United States Department of Labor
Employees' Compensation Appeals Board

V.B., Appellant	)	
and	)	**Docket No. 17-1847**
	)	**Issued: April 4, 2018**
DEPARTMENT OF VETERANS AFFAIRS, NEW MEXICO HEALTHCARE SYSTEM, Albuquerque, NM, Employer	)	

Appearances:
Rosario D. Vega Lynn, Esq., for the appellant[1]
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 August 31, 2017 appellant, through counsel, filed a timely appeal from a May 8, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant met her burden of proof to establish an allergic reaction causally related to the accepted January 14, 2016 employment incident.

FACTUAL HISTORY

On February 5, 2016 appellant, then a 52-year-old civilian pay supervisor, filed a traumatic injury claim (Form CA-1) alleging that, on January 14, 2016, she developed a headache due to an allergic reaction to latex in an elevator or a building at work.

OWCP received letters and e-mails dated March 2 and 4, 2016 from counsel which indicated that on January 14, 2016 appellant and other employees were exposed to toxic fumes from an elevator shaft in a building at work. Counsel further noted that appellant informed her supervisor about her exposure and headache, dizziness, and nausea, for which she sought medical treatment. She maintained that appellant was unable to work as of February 4, 2016 due to her condition.

By development letter dated March 25, 2016, OWCP notified appellant of the deficiencies of her claim and afforded her 30 days to submit additional medical and factual evidence. On the same date it requested that the employing establishment provide a list of potentially harmful substances to which she had been exposed, the tasks she performed which resulted in exposure, and exposure data.

OWCP received a March 4, 2016 memorandum in which the employing establishment noted that appellant's absence from work from January 15 through February 28, 2016, due to her disability or medical care for a disabling, job-related traumatic injury on January 14, 2016, should be charged as an authorized absence pursuant to the VA Handbook.

OWCP also received medical records from the employing establishment's medical facility which included a January 14, 2016 progress note signed by Dr. Angeline G. Fitzgerald, Board-certified in emergency medicine, indicating that appellant had returned to the emergency room for worsening headache, changes in vision, vomiting, confusion, numbness or weakness in her arms or leg, other problems, and fever. Dr. Fitzgerald examined her and provided a clinical impression of allergic reaction and vascular headache.

A January 14, 2016 false fire alarm incident report noted that an elevator started to burn and produced minor amounts of smoke. An onsite facility industrial hygienist verified the odors. Onsite engineering electricians stated that the elevator belt produced the smells/odors. The belt was replaced immediately by an onsite contractor. After consulting with the contractor it was found that friction and slippage from the belt produced the minor smoke and odor.

OWCP received various reports from Dr. H. Preston Matthews, a family practitioner. In a January 18, 2016 return to work certificate, Dr. Matthews noted that appellant was exposed to toxins. He advised that she could return to work on January 25, 2016. In a January 25, 2016 return to work certificate, Dr. Matthews advised that appellant could return to work on February 2, 2016 with no restrictions. On March 14, 2016 he noted that she had known depression. Dr. Matthews

indicated that appellant presented to recheck headaches possibly secondary to toxic exposures from burning latex at work. He noted that she had seen Dr. Douglas Barrett, a Board-certified neurologist and psychiatrist, who also suspected headaches triggered from previous toxic exposure at work. Dr. Matthews reported examination findings and assessed depression, insomnia, and migraine. In a March 14, 2016 return to work certificate, he recommended that appellant not work for an indefinite period due to her current symptoms and illness. Dr. Matthews, in a March 21, 2016 attending physician's report (Form CA-20), noted a history of her being exposed to an elevator fire on January 14, 2016. He further noted that appellant developed a severe headache and that she had previous migraines. Dr. Matthews discussed findings on examination and diagnosed headache due to possible toxic exposure. He checked a box marked "Yes" indicating that the diagnosed condition was caused or aggravated by an employment activity. Dr. Matthews advised that appellant was totally disabled from January 14, 2016 for an indefinite period of time.

