United States Department of Labor
Employees' Compensation Appeals Board

C.V., widow of P.V., Appellant	)	
and	)	**Docket No. 15-0083**
	)	**Issued: October 13, 2016**
DEPARTMENT OF AGRICULTURE, U.S. FOREST SERVICE, Bonners Ferry, ID, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 15, 2014, appellant timely appealed May 22, July 2, and October 9, 2014 nonmerit decisions of the Office of Workers' Compensation Programs (OWCP). As more than 180 days elapsed from OWCP's last merit decision dated May 15, 2013, to the filing of this appeal, pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board lacks jurisdiction over the merits of the claim.

ISSUES

The issues are: (1) whether OWCP properly declined to reopen appellant's case for merit review under 5 U.S.C. § 8128(a) on May 22, 2014; and (2) whether OWCP properly denied appellant's requests for reconsideration on July 2 and October 9, 2014 as untimely filed and failing to demonstrate clear evidence of error.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 23, 2009 appellant filed a survivor's claim (Form CA-5) alleging that her husband's, the employee's, March 11, 2009 death was the result of his employment-related asthma. The employee was hospitalized beginning March 7, 2009 following a syncopal episode and marked bradycardia with apparent atrial fibrillation. He had a history of biventricular congestive heart failure and chronic renal failure, and was initially referred to the emergency room (ER) because of his kidney disorder. Around noon on March 11, 2009, the employee had an episode of bradycardia and then flat-lined (asystole). In accordance with his prior instructions, hospital personnel made no attempt to resuscitate the employee. His death certificate listed the immediate cause of death as diffuse amyloidosis with associated heart and renal failure. Additionally, the death certificate identified congestive heart failure and reactive airways dysfunction syndrome as other significant conditions contributing to death, but not resulting in the underlying cause. A March 17, 2009 autopsy revealed, *inter alia*, AL-type amyloid deposits. There was evidence of amyloidosis effecting the heart, kidneys, lungs, spleen, liver, and adrenals.

Between 1981 and 1987, the employee worked as a forestry technician, which was a primary firefighter position.[2] He had an accepted occupational disease claim for smoke-induced asthma under OWCP File No. xxxxxx834, which arose on or about June 23, 1986. The employee last worked for the employing establishment in September 1987. In March 1996, OWCP accepted, under the present claim, permanent aggravation of smoke-induced asthma, assigned File No. xxxxxx268 with a September 4, 1987 date of injury.[3] The employee had been receiving FECA wage-loss compensation benefits until his death on March 11, 2009 at the age of 64.

Appellant's claim for survivor benefits (Form CA-5) was accompanied by a September 22, 2009 report from Dr. Paul J. Marks, a Board-certified internist with subspecialties in pulmonary disease and critical care medicine. Dr. Marks indicated that the direct cause of death was diffuse amyloidosis leading to heart and renal failure. He also noted that occupational asthma was a contributory cause of death. Dr. Marks explained that while the employee's death was primarily due to sequelae of amyloidosis, his occupational asthma "probably" aggravated his heart failure to a degree.

In an April 16, 2010 report, Dr. Marks indicated that the employee had been under his care from April 2007 until his death in March 2009. He had treated him for his employment-related asthma. Dr. Marks noted that in November 2008, the employee began to have increased dyspnea, wheezing, and ankle edema. When he returned in December 2008, Dr. Marks thought the employee was developing congestive heart failure and renal dysfunction. He was subsequently evaluated by a cardiologist and nephrologist. Dr. Marks further noted that on March 7, 2009, the employee presented in heart failure and renal failure. And while being

[2] The employee was a seasonal/temporary employee who worked approximately eight months each year over a seven-year period.

[3] The two employment-related asthma claims have been combined, with the current claim (xxxxxx268) designated the master file.

treated for those problems, he was being evaluated for suspected amyloidosis, which was later confirmed by autopsy. Dr. Marks indicated that the employee had an episode of bradycardia that deteriorated to asystole and death. He reiterated that the employee's death was primarily due to the sequelae of amyloidosis, which caused congestive heart failure, and also acute renal failure. Dr. Marks explained that these were factors unrelated to his employment. However, he further indicated that the employee's occupational asthma probably -- more likely than not -- caused some degree of pulmonary hypertension and *cor pulmonale*, which contributed to his heart failure and arrhythmias. And as such, the employee's occupational asthma was a contributing factor to his death.

