United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 16-0116**
	)	**Issued: May 25, 2016**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Saginaw, 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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 28, 2015 appellant, through counsel, filed a timely appeal from a June 29, 2015 merit decision and an October 22, 2015 nonmerit 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 this case.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that a respiratory or pulmonary condition was causally related to his federal employment; and, (2) whether OWCP properly refused to reopen his claim for further review of the merits pursuant to 5 U.S.C. § 8128(a).

On appeal counsel asserts that OWCP did not consider appellant's evidence.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 29, 2013 appellant, then a 52-year-old carpenter, filed an occupational disease claim (Form CA-2) alleging that his employment duties caused a lung condition that resulted in a hospitalization where he was placed on life support. He first became aware of the condition and realized it was caused or aggravated by employment on November 30, 2011. The employing establishment noted that appellant was last exposed to the claimed conditions on December 5, 2011.

By letter dated June 7, 2013, OWCP informed appellant of the evidence needed to support his claim. In response, in statements dated June 23 and 24, 2013, appellant related that, beginning in November 2011, he was working in a basement office that was being renovated. He noted that a contractor removed asbestos, which made the area very warm, and then Ardex Feather Finish was applied, and he inhaled fine particles of Ardex dust, which resulted in acute respiratory failure with symptoms of significant chest pain, vomiting, hematuria, decreased urine output, overall weakness, and swollen throat with the inability to swallow. Appellant was hospitalized on December 3, 2011 in critical condition where a tracheostomy was performed for airway management. He noted that his symptoms reappeared on March 13, 2013 when he developed laryngospasm and had difficulty breathing. Appellant reported working at the employing establishment since October 1988. Over his course of employment, he was exposed to sawdust, cement, concrete, silica, drywall dust, and other hazardous materials associated with woodworking, construction, and demolition. Appellant stated that, over time, due to a combination of acute and long-term exposures, he developed permanent lung damage due to pulmonary nodules, lung scarring, shortness of breath, restricted breathing, and uncontrolled asthma, which impacted activities of daily living and his ability to do his job.

In support of his claim, appellant submitted medical evidence including hospital records from December 2011.[2] Emergency department records, completed by Dr. Tracie S. Potis, Board-certified in emergency medicine, dated December 3, 2011, noted a history that he had never smoked and that he was first seen in mild distress with complaints of vomiting, sore throat, and hematuria. She reported a history that appellant had a several-day history of weakness, vomiting, and severe throat pain, and that he had fallen twice over the last month. Physical examination at that time showed no respiratory distress. While in the emergency department, appellant's breathing became compromised, and a computerized tomography (CT) scan was performed. He was admitted in critical condition. A December 3, 2011 neck soft tissue CT scan demonstrated a compromised airway in the supraglottic region, consistent with postinflammatory changes. Admission history and physical examination was completed by Dr. Robert L. Borenitsch, a Board-certified osteopath specializing in otolaryngology. He noted physical examination findings and reported that appellant was taken to the operating room where a tracheostomy was done.

Appellant was seen in consultation on December 4, 2011 by Dr. Farhan Ansari, Board-certified in internal medicine and pulmonary disease. Dr. Ansari reviewed the hospital record,

[2] Appellant also submitted hospital records from an admission in May 2011 for acute appendicitis, where he underwent laparoscopic appendectomy.

noted that appellant was on a ventilator, and provided examination findings. He diagnosed acute respiratory failure related to upper airway edema, posttracheostomy; upper airway edema probably related to vomiting with respiration and inflammation from acid-induced inflammation; possible aspiration pneumonia; hematuria, etiology unclear; and history of recent loss of balance, etiology not clear.

On December 5, 2011 appellant was seen in consultation by Dr. Amir Jundi, Board-certified in internal medicine and nephrology, who reviewed appellant's record, provided findings, and noted that appellant had a history of medullary sponge kidney and microscopic hematuria who was admitted with compromised airway and gross hematuria.