In a February 4, 2016 note, Dr. Justin L. Hazen, an employing establishment physician Board-certified in emergency medicine, noted that appellant had returned to the emergency room due to fever, chills, syncope, and chest pain. He diagnosed headache.

In another progress note dated February 4, 2016, James Bleen, an employing establishment physician assistant, noted a history that possibly on January 14, 2016 appellant was exposed to overheating/burning in an elevator in a building at work. He reported that appellant's employee was seen for a similar incident. Mr. Bleen reported her symptom of severe headache and that she sought treatment in the employing establishment's emergency department. In an employing establishment report of employee's emergency treatment also dated February 4, 2016, he related that she had a reaction to items burning/overheating in a building elevator on January 14, 2016.

A February 8, 2016 medical excuse from appellant's healthcare provider, signed by Tracey Atma on behalf of Dr. Matthews, advised that appellant had persistent cough and ongoing headaches. Appellant was placed off work indefinitely until examination by a pulmonary and neurology specialist.

Counsel submitted a February 23, 2016 report from Dr. Barrett. He advised that he last saw appellant on October 28, 2015 when she reported excellent migraine control with medication. Dr. Barrett noted that on January 14, 2016 she had workplace smoke inhalation which created upper respiratory symptoms with coughing, nasal congestion, and hives. Appellant was seen in an emergency room and antihistamines helped clear her symptoms. She stayed off work for two weeks since, concurrent with this incident, she had a continuous and unremitting headache. When appellant's condition seemed to improve, she returned to work. Dr. Barrett related, however, that the work environment stimulated a recurrence of some upper respiratory symptoms and intensification of her headache. Appellant had been off work since that time. Dr. Barrett noted her treatment and related that she presented with chronic neck pain and migraines. He noted findings and assessed status migrainosus with an impression that appellant's condition was a result of an inhalation insult that unmasked her latent migraine problems. Dr. Barrett found no evidence of new intracranial pathology. On April 12, 2016 he reiterated a history of the claimed January 14, 2016 incident and his opinion that the incident not only caused pulmonary problems, but also a marked exacerbation of appellant's migraines. Dr. Barrett asserted that this resulted in a conversion from episodic to chronic daily migraines. He reported that appellant's condition was gradually and progressively under control with treatment. Dr. Barrett maintained, nonetheless,

that she was now extremely sensitive to odors in her workplace which reportedly had not been thoroughly cleaned. These odors triggered appellant's recurrent migraines and for this reason she could not return to work for an unknown period of time. Dr. Barrett advised that the duration of this restriction was dependent on the workplace environment and her response to ongoing migraine therapy. He concluded that appellant's absence from work was medically necessary.

The employing establishment, in an April 13, 2016 letter, related that it did not know what, if any, potentially harmful substances appellant may have been exposed to on January 14, 2016. It had not received a safety data report from the elevator manufacturer or the inspection report for the incident. The employing establishment noted that appellant became ill while at the employee health unit where she had escorted one of her employees for treatment after the claimed January 14, 2016 incident. Appellant was then referred to the employing's establishment emergency department.

By decision dated April 29, 2016, OWCP denied appellant's traumatic injury claim because the medical evidence of record did not establish causal relationship between her diagnosed medical condition and the accepted January 14, 2016 employment incident.

OWCP received a May 5, 2016 report from Dr. Matthews who assessed insomnia, post-traumatic stress disorder (PTSD), and headache. Dr. Matthews advised that appellant's insomnia and headache were uncontrolled and that her PTSD was most likely secondary to her traumatic experience at work with toxic exposures. He suspected that her headache was also secondary to her toxic work exposure.

On June 1, 2016 appellant requested a review of the written record by an OWCP hearing representative. In a May 23, 2016 letter, she related a history of the January 14, 2016 work incident and described her resultant headaches and medical treatment.