OWCP referred the case for a second opinion by Dr. Maroun M. Tawk, a Board-certified internist with subspecialties in pulmonary disease, critical care medicine, and sleep medicine. In an August 3, 2010 report, Dr. Tawk indicated there was no relationship between the employee's death and his accepted condition. He noted that amyloidosis, renal failure, and congestive heart failure were not causally related to the employee's smoke-induced asthma. Dr. Tawk explained that the employee's death was most likely related to amyloidosis, not occupational asthma. He further explained that the medical literature did not establish a relationship between long-term asthma and secondary amyloidosis.[4]

In a November 23, 2010 supplemental report, Dr. Tawk noted that the employee had a history of occupational asthma and had last worked as a firefighter in 1987. He further noted that the employee's death was mostly related to systemic amyloidosis, and there was no evidence that he died from an asthma attack. According to Dr. Tawk, the employee's death was unrelated to his accepted condition. He explained that the autopsy showed amyloid deposition in the interstitium and the vascular system, but no significant pathology at the level of the airways. Dr. Tawk further explained that asthma was an airways disease, not an interstitial disease. Therefore, he found the employee's death was unrelated to his history of asthma or occupational asthma. Dr. Tawk reiterated that the medical literature did not reveal any clear relationship between occupational asthma and systemic amyloidosis.

In a February 17, 2011 decision, OWCP denied appellant's claim for survivor's benefits based on Dr. Tawk's opinion.

Appellant timely requested reconsideration and submitted additional evidence.

In a December 9, 2009 report, Dr. James E. Lies, a Board-certified cardiologist, noted that he treated the employee during the final months of his life. Dr. Lies indicated that the

[4] Dr. Tawk described the three major subtypes of amyloidosis, which include primary (AL), secondary (AA), and hereditary/familial. He explained that primary amyloidosis -- a plasma disorder that affects the bone marrow -- was the most common form and was not associated with other diseases. However, Dr. Tawk noted that primary amyloidosis may also occur in association with multiple myeloma. With regard to secondary amyloidosis, he explained that this type occurred in association with chronic inflammatory or infectious diseases, such as rheumatoid arthritis, tuberculosis, osteomyelitis, and Hodgkin's disease. Dr. Tawk further explained that most patients with secondary amyloidosis have had the related inflammatory disease for more than a decade. Lastly, he noted that hereditary/familial amyloidosis was the only inherited form of the disease and was rare. Dr. Tawk further noted that this type of amyloidosis occurred in most ethnic groups, and each family had a distinctive pattern of symptoms and organ involvement.

employee had severe biventricular heart failure and renal failure, which was related to his amyloidosis. He also noted that amyloidosis was the major contributing factor to the employee's March 11, 2009 death. Dr. Lies further noted that the progression of amyloidosis would be considered idiopathic. He reportedly did not know any occupational reason for the employee acquiring amyloidosis. Dr. Lies also indicated that the employee had coexistent severe lung disease, asthmatic bronchitis, sleep apnea, and metabolic syndrome. Additionally, he referenced the death certificate which identified congestive heart failure and reactive airways dysfunction syndrome (RADS) as other significant conditions contributing to death, but not resulting in the underlying cause. Dr. Lies explained that asthma/RADS results in less oxygenated blood being pumped to the heart and can cause the heart to beat faster. He further explained that this can result in pulmonary hypertension and right-sided heart failure -- *cor pulmonale*. Dr. Lies noted that a March 9, 2009 echocardiogram showed marked right ventricular hypertrophy.

In a June 9, 2010 report, Dr. Michael R. Novak, a Board-certified family practitioner, indicated that smoke inhalation as a firefighter caused chronic pulmonary fibrosis, which was a contributing factor to the employee's March 11, 2009 death.

Dr. John W. Ellis, Board-certified in family medicine and environmental medicine, provided a February 11, 2011 report. He explained that the employee died due to amyloidosis and heart failure. Dr. Ellis also indicated that the employee's asthma aggravated his *cor pulmonale*, which in turn aggravated his heart failure and caused his death. As to what caused the amyloidosis, he indicated that he could not say with reasonable certainty and probability that the condition was due to the employee's prior exposure to toxic fumes. However, Dr. Ellis noted it was possible that smoke inhalation could have caused a toxic reaction resulting in the development of amyloidosis. He explained that fires produced many toxic chemicals and carcinogens, and hardwood fires caused toxic fumes. Dr. Ellis further noted that pine wood caused even greater toxic fumes because of the amount of resin and its higher burning point. He concluded that while heart failure was the primary cause of death, the employee's asthma definitely contributed to the *cor pulmonale* and his eventual heart failure.

By decision dated May 6, 2011, OWCP declined to modify its February 17, 2011 decision denying survivor's benefits. It continued to rely on Dr. Tawk's August 3 and November 23, 2010 reports. The decision noted, *inter alia*, that as Dr. Ellis did not specialize in pulmonary diseases, his February 11, 2011 opinion was highly speculative regarding the relationship between toxic exposure and amyloidosis.

