing causal relationship. Nurse practitioners are not considered physician as defined under FECA.[11]

As noted, causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[12] A physician's opinion on causal relationship must be based on a complete factual and medical background.[13] The mere fact that a condition manifests itself during a period of employment is insufficient to establish causal relationship.[14]

[7] *Victor J. Woodhams, id*.

[8] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[9] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

[11] *See supra* note 8.

[12] *Robert G. Morris*, *supra* note 6.

[13] *Victor J. Woodhams*, *supra* note 6.

[14] 20 C.F.R. § 10.115(e).

Temporal relationship alone will not suffice.[15] Furthermore, appellant's personal belief that her employment activities either caused or contributed to her condition is insufficient, by itself, to establish causal relationship.[16]

The February and April 2014 Kaiser Permanente records do not specifically address appellant's accepted occupational exposure. Similarly, Dr. Nam's September 8, 2014 report does not mention occupational exposure as a causative factor. Consequently, this evidence is insufficient to establish that appellant's rhinitis and acute upper respiratory infection are employment related.

The remaining medical evidence was provided by Dr. Miller, from the employing establishment's occupational health unit. When he saw appellant on January 22, 2013 she complained of an upper respiratory infection, with nasal drainage, throat soreness, and a loss of appetite. Appellant claimed to have been exposed to dust and mold. Dr. Miller described her condition as "reaction to environmental allergen." He referenced a June 4, 2012 incident, but did not otherwise explain the particular incident. Based on the information provided, it is unclear how Dr. Miller was able to attribute appellant's upper respiratory infection to an "environmental allergen."

Appellant returned to the occupational health unit on April 2, 2013. She complained of upper respiratory symptoms, which she attributed to mold exposure. Appellant described a May 2012 incident where an overhead pipe leaked water onto her desk and computer. Dr. Miller noted that she had a prior history of allergies, with continued intermittent upper respiratory exacerbation. He provided a differential (rule out) diagnosis of mold vs. allergies. At the time, Dr. Miller was apparently unsure of the cause of appellant's condition. Consequently, his April 2, 2013 report fails to establish a causal relationship between her respiratory condition and her accepted occupational exposure.

On December 3, 2013 Dr. Miller provided an assessment of respiratory allergy exacerbation secondary to environment. Appellant reported that the ceiling in the lab where she worked had been leaking and was awaiting repair and replacement of the ceiling tiles. Her symptoms had reportedly begun two weeks prior. However, appellant noted that the laboratory was closed the previous evening, and when she returned to work she experienced a runny nose, itchy eyes, sneezing, and headache. Dr. Miller recommended that she avoid her work area until construction was completed. Although there is an apparent temporal relationship between appellant's increased symptoms and her reported occupational exposure, he nonetheless failed to explain how her respiratory allergy was exacerbated by the work environment on or about December 3, 2013.

Lastly, Dr. Miller's September 16, 2014 report incorrectly noted that appellant had been formally diagnosed with asthma. He did not identify the source of the diagnosis. Appellant had recently visited the Atlanta Allergy and Asthma Clinic, but as previously noted Dr. Nam did not provide a definitive diagnosis of asthma. Assuming arguendo that appellant has asthma,

[15] *See D.I.*, 59 ECAB 158, 162 (2007).

[16] 20 C.F.R. § 10.115(e); *Phillip L. Barnes*, 55 ECAB 426, 440 (2004).

Dr. Miller's September 16, 2014 report is still insufficient to establish causal relationship. He indicated that appellant's asthma was aggravated by fumes, chemicals, perfumes, and particulate matter present in her workspace. However, Dr. Miller's description of appellant's workplace exposure was inconsistent with her accepted occupational exposure -- wet ceiling tiles, mold, and construction. A physician's opinion on causal relationship must be based on a complete and correct factual and medical background.[17] Dr. Miller's September 16, 2014 report is insufficient to establish a diagnosis of employment-related asthma.

The Board finds that the medical evidence of record fails to establish that appellant's claimed respiratory condition is causally related to her accepted employment exposure. Accordingly, OWCP properly denied appellant's occupational disease claim.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that her respiratory condition is causally related to her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the December 22, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 5, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

[17] *Victor J. Woodhams*, *supra* note 6.