Appellant submitted a May 12, 2016 report from Dr. Barrett who noted her long-standing history of migraines. Dr. Barrett noted seeing her on February 23, 2016 after the January 14, 2016 incident appeared to trigger a sequence of events which had unmasked her latent tendency for migraine attacks. Appellant continued to have pulmonary symptoms for which she was being seen by a lung specialist. She continued to experience frequent recurrent migraine attacks that were difficult to control and required several trips to the emergency room. Dr. Barrett related that appellant required aggressive therapy to control her migraines and that she could not work during her treatment. He reported that her neurologic examination was intact and that there was no evidence to suggest an alternative source to this problem. Dr. Barrett opined that, based on appellant's history, it was clear that the inhalational injury of January 14, 2016 had set in motion a cascade of events leading to reactivation of her migraine disorder. On May 16, 2016 he reported her history and findings on physical, neurological, and psychiatric examination. Dr. Barrett diagnosed intractable migraine without aura without status migranosus. He advised that appellant had evolved from well-controlled migraine attacks to chronic daily migraines that were not responding well to standard medical therapy. There was no clinical evidence for intracranial pathology and she had normal intracranial pressure. Dr. Barrett noted that by history this evolution occurred concurrent with appellant's inhalational injury at work in January 2017. In a May 31, 2016 return to work certificate, he noted that she was undergoing medical treatment for an on-the-job injury. Dr. Barrett noted that she was off work through June 30, 2016.

Appellant submitted e-mails dated January 14 and 21, 2016 indicating that her subordinate employee was exposed to fumes in a building at work on January 14, 2016. The employee experienced light-headedness, headache, and throat pain and was treated at the employing establishment's health unit. Appellant also submitted e-mails dated April 5 through May 23, 2016 between her, counsel, OWCP, and the employing establishment concerning an investigation of her exposure to toxic fumes, medical evidence supportive of causal relationship between her condition and the accepted work incident, and her request for medical leave. Documents dated July 11 and August 5, 2016 addressed the employing's establishment request for medical documentation and appellant's request for accommodation.

By decision dated November 1, 2016, an OWCP hearing representative affirmed the April 29, 2016 decision. The hearing representative found that the medical evidence submitted failed to provide a rationalized medical opinion relating appellant's diagnosed conditions to her accepted January 14, 2016 employment incident.

On March 6, 2017 appellant, through counsel, requested reconsideration. She submitted reports dated January 14, 2016 to February 24, 2017 from Dr. Donald K. Porter, a Board-certified internist, who noted the January 14, 2016 work incident and discussed findings on examination. Dr. Porter diagnosed mild reactive airways disease, post-nasal drip, chest discomfort, gastroesophageal reflux disease without esophagitis, and need for pneumococcal vaccination. On February 22, 2016 he advised that appellant probably developed some mild reactive airways disease due to exposure to unknown fumes in mid-January at the employing establishment. Dr. Porter reported that she had no idea about the cause of the fumes. He related that he hoped appellant's chest complaints would resolve with corticosteroid therapy. Appellant clearly had some ocular nasopharyngeal irritation as a result of inhaling the fumes and now she was constantly clearing her throat. Dr. Porter suspected post-nasal drip due to her fume exposure. On May 2, 2016 he noted appellant's complaints of chest heaviness in the middle of the night and advised that her post-nasal drip had been eliminated with the use of Flonase. In a September 14, 2016 progress note, Dr. Porter opined that her mild reactive airways disease was induced by her fume exposure in January 2016. He maintained that, while it was possible that appellant's esophageal reflux with post-nasal drainage could be contributing to her cough, she was on a very aggressive regimen and it would be interesting to see if her cough disappeared completely over the next few months.