Appellant again requested reconsideration on July25, 2011. Dr. Marks provided a July 15, 2011 supplemental report wherein he noted that a March 9, 2009 echocardiogram confirmed the presence of pulmonary hypertension and *cor pulmonale*. He indicated that occupational asthma caused the pulmonary hypertension and *cor pulmonale*, which contributed to the employee's heart failure and arrhythmias, and his ultimate demise.

OWCP referred the case back to Dr. Tawk. In a September 9, 2011 supplemental report, Dr. Tawk indicated that the employee's asthma did not contribute in any way to his death on March 11, 2009. He noted that the pathology report was very clear that the employee had diffuse amyloidosis that led to renal and heart failure. Dr. Tawk reiterated that there was no relationship between occupational asthma and secondary amyloidosis. He further explained that the progress

notes from the employee's last hospitalization revealed that he was admitted for generalized weakness and not for acute respiratory distress. Dr. Tawk noted that the employee had heart problems aggravated by hyperkalemia (high blood potassium), which manifested itself as severe bradycardia. There was no evidence at the time of admission that the employee was in asthma exacerbation. Dr. Tawk further noted that the March 9, 2009 physical examination of the employee's lungs was completely normal with no evidence of rales, ronchi, or wheezing. Additionally, he noted that the autopsy did not reveal any significant airway inflammation. And absent significant airway inflammation, a hallmark of acute exacerbation of asthma, one would not be able to associate, in whole or in part, the reactive airway disease to the employee's death. Lastly, Dr. Tawk noted that the pathology report confirmed the presence of parenchymal (interstitial) amyloidosis. In summary, he indicated that the employee's asthma did not contribute in any way ("aggravation or acceleration") to his death on March 11, 2009.

By decision dated September 20, 2011, OWCP denied modification of its prior decision regarding entitlement to survivor's benefits. Again, it relied on Dr. Tawk's opinion as a basis for finding that the employee's March 11, 2009 death was not employment related.

On January18, 2012, appellant again requested reconsideration.

Dr. Stevan Correa, a Board-certified family practitioner, examined the employee on March 7, 2009 just prior to his hospitalization at another facility. In a December 12, 2011 report, he indicated that the employee appeared to be in congestive heart failure, exacerbated by renal failure. Because of the serious nature of his condition, Dr. Correa had the employee transferred to another hospital (St. Helena) where he would have access to hemodialysis. He further noted that employee's main complaints at the time were worsening dyspnea and orthopnea. Having reviewed the St. Helena records, Dr. Correa noted that an echocardiogram documented a significant component of right ventricular dysfunction and significant pulmonary hypertension. He indicated that the employee's obstructive sleep apnea and history of occupational asthma were contributing factors in the development of his pulmonary hypertension and right ventricular dysfunction, which led to worsening of *cor pulmonale*, and ultimately, his presentation in fulminant congestive heart failure on March 7, 2009.

In a January 2, 2012 report, Dr. William G. Hughson, a Board-certified internist with a subspecialty in pulmonary disease, noted he had reviewed various records provided by appellant, including Dr. Tawk's reports.[5] He indicated that the underlying disease that primarily caused the employee's death was systemic amyloidosis, which affected multiple organs and ultimately lead to heart and kidney failure. Dr. Hughson also acknowledged that there was no epidemiological evidence that occupational asthma/RADS caused primary (AL) amyloidosis, but posited there "might" be a causal association between asthma/RADS and secondary amyloidosis. He commented that the notion that asthma played no part in the employee's death seemed arbitrary and illogical. In contrast, Dr. Hughson was of the opinion that the employee's accepted condition shortened his life and contributed to his death. He noted the March 9, 2009 echocardiogram revealed right ventricular dilation and pulmonary hypertension. Dr. Hughson reasoned that asthma can be associated with those findings, while acknowledging that the

[5] Dr. Hughson is also Board-certified in occupational medicine.

employee's amyloidosis was probably contributing as well. He further commented that any reasonable physician would agree that asthma was an impediment and it diminished the likelihood of the employee's survival.

In a March 23, 2012 decision, OWCP again denied modification of its prior decision. It found Dr. Hughson's January 2, 2012 opinion of diminished probative value.

Appellant again requested reconsideration on April 2 and 9, and May 14, 2012. Accompanying the April 2 and May 14, 2014 reconsideration requests was an April 30, 2012 report from Dr. Lies. Dr. Lies referenced his February 19, 2009 treatment notes and explained that the employee's renal disease and asthma/RADS limited the type of therapy available, which might have otherwise stabilized his cardiovascular status and improved longevity.

OWCP denied modification by decision dated September 7, 2012. The senior claims examiner noted, *inter alia*, that Dr. Lies' latest report did not discuss how the employee's death was related to the accepted employment injury.

On September 17, 2012 appellant filed another request for reconsideration. She resubmitted Dr. Correa's December 12, 2011 report, noting that OWCP failed to specifically address his findings in either of its last two decisions.