A discharge summary, completed by Dr. Hassan A. Elmalik, Board-certified in internal medicine, noted that appellant was discharged on December 14, 2011. He reported a history that appellant was admitted with severe shortness of breath that started while working in a hot closed environment while changing flooring and carpeting, and that he had been doing this job for decades. Dr. Elmalik advised that appellant's symptoms were attributed to exposure to concentrated chemicals in a closed and hot environment. He indicated that on discharge appellant still had a tracheostomy tube and had mild weakness. Discharge diagnoses were upper airway edema of unclear etiology, likely related to chemical exposure; respiratory failure requiring mechanical ventilation; status post tracheostomy placement; secondary diabetes mellitus, uncontrolled due to steroids; hypertension, controlled; and diabetes mellitus, secondary to systemic steroids. Appellant was discharged home on medication and was to follow up with Dr. Borenitsch, Dr. Ansari, and his family physician.

In reports dated December 29, 2011 to March 1, 2012, Dr. Borenitsch described appellant's course of recovery. On January 5, 2012 he reported that appellant had no respiratory distress, and March 1, 2012 advised that appellant was doing very well with no further inflammation, drainage, coughing, or dysphagia. Examination was unremarkable.

On January 16, 2012 Dr. Ansari noted that appellant's trachestomy tube was removed on January 5, 2015. He advised that appellant's history was negative for asthma and performed physical examination. Dr. Ansari diagnosed congestion of upper airway, post upper airway severe edema, resolved, post heated epoxy exposure. An August 6, 2012 chest x-ray found no infiltrate or nodule.

On January 7, 2013 Dr. Hallie Wilson, a family physician, advised that appellant's examination was normal. On March 11, 2013 she noted a history that he had a past allergic reaction to industrial dust with tracheostomy placement. Dr. Wilson felt that the tracheostomy incision could have developed extra tissue which interfered with breathing. She diagnosed difficulty breathing, and referred appellant to Dr. Borenitsch.

In a March 18, 2013 report, Dr. Borenitsch noted the history of the 2011 incident, stating that this was presumably due to some type of a chemical, and that appellant had done well until the past few weeks. He noted that appellant reported that three weeks previously he had difficulty breathing while drinking in a restaurant and had some continued feeling of difficulty but no significant dysphagia. Dr. Borenitsch advised that it sounded like laryngospasm. Physical examination was unremarkable. A direct fiberoptic laryngoscopic examination showed

that the supraglottic and glottis areas were normal, but appellant could not visualize the subglottic area. He recommended a CT scan. An April 5, 2013 CT scan of the neck showed focal airway narrowing immediately caudal to the level of the glottis, perhaps reflecting a stenotic area in which could be scar tissue from a tracheostomy, or prolonged intubation.

An April 18, 2013 sleep study demonstrated no evidence of sleep disordered breathing. On May 10, 2013 Dr. Normal Dertad Hogikyan, Board-certified in otolaryngology, noted that larynx and trachea endoscopic examination demonstrated minimal contour deformity at the prior tracheostomy site and no subglottic or tracheal stenosis. A May 15, 2013 chest x-ray was normal. A May 17, 2013 CT scan of the chest demonstrated nodules in the subpleural right lower lobe. An August 13, 2012 chest x-ray was normal.

In a June 20, 2013 report, Dr. Borenitsch noted initially seeing appellant in the emergency room on December 3, 2011 for acute upper respiratory obstruction with laryngeal edema and pending respiratory distress that was shown on both CT scan and endoscopically. He noted that appellant was immediately taken to the operating room where a tracheostomy was performed, that he was treated initially with a respirator, weaned off the respirator, and eventually weaned off the tracheostomy. Dr. Borenitsch advised that appellant was seeking disability because he believed that chemical and heat exposure at work triggered his respiratory obstruction.

A June 21, 2013 pulmonary function study demonstrated a mild restrictive lung defect and no obstructive defect. On July 23, 2013 Dr. Wilson noted that appellant related that it was extremely difficult for him to breath at work with any type of exertion. She opined that appellant's exposure to industrial material contributed to the restrictive lung disease and asthma which kept him from working without persistent shortness of breath.