OWCP subsequently declared a conflict in medical opinion between Dr. Tawk and Dr. Hughson.

Appellant also submitted a December 14, 2012 report from Dr. Maria E. Samsonov, a Board-certified nephrologist, who treated the employee during his March 2009 hospitalization. Dr. Samsonov explained that amyloidosis would have made survival from acute events less likely as it affects multiple organ systems, including the heart and kidneys. She noted that the presence of lung disease/pulmonary hypertension can impede management of heart disease, and consequently worsen renal failure. Dr. Samsonov further explained that the interrelated nature of organ systems and renal failure in particular, contributes to poor outcomes, as was the employee's case.

In a May 3, 2013 report, the impartial medical examiner, Dr. Hsien-Wen Hsu, a Board-certified internist with subspecialties in pulmonary disease and critical care medicine, selected due to the conflict in medical opinion in the case, agreed with Dr. Tawk that the employee died due to amyloidosis, and that his accepted condition of asthma neither caused nor aggravated the employee's eventual death. He explained that the March 9, 2009 echocardiogram findings, which others believed demonstrated asthma-related pulmonary hypertension, were in fact attributable to restrictive cardiomyopathy due to amyloidosis. Dr. Hsu further explained that the amyloidosis alone would account for the employee's pulmonary arterial pressure. Additionally, he indicated that even if there was an element of pulmonary hypertension, it was most likely related to the employee's very severe sleep apnea, and not his asthma. Moreover, Dr. Hsu noted that the employee's March 7, 2009 arterial blood gas results -- near normal Pco2 -- was further evidence that argued against a chronic lung disease being severe enough to change the employee's life expectancy.

In a May 15, 2013 decision, OWCP denied modification of its September 7, 2012 decision. It based its decision on the impartial medical examiner's May 3, 2013 report. The senior claims examiner found that the employee's death was unrelated to the mechanism of injury or the accepted employment-related conditions. Consequently, he denied appellant's claim for survivor's benefits.

In an August 29, 2013 letter, appellant requested that OWCP investigate whether the employee's occupational exposure to unspecified toxic fumes, vapors, and gases contributed to his development of AL amyloidosis. She noted that none of the employee's treating physicians had considered this possible connection because AL amyloidosis was only diagnosed after his death. Appellant further noted that the Department of Veterans Affairs presumed that AL amyloidosis was service-connected where there was a history of in-service exposure to Agent Orange or other herbicides. While the employee was not a veteran, appellant claimed that wood smoke shared many of the same toxins as Agent Orange. She included an August 1, 2013 report from Dr. David C. Seldin, a hematologist and director of the Amyloidosis Center at Boston University School of Medicine. Dr. Seldin indicated that there was no doubt that the employee's exposure to smoke as a firefighter would have had the "potential" to contribute to the development of cancer and blood diseases like AL amyloidosis.

In a similar report dated August 6, 2013, Dr. Seldin noted that based on records obtained from appellant, the employee died due to AL amyloidosis, a malignant bone marrow plasma cell disorder. He further noted there was a "strong possibility" -- greater than 50 percent -- that exposure to toxic products of combustion as a firefighter contributed to acquiring this disease and to the employee's death.

On September 27 and 30, 2013 appellant again requested reconsideration. In a separate letter dated September 27, 2013, she asked OWCP to expand the employee's claim to include AL amyloidosis and other consequential injuries, including hiatal hernia, obesity, gastroesophageal reflux disease (GERD), obstructive sleep apnea, and seizure disorder. She also requested that OWCP refer the case to a hematologist/toxicologist knowledgeable in woodland fires and the effects of toxins.

Appellant submitted various medical records dating back to September 1986. She also submitted a July 12, 2013 report from Dr. James Lea, a Board-certified neurologist. Dr. Lea noted that he treated the employee in December 2004 for a generalized convulsive seizure in the context of significant sleep deprivation, which in turn was brought on by asthma with associated coughing attacks. He explained that chronic obstructive pulmonary disease did not cause the seizure, but coughing associated with asthma likely resulted in sleep deprivation, and sleep deprivation was a well-recognized trigger for an underlying seizure disorder. As such, Dr. Lea opined that occupational exposure to smoke "may" have been a contributing factor to the employee's clinical seizure disorder.

OWCP also received a November 8, 2013 report from Dr. Jerry E. Douglas, a Board-certified internist and family practitioner. Dr. Douglas indicated that he had not treated the employee during his lifetime, but had since reviewed his records. He specifically focused on the employee's obesity, noting that in 2008 he weighed a maximum of 274 pounds. Dr. Douglas explained that obesity increases dyspnea and is often the major contributor to obstructive sleep

apnea. He also noted that weight loss was difficult with underlying lung disease, and it appeared that the employee's weight was an aggravating factor with respect to his shortness of breath and obstructive sleep apnea.

In a December 20, 2013 nonmerit decision, OWCP denied appellant's request for reconsideration. It explained that it previously reviewed the medical evidence to determine which conditions should be accepted. Additionally, OWCP explained that because the issue on reconsideration was medical in nature, appellant's belief regarding the connection between AL amyloidosis and smoke exposure was immaterial. It also noted that while some of the recently submitted medical evidence was new to the record, it was nonetheless cumulative and substantially similar to evidence already contained in the case file. OWCP indicated that Dr. Hsu, the impartial medical examiner, had previously determined that the employee's death was unrelated to his employment as a forestry technician, and the current request for reconsideration did not present evidence sufficient to warrant merit review of the May 15, 2013 decision.

On January14, 2014 appellant again requested reconsideration. She submitted the appeal request form that accompanied OWCP's prior decision. Appellant did not present any additional evidence or argument with her request for reconsideration. Consequently, by decision dated February 3, 2014, OWCP denied merit review pursuant to 5 U.S.C. § 8128(a).

Appellant filed another request for reconsideration on February10, 2014. She argued that the previously submitted reports from Dr. Seldin, Dr. Lea, and Dr. Douglas were sufficient to warrant further merit review. Appellant also argued that neither Dr. Tawk nor Dr. Hsu specifically addressed whether the employee's occupational exposure caused or contributed to his death due to AL amyloidosis. She also identified several perceived deficiencies in the impartial medical examiner's May 3, 2013 report. However, appellant did not submit any additional medical evidence with her request for reconsideration.

In a March 3, 2014 decision, OWCP denied appellant's request for reconsideration and did not review the merits of the claim. The claims examiner addressed the numerous arguments appellant raised in her February10, 2014 request, but found none of them warranted merit review of the May 15, 2013 decision.[6]

On May 13, 2014 appellant timely requested reconsideration of OWCP's May 15, 2013 merit decision, *via* a May 7, 2014 letter. She reiterated her request that OWCP further develop the case and expand the claim to include AL amyloidosis, obesity, sleep apnea, hiatal hernia, GERD, and seizure disorder as accepted conditions. Appellant argued that Dr. Seldin's August 2013 reports established a causal relationship between the employee's occupational exposure and AL amyloidosis. She also reiterated that neither Dr. Tawk nor the impartial medical examiner specifically addressed whether the employee's occupational smoke exposure caused or contributed to his AL amyloidosis.

In support of her request for reconsideration, appellant submitted a May 7, 2014 report from David H. Sherr, Ph.D., a cancer biologist and toxicologist. Dr. Sherr indicated that several

[6] OWCP incorrectly stated that the record did not include Dr. Seldin's August 1 and 6, 2013 reports.

of the chemicals produced during forest fires that the employee would have been chronically exposed to -- polycyclic aromatic hydrocarbons, dioxins, alkaloids, and benzenes -- could easily have induced pulmonary inflammation leading to an asthma-like condition. He further indicated that there was compelling evidence that the chemicals the employee was exposed to while fighting forest fires contributed to the development of the low malignancy plasma cells that are the root cause of AL amyloidosis. Dr. Sherr also noted the link between dioxin exposure in Agent Orange and AL amyloidosis. He concluded that it was very likely that the employee's death was a direct consequence of his exposure to aromatic hydrocarbons, chlorinated biphenyl, and dioxin while performing his duties for the employing establishment.

Appellant also resubmitted several reports from Dr. Seldin, Dr. Lea, Dr. Lies, Dr. Samsonov, and Dr. Douglas. Additionally, she resubmitted partial records from the employee's March 7 to 11, 2009 hospitalization.

In a May 22, 2014 nonmerit decision, OWCP denied appellant's request for reconsideration. It explained that most of the evidence submitted on reconsideration was already part of the record when it issued the March 3, 2014 nonmerit decision. Additionally, OWCP noted that the only purported new medical evidence since the last decision was the May 7, 2014 report from Dr. Sherr. However, Dr. Sherr was not considered a "physician" as defined under FECA, and therefore, OWCP found that his report could not be considered medical evidence. The claims examiner also noted that appellant's disagreement with the impartial medical examiner's opinion was immaterial as she was not a physician. Lastly, it noted that appellant previously argued in favor of expanding the claim, and she had not submitted any new medical evidence supporting her argument. Consequently, OWCP found insufficient evidence and/or argument to warrant further review of its May 15, 2013 merit decision.

By letter dated June 13, 2014, received June 18, 2014, appellant again requested reconsideration. She submitted the appeal request form that accompanied the May 22, 2014 decision, which OWCP received on June 18, 2014. In a separate letter, also dated June 13, 2014, appellant indicated that she was submitting a new report from Dr. Seldin dated June 12, 2014.[7] Additionally, she resubmitted Dr. Seldin's August 6, 2013 report and Dr. Sherr's May 7, 2014 report. Appellant also continued to question OWCP's refusal to conduct a merit review based on the new evidence obtained following the impartial medical examiner's May 3, 2013 review of the case.