The employing establishment provided a position description for appellant's carpenter. This indicated that the position required exposure to moderate or high noise levels, sawdust in the air, glue fumes, and hazards associated with woodworking and related power equipment. Use of protective devices such as safety glasses, respirators, and gloves was required.

In a June 26, 2013 statement, Larry E. Unrein, appellant's supervisor, noted that the 2011 project took place in phases over several months, with contractors removing all the asbestos. The work entailed the removal of walls, installation of doors, and flooring, with Ardex Feather Finish being used. Mr. Unrein related that, after asbestos removal, the worksite became very warm, but precautions were taken to reduce the heat, including opening windows, and installing ventilation equipment. Appellant did not work on the project daily and he was provided with ventilation equipment. Mr. Unrein advised that all carpenter shop personnel had used Ardex Feather Finish for many years on a periodic basis in short durations as necessary to level concrete floors for the installation of flooring and walls. He related that since the November 2011 incident appellant did not work with materials he felt could cause breathing problems and that his current day-to-day routine was performing locksmith duties. Mr. Unrein also noted that in the past appellant would do outside renovation work.

In a February 23, 2014 decision, OWCP accepted that exposure at work occurred, but denied the claim because the medical evidence of record was not sufficient to establish that a respiratory condition was caused or aggravated by factors of appellant's employment.

Appellant timely requested a hearing before an OWCP hearing representative. In a treatment note dated May 30, 2014, Dr. Sajeda Nusrat, Board-certified in family medicine, noted that appellant was seen to establish care and that he reported that he had silicosis and complaints of shortness of breath and back pain. He reviewed old records, provided examination findings, and recommended additional studies. On June 19, 2014 Dr. Luis Pena-Hernandez, a Board-certified internist, reported that appellant had extrinsic asthma, exacerbated by humidity, and exercise. He advised that spirometry that day was normal. Dr. Pena-Hernandez provided examination findings and diagnosed moderate persistent asthma and abnormal CT scan of lung. On July 11, 2014 Dr. Nusrat noted the history of the 2011 hospitalization. He reported that appellant had increased problems with intermittent coughing and wheezing. A pulmonary function test that day demonstrated moderate restriction. Appellant was referred to an otolaryngologist. A pulmonary function study on August 7, 2014 demonstrated reactive airway disease/asthma.

On an August 7, 2014 treatment note, Dr. Ansari noted seeing appellant in follow up for reactive airway disease, restrictive lung disease, chronic asthma, and a history of lung nodules with complaints of shortness of breath with exertion, chest heaviness, and cough. Dr. Ansari provided findings and reviewed prior tests, including the August 2014 pulmonary function study, stating that it showed mild restriction with significant bronchodilator response. He diagnosed suspected reactive airway disease presenting as asthma; lung nodules since November 2013; restrictive lung disease, reason unknown; chronic asthma; history of respiratory failure following upper airway edema after inhalation of heated epoxy, noting "breathing not the same since injury;" and constant chest pain, likely muscular. On an August 7, 2014 statement for disability retirement, Dr. Ansari advised that appellant had reactive airway disease or asthma, "probably induced by inhalational injury" when appellant inhaled heated epoxy in December 2011. On a statement for disability retirement dated August 13, 2014, Dr. Nusrat advised that appellant had "chronic respiratory failure-harmful inhalants; tracheostomy patient; pulmonary function study shows moderate restrictions; reactive airway disease."

Appellant signed an application of immediate retirement on September 8, 2014. Time and attendance records from December 30, 2012 through September 20, 2014 indicated that he occasionally took sick leave and occasionally worked overtime.

At the hearing, held on October 17, 2014, counsel asserted that the evidence established cumulative exposure to dust and Ardex Feather Finish. Appellant testified that at the end of November 2011 he was working overtime in a basement getting floors ready for renovation by using Ardex Feather Finish. He described the Ardex process, and stated that he became ill over several days at home and had to be hospitalized for a number of days. The hearing representative noted that exposure had been accepted and described the type of medical evidence needed to establish causal relationship. The record was left open for 30 days. Appellant thereafter submitted a material safety data sheet regarding Ardex Feather Finish. A November 8, 2013 CT scan of the chest demonstrated stable nodules in the anterior right lower lobe, when compared to a May 17, 2013 study.

The employing establishment submitted information that appellant had a private building business, and provided information regarding the type of mask provided to him, and product information regarding Ardex Feather Finish.

By decision dated January 2, 2015, an OWCP hearing representative affirmed the February 13, 2014 decision finding the medical evidence of record insufficient to establish appellants claim.

Appellant requested reconsideration on April 6, 2015.[3] He again submitted material data safety sheets regarding Ardex Feather Finish and the July 11, 2014 treatment note from Dr. Nusrat.

In a February 28, 2015 report, Dr. James E. Blessman, Board-certified in internal and occupational medicine, noted reviewing medical records and performing a physical examination. He opined that appellant had evidence of an occupational lung disease with both obstructive and restrictive features. Dr. Blessman advised that the Ardex product, to which appellant was exposed, could cause significant respiratory tract irritation, when the inhaled dust becomes moist. He continued that, while appellant had worked with this product for some time, there were unique circumstances that, could have supported an increased exposure, indicating that he mixed the product in a sink that allowed the dust to be closer to his breathing zone; that he ate his meals in the room where he mixed, which allowed for oral exposure; that the room was hot which could have increased the amount of body moisture and breathing rate which increased the the potential for an internal alkaline burn. Dr. Blessman noted that there had been a continued decline in appellant's lung volumes at a rate that could not be explained by age, with continued work, noting that the decline could be due to a different exposure other than the inciting event, and that the volumes nearly returned to normal with 10 days of workplace avoidance, even though some symptoms remained, which further supported his opinion regarding the relationship between work exposures and appellant's current health condition. He noted further concerns about nonoccupational exposures such as woodworking and appellant's nutrition, but concluded it was most likely work factors primarily responsible for his health decline.

In a letter dated March 4, 2015, Martha B. Yoder, director of the Michigan Occupational Safety and Health Administration, noted that appellant's name had been reported as possibly having an occupational lung disease. Appellant was instructed to contact a physician at Michigan State University for follow-up.

Dr. Ansari, in an April 22, 2015 treatment note, reported appellant's status and diagnosed chronic asthma. Pulmonary function studies were performed that day.

In a merit decision dated June 29, 2015, OWCP denied modification of the prior decisions finding that the evidence submitted by appellant on reconsideration was the prior decisions insufficient to establish causal relationship.

On an appeal request form dated October 10, 2015, received by OWCP on October 16, 2015 appellant again requested reconsideration. In a nonmerit decision dated October 22, 2015,

[3] In correspondence received by OWCP on April 29, 2015, counsel also requested reconsideration.

OWCP denied the reconsideration request, noting that he did not raise substantive legal questions, or include new and relevant evidence.

LEGAL PRECEDENT -- ISSUE 1

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 of FECA, 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 is causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[4]

OWCP regulations define the term "occupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or shift."[5] 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 diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion 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.[6]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 employee.[8] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[9]

[4] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[5] 20 C.F.R. § 10.5(ee).

[6] *Supra* note 4.

[7] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[8] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[9] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

ANALYSIS -- ISSUE 1

The Board finds that appellant did not meet his burden of proof to establish a respiratory or pulmonary condition was caused by federal employment factors. The medical evidence is insufficient to establish causal relationship.

The record supports that on November 30 and December 1, 2011 appellant worked overtime at the employing establishment applying Ardex Feather Finish. He then became ill and was hospitalized from December 3 to 14, 2011. Medical evidence from the hospitalization includes emergency room reports in which Dr. Potis reported that appellant had a several-day history of weakness, vomiting, and severe throat pain, and that while in the emergency room his breathing became compromised. The admission history and examination completed by Dr. Borenitsch noted that appellant had a tracheostomy procedure and was placed on a ventilator. He offered diagnoses that included acute respiratory failure, upper airway edema, and possible aspiration pneumonia. Neither Dr. Potis nor Dr. Borenitsch implicated employment exposure in their analysis. The Board has long held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[10]