By decision dated July 2, 2014, OWCP found that appellant's request for reconsideration was untimely filed and failed to demonstrate clear evidence of error with respect to the May 15, 2013 merit decision. It noted that it had not received Dr. Seldin's June 12, 2014 report, and the other two referenced reports were previously submitted. Additionally, OWCP noted that although the December 20, 2013 decision did not specifically mention Dr. Seldin's August 6, 2013 report by name, the decision noted the doctor's comments about "malignant bone marrow plasma cell disorder AL amyloidosis." Consequently, it found that appellant failed to demonstrate clear evidence of error.

[7] Although appellant claimed to have submitted a June 12, 2014 report from Dr. Seldin, the record does not reveal OWCP having received the referenced report at that time.

On July 14, 2014 OWCP received appellant's July 7, 2014 request for reconsideration. She submitted a June 12, 2014 report from Dr. Seldin, and another copy of Dr. Sherr's May 7, 2014 report.

In his June 12, 2014 supplemental report, Dr. Seldin opined that it was "very probable" that the employee's exposure as a primary firefighter from 1981 to 1987 contributed to the development of AL amyloidosis. He described the employee's duties as including prescribed burns, gas and diesel equipment use and maintenance, torch man, and fighting many local and off-district wildfires. Dr. Seldin explained that wildland firefighters have more exposure to associated toxins in a fire season than urban firefighters have in a year, and that the employee had several well-documented incidents of smoke inhalation during those years (1981-1987). He also noted that the employee continued to have adverse effects from his employment injuries until his death. Dr. Seldin further explained that, while not everything was known about the causes of amyloidosis, exposure to carcinogens, herbicides, and radiation were all recognized contributors to the development of plasma cell diseases, including multiple myeloma and AL amyloidosis. He expressed hope that the information provided would be taken into account in recognizing the high likelihood that the employee's occupational exposure contributed to the onset of his ultimately fatal disease.

By decision dated October 9, 2014, OWCP denied appellant's latest request for reconsideration as it was untimely filed and failed to demonstrate clear evidence of error. It noted that it previously addressed Dr. Sherr's May 7, 2014 report. And with respect to Dr. Seldin's June 12, 2014 report, OWCP continued to find that the impartial medical examiner's opinion represented the special weight of the evidence.

LEGAL PRECEDENT -- ISSUE 1

To require OWCP to reopen a case for merit review under section 8128(a) of FECA,[8] OWCP's regulations provide that a claimant must submit a written application for reconsideration that sets forth arguments and contains evidence that either: (i) shows that OWCP erroneously applied or interpreted a specific point of law; (ii) advances a relevant legal argument not previously considered by OWCP; or (iii) constitutes relevant and pertinent new evidence not previously considered by OWCP.[9]

20 C.F.R. § 10.608(b) states that any application for review that does not meet at least one of the requirements listed in 20 C.F.R. § 10.606(b)(3) will be denied by OWCP without review of the merits of the claim.[10]

ANALYSIS -- ISSUE 1

OWCP's last merit decision of record is dated May 15, 2013. In that decision, it found that the impartial medical examiner's May 3, 2013 report represented the special weight of the

[8] 5 U.S.C. § 8128(a).

[9] 20 C.F.R. § 10.606(b)(3).

[10] *Id*. at § 10.608(b); *see also Norman W. Hanson*, 45 ECAB 430 (1994).

evidence regarding the employee's cause of death. In essence, OWCP continued to find that appellant was not entitled to survivor's benefits because she failed to establish that the employee's death was causally related to his accepted work-related conditions of smoke-induced asthma and permanent aggravation of smoke-induced asthma.

When appellant filed her survivor's benefits claim in September 2009, she initially presented medical evidence indicating that the employee's occupational asthma was a contributory cause of death. At the time, Dr. Marks represented that the direct cause of death was diffuse amyloidosis leading to congestive heart failure and acute renal failure, which was not employment related. However, he believed the employee's occupational asthma probably aggravated his heart failure to a degree. In response to the initial medical evidence, OWCP assisted in the development of the case to determine whether the employee's smoke-induced asthma either caused or contributed to his death. It ultimately declared a conflict in medical opinion, which resulted in Dr. Hsu's May 3, 2013 finding that the employee died due to amyloidosis, and that his accepted condition of asthma neither caused nor aggravated his eventual death. Appellant now believes that the employee's AL amyloidosis was employment related, and she faults OWCP for not developing the record regarding the etiology of this particular condition.[11]