Dr. Ansari saw appellant on December 4, 2011. He diagnosed acute respiratory failure related to upper airway edema, posttracheostomy; upper airway edema probably related to vomiting with respiration and inflammation from acid-induced inflammation; possible aspiration pneumonia; hematuria, etiology unclear; and history of recent loss of balance, etiology not clear. In a discharge summary, Dr. Elmalik advised that appellant's symptoms when hospitalized were attributed to concentrated chemicals in a closed, hot environment. He diagnosed: upper airway edema of unclear etiology, likely related to chemical exposure; respiratory failure requiring mechanical ventilation; status post tracheostomy placement; secondary diabetes mellitus, uncontrolled due to steroids; hypertension, controlled; and diabetes mellitus, secondary to systemic steroids. Dr. Elmalik did not demonstrate specific knowledge of appellant's job duties or offer sufficient explanation of how the exposure resulted in appellant's symptoms. Furthermore, his list of diagnoses are couched in equivocal terms, noting unclear etiology, and "likely" exposure. While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[11] The Board finds that neither Dr. Ansari nor Dr. Elmalik provided a clear and unequivocal opinion as to the cause of appellant's diagnosed conditions. The Board also notes that the record from the December 2011 hospitalization does not include daily progress notes completed by physicians during the course of appellant's hospital stay from December 3 to 14, 2011.

Dr. Ansari provided a follow-up report on January 16, 2012 at which time he diagnosed congestion of upper airway, post upper airway severe edema, resolved, post heated epoxy exposure. He did not provide any explanation regarding the epoxy exposure such as where or when this occurred and for what duration. Dr. Borenitsch also provided follow-up reports dated

[10] *Willie M. Miller*, 53 ECAB 697 (2002).

[11] *Ricky S. Storms*, 52 ECAB 349 (2001).

December 29, 2011 to March 1, 2012. He, however, did not discuss any cause of a diagnosed condition.

In a January 7, 2013 report, Dr. Wilson noted a history that appellant had an allergic reaction to industrial dust in the past with tracheostomy placement and felt that the tracheostomy incision could have developed extra tissue which was interfering with his breathing. She diagnosed difficulty breathing and a normal examination, and referred him to Dr. Borenitsch. In a March 18, 2013 report, Dr. Borenitsch noted that appellant had a recent episode that sounded like laryngospasm. He recommended CT scan which demonstrated a stenotic area that could be scar tissue from the tracheostomy. On June 20, 2013 Dr. Borenitsch reported that appellant was seeking disability because he believed exposure to chemicals and heat at work precipitated his respiratory problems. Dr. Wilson opined on July 23, 2013 that appellant's exposure to industrial material contributed to asthma and restrictive lung disease.

The Board finds that neither Dr. Wilson nor Dr. Borenitsch sufficiently explained why the accepted exposure in late 2011 caused appellant's symptoms in 2013. The employing establishment indicated that appellant no longer worked around chemicals and, instead, performed locksmith duties. Neither physician expressed knowledge of the accepted exposure or sufficiently explained how or why this caused appellant's condition. Without a detailed medical report describing how and why appellant's current respiratory condition was caused by employment factors, he has not met his burden of proof.[12]

While Dr. Nusrat and Dr. Pena-Hernandez provided reports dated May 30 to July 11, 2014 in which silicosis and asthma were diagnosed, neither physician provided a cause of the diagnosed conditions.

On August 7, 2014 Dr. Ansari noted a history of epoxy exposure in December 2011 that caused respiratory failure and that breathing had not been the same since the injury. He further indicated that appellant's diagnosed reactive airway disease or asthma was probably induced by the 2011 inhalational injury. A medical opinion must not be speculative or equivocal and should be expressed in terms of a reasonable degree of medical certainty.[13] In his April 22, 2015 treatment note, Dr. Ansari merely diagnosed chronic asthma and did not discuss a cause of appellant's condition.

Dr. Blessman also couched his February 28, 2015 report in equivocal terms. While he discussed how Ardex exposure could cause respiratory problems and noted that appellant worked with the product, he did not exhibit specific knowledge of how and when appellant was exposed, and even though he noted unique circumstances such as mixing the product in a sink and eating in the room where it was mixed, he merely indicated that these could have caused an internal alkaline burn.