In her May7, 2014 request for reconsideration, appellant expressed disagreement with the impartial medical examiner's opinion. She also reiterated her request to expand the claim to include AL amyloidosis, obesity, seizure disorder, sleep apnea, hiatal hernia, and GERD as accepted conditions.[12] Appellant's May 7, 2014 request for reconsideration was timely filed, however, she neither alleged nor demonstrated that OWCP erroneously applied or interpreted a specific point of law. Additionally, she did not advance any relevant legal arguments not previously considered by OWCP. The Board thus finds that appellant is not entitled to a review of the merits based on the first and second requirements under section 10.606(b)(3).[13]

Appellant also failed to submit any relevant and pertinent new evidence with her May7, 2014 request for reconsideration. The issue on reconsideration was whether there was a causal relationship between the employee's death and his accepted condition. Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[14] Although appellant submitted new evidence with her May 7, 2014 request for

[11] Where a claimant claims that a condition not accepted or approved by OWCP was due to an employment injury, she/he bears the burden of proof to establish that the condition is causally related to the employment injury. *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004). When an injury arises in the course of employment, every natural consequence that flows from that injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to the employee's own intentional misconduct. *Mary Poller*, 55 ECAB 483, 487 (2004); 1 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* 10-1 (2006). Thus, a subsequent injury, be it an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury. *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139, 141 n.7 (2001).

[12] Appellant initially raised this issue in correspondence dated August 29 and September 27, 2013, which OWCP previously addressed in its December 20, 2013 nonmerit decision.

[13] 20 C.F.R. § 10.606(b)(3)(i) and (ii).

[14] *See Robert G. Morris*, 48 ECAB 238 (1996).

reconsideration, Dr. Sherr is not considered a "physician" as defined under FECA.[15] Consequently, his May 7, 2014 report is not probative on the issue of whether the employee's death was employment related. Appellant also resubmitted several reports from various physicians, and partial records from the employee's March 2009 hospitalization. However, providing additional evidence that either repeats or duplicates information already of record does not constitute a basis for reopening a claim.[16] Because appellant did not provide any relevant and pertinent new evidence, she is not entitled to a review of the merits based on the third requirement under section 10.606(b)(3).[17] Accordingly, OWCP properly declined to reopen appellant's case under 5 U.S.C. § 8128(a).

LEGAL PRECEDENT -- ISSUE 2

Pursuant to 5 U.S.C. § 8128(a), a claimant is not entitled to a review of an OWCP decision as a matter of right.[18] This section vests OWCP with discretionary authority to determine whether it will review an award for or against compensation.[19] OWCP, through regulations, has imposed limitations on the exercise of its discretionary authority under 5 U.S.C. § 8128(a) of FECA. As one such limitation, 20 C.F.R. § 10.607 provides that an application for reconsideration must be received within one year of the date of OWCP s decision for which review is sought.[20] OWCP will consider an untimely application only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision. The evidence must be positive, precise, and explicit and must manifest on its face that OWCP committed an error.[21]

ANALYSIS -- ISSUE 2

On June 18, 2014 OWCP received from appellant the appeal request form dated June 13, 2014 that accompanied the May 22, 2014 decision. As this was more than a year after the latest merit decision dated May 15, 2013, the request for reconsideration was untimely filed pursuant to 20 C.F.R. § 10.607(a). With her June 13, 2014 request, appellant resubmitted Dr. Seldin's August 6, 2013 report and Dr. Sherr's May 7, 2014 report. She also claimed to have submitted a June 12, 2014 report from Dr. Seldin. However, the record does not indicate that OWCP

[15] The term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). Despite his background in environmental health, pathology, and immunology, under FECA Dr. Sherr is not considered qualified to offer a medical opinion regarding the employee's cause of death. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a (January 2013).

[16] *James W. Scott*, 55 ECAB 606, 608 n.4 (2004).

[17] 20 C.F.R. § 10.606(b)(3)(iii).

[18] 5 U.S.C. § 8128(a).

[19] Under section 8128 of FECA, [t]he Secretary of Labor may review an award for or against payment of compensation at any time on his own motion or on application.

[20] 20 C.F.R. § 10.607 (2012).

[21] *D.O.*, Docket No. 08-1057 (issued June 23, 2009); *Robert F. Stone*, 57 ECAB 292 (2005).

received Dr. Seldin's June 12, 2014 report at that time. On reconsideration, appellant continued to question OWCP's refusal to conduct a merit review based on the new evidence obtained following the impartial medical examiner's May 3, 2013 review of the case.

In its July 2, 2014 decision, OWCP found that the August 6, 2013 and May 7, 2014 reports were previously of the record and had already been reviewed. It also explained that it had not received Dr. Seldin's June 12, 2014 report. Because appellant's June 13, 2014 reconsideration request was untimely filed, OWCP properly considered whether she demonstrated clear evidence of error with respect to the May 15, 2013 decision.