Numerous diagnostic studies and Dr. Hogikyan's May 10, 2013 report did not provide a cause of any diagnosed conditions and medical evidence that does not offer any opinion

[12] *See W.S.*, Docket No. 14-1022 (issued July 1, 2014).

[13] *Supra* note 10.

regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[14] The March 4, 2015 correspondence from Ms. Yoder does not constitute probative medical evidence as she is not a physician, and she merely noted that appellant had been reported as possibly having an occupational lung disease.

Appellant argues on appeal that OWCP did not consider all evidence submitted. The June 29, 2015 OWCP decision listed all evidence submitted with the April 6, 2015 reconsideration request with the exception of Dr. Ansari's April 22, 2015 treatment note and the pulmonary function study report that day. The issue in this case is whether appellant met his burden to establish that the claimed pulmonary condition is causally related to factors of his federal employment. In the April 22, 2015 report, Dr. Ansari diagnosed chronic asthma. He did not mention a cause of the condition. Likewise, the pulmonary function study included no physician's opinion on causal relationship. As noted above, medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[15] The only evidence submitted on reconsideration that discussed causal relationship was the February 28, 2015 report from Dr. Blessing discussed above, which was thoroughly reviewed by OWCP in its June 29, 2015 decision.

The opinion of a physician supporting causal relationship must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to a claimant's federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.[16] It is appellant's burden to establish that the claimed pulmonary condition is causally related to factors of his federal employment. In the case at hand, appellant submitted insufficient evidence to show that the diagnosed pulmonary condition was caused by employment factors.

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.

LEGAL PRECEDENT -- ISSUE 2

Section 8128(a) of FECA vests OWCP with discretionary authority to determine whether it will review an award for or against compensation, either under its own authority or on application by a claimant.[17] Section 10.608(a) of OWCP's regulations provides that a timely request for reconsideration may be granted if OWCP determines that the employee has presented evidence and/or argument that meets at least one of the standards described in section 10.606(b)(3).[18] This section provides that the application for reconsideration must be submitted

[14] *Supra* note 11.

[15] *Id.*

[16] *A.D.*, 58 ECAB 149 (2006).

[17] 5 U.S.C. § 8128(a).

[18] 20 C.F.R. § 10.608(a).

in writing and set forth arguments and contain evidence that either: (1) shows that OWCP erroneously applied or interpreted a specific point of law; (2) advances a relevant legal argument not previously considered by OWCP; or (3) constitutes relevant and pertinent new evidence not previously considered by OWCP.[19] Section 10.608(b) provides that when a request for reconsideration is timely but fails to meet at least one of these three requirements, OWCP will deny the application for reconsideration without reopening the case for a review on the merits.[20]

ANALYSIS -- ISSUE 2

On October 16, 2015 appellant merely indicated on an appeal request form that he was requesting reconsideration with OWCP. He submitted no evidence or argument.

The Board finds that, as appellant did not assert that OWCP erroneously applied or interpreted a point of law or advance a relevant legal argument not previously considered by OWCP, he was not entitled to a review of the merits of her claim based on the first and second above-noted requirements under section 10.606(b)(3).[21]

With respect to the third above-noted requirement under section 10.606(b)(3), appellant submitted no additional evidence.

As appellant did not show that OWCP erred in applying a point of law, advance a relevant legal argument not previously considered, or submit relevant and pertinent new evidence not previously considered by OWCP, OWCP properly denied his reconsideration request.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that a respiratory condition was causally related to his federal employment, and that OWCP properly refused to reopen his claim for further review of the merits pursuant to 5 U.S.C. § 8128(a).

[19] *Id*. at § 10.608(b)(1) and (2).

[20] *Id*. at § 10.608(b).

[21] *Id*. at § 10.606(b)(2); *see R.M.*, 59 ECAB 690 (2008).

ORDER

IT IS HEREBY ORDERED THAT the October 22 and June 29, 2015 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: May 25, 2016
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board