Appellant noted that Dr. Hsu did not specifically address whether the employee's occupational exposure caused or contributed to the development of his AL amyloidosis. She also faulted OWCP for not undertaking further development to determine the etiology of this condition. The Board notes that appellant waited almost four years before raising this particular issue. When she filed her claim (Form CA-5) in September 2009, initial reports from Dr. Marks and Dr. Lies indicated that the employee's amyloidosis was not employment related. In fact, Dr. Lies characterized it as idiopathic and commented that he did not know any occupational reason why the employee would get amyloidosis. Similarly, Dr. Ellis reported in February 2011 that he could not state with reasonable certainty that the employee's amyloidosis was caused by toxic fume exposure. The prevailing view at the time was that the employee's smoke-induced asthma aggravated his heart condition (pulmonary hypertension/*cor pulmonale*) and contributed to his ultimate heart failure. OWCP developed the case based on this particular theory of causal relationship, with an emphasis on whether the employee's asthma was related to amyloidosis and/or his heart and renal failure. It issued six merit decisions denying survivor's benefits before appellant first raised her current theory of causal relationship in August 2013.

While evidence of a procedural error could potentially demonstrate clear evidence of error, in this instance the alleged procedural flaw post-dated the latest merit decision issued on May 15, 2013.[22] The Board notes that OWCP actively participated in the development of the case prior to issuing its May 15, 2013 merit decision.[23] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[24] Although neither Dr. Tawk nor Dr. Hsu specifically addressed whether there was a causal relationship between the employee's occupational smoke exposure and amyloidosis, appellant did not raise her alternative theory of causation until after OWCP issued its May 15, 2013 decision. As such, the Board finds that appellant's June 13, 2014 request for reconsideration did not raise a substantial question concerning the correctness of OWCP's May 15, 2013 merit decision. Accordingly, the Board shall affirm OWCP's July 2, 2014 nonmerit decision based on appellant's failure to demonstrate clear evidence of error.

[22] *See Thankamma Mathews*, 44 ECAB 765 (1993).

[23] Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done. *William J. Cantrell*, 34 ECAB 1223 (1983).

[24] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

Appellant's July 7, 2014 letter requesting reconsideration was also untimely filed as OWCP received it on July 14, 2014, more than one year after the May 15, 2013 merit decision. As such, appellant must demonstrate clear evidence of error with respect to OWCP's latest merit decision denying survivor's benefits. With her July 7, 2014 request, appellant submitted Dr. Seldin's June 12, 2014 report.[25] Appellant reiterated her request that OWCP accept amyloidosis as being causally related to her husband's "toxic exposure." In his June 12, 2014 supplemental report, Dr. Seldin indicated that it was "very probable" that the employee's exposure as a primary firefighter from 1981 to 1987 contributed to the development of AL amyloidosis. Dr. Seldin explained that while not everything was known about the causes of amyloidosis, exposure to carcinogens, herbicides, and radiation were all recognized contributors to the development of plasma cell diseases, including multiple myeloma and AL amyloidosis. This June 12, 2014 report is substantially similar to Dr. Seldin's August 1 and 6, 2013 reports, which appellant initially submitted in September 2013, and OWCP previously considered.

In her latest request for reconsideration, appellant indicated that she had not suspected her husband's smoke inhalation caused amyloidosis until 2013. As previously noted, it was not until August 29, 2013 that appellant shared her latest theory on causal relationship with OWCP. And at that time, she requested that OWCP investigate whether her husband's occupational exposure contributed to his development of AL amyloidosis. Again, OWCP's post-May 15, 2013 refusal to reopen the survivor's claim and undertake further medical and/or factual development does not adversely reflect on the correctness or propriety of its May 15, 2013 merit decision. The previous development of the record was consistent with the then-prevailing theory on causal relationship, and appellant has failed to submit evidence or argument demonstrating a clear procedural error on OWCP's part. Accordingly, the Board finds that appellant's July 7, 2014 request for reconsideration was untimely filed and failed to demonstrate clear evidence of error with respect to OWCP's May 15, 2013 merit decision denying survivor's benefits.

CONCLUSION

The Board finds that OWCP properly denied further merit review with respect to appellant's May 7, 2014 timely request for reconsideration. As to her June 13 and July 7, 2014 requests for reconsideration, OWCP properly found that both were untimely filed and failed to demonstrate clear evidence of error.

[25] Appellant also submitted another copy of Dr. Sherr's May 7, 2014 report, which OWCP previously found insufficient because he is not considered a "physician" as defined under FECA.

ORDER

IT IS HEREBY ORDERED THAT the October 9, July 2 and May 22, 2014 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: October 13, 2016
Washington, DC

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

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

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