On May 2, 2016 Dr. Porter noted her complaints of chest heaviness in the middle of the night. In a June 14, 2016 progress note, he related that he believed that appellant's mild reactive airways disease was likely a consequence of whatever fume exposure she had in January 2016. On February 24, 2017 Dr. Porter advised that it appeared that her reactive airway disease had resolved during her last visit in September 2016, but unfortunately she had redeveloped symptoms very suggestive of asthma in the absence of any triggering event and despite proper use of her Dulera. He maintained that her pulmonary condition was clearly related to her January 2016 fume exposure. Dr. Porter indicated that appellant never had similar complaints in the past and, unfortunately, he believed that she was now crossing the threshold of meeting the definition of mild persistent asthma.

A February 22, 2016 spirometry report indicated that the test results were questionable due to appellant's inability to perform the maneuvers according to the American Thoracic Society standards. Appellant indicated that she had a massive headache and that her throat felt like it was

closing up. The technician then stopped performing the test. Also provided was a February 16, 2016 chest x-ray report which was normal.

By decision dated May 8, 2017, OWCP denied modification of its November 1, 2016 decision. It found that appellant had not provided a rationalized medical opinion explaining how her diagnosed condition was caused by the January 14, 2016 work incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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[4] including that he or she sustained an injury in the performance of duty and that any specific condition or disability from work for which compensation is causally related to that employment injury.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established.[6] There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place, and in the manner alleged.[7] Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.[8]

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[9]

ANALYSIS

It is undisputed that on January 14, 2016 appellant was working as a civilian pay supervisor and was exposed to smoke and odor from a malfunctioning elevator. However, she has failed to submit sufficient medical evidence to establish that her diagnosed medical conditions were causally related to the accepted January 14, 2016 employment incident.

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[3] *Id.*

[4] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[5] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[6] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

[7] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[8] *T.H.*, 59 ECAB 388 (2008).

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

In a series of reports dated January 18 to May 5, 2016, Dr. Matthews noted a history of the accepted January 14, 2016 employment incident and diagnosed, among other things, migraine, unspecified without mention of intractable migraine, and headache due to "possible" toxic exposure. He initially advised that appellant could return to work with no restrictions on January 25 and February 2, 2016 and later placed her off work from March 14, 2016 through an indefinite period of time. Dr. Matthews also indicated that she was totally disabled beginning January 14, 2016. In a March 21, 2016 Form CA-20 report, he checked a box marked "Yes" indicating that appellant's headache due to "possible" toxic exposure was caused or aggravated by the January 14, 2016 employment incident. The Board finds, however, that Dr. Matthews' opinion on causal relationship is speculative in nature. The Board has held that medical opinions that are speculative or equivocal in character are of diminished probative value.[10] Moreover, the Board has held that a checkmark on a form report, without supporting rationale, is of limited probative value, and is insufficient to establish the claim.[11] Dr. Matthews did not explain why exposure to smoke and odor from a malfunctioning elevator would cause or contribute to appellant's diagnosed condition and resultant disability from work. For these reasons, the Board finds that his reports are insufficient to meet her burden of proof.

Dr. Barrett's reports dated February 23 to May 31, 2016 reports noted a history of the accepted January 14, 2016 work incident, diagnosed status migrainosus, and found that appellant was totally disabled for work as of April 12, 2016 through an unknown period of time. He opined that the accepted employment incident caused her migraine condition and pulmonary problems. Dr. Barrett maintained that odors in appellant's workplace, which had not been thoroughly cleaned, triggered her recurrent migraines, and resulted in her inability to return to work. The Board has found that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[12] Dr. Barrett did not adequately explain how the accepted workplace exposure caused appellant's headaches and disability. The Board finds that the lack of medical rationale diminishes the probative value of Dr. Barrett's opinion.[13]

In a series of reports from January 14, 2016 to February 24, 2017, Dr. Porter diagnosed, among other things, mild reactive airways disease. He failed, however, to sufficiently explain the reasons why he opined that appellant's condition was caused by the January 14, 2016 employment incident. Furthermore, Dr. Porter's opinion on causal relationship was also based on the fact that she never complained of pulmonary problems in the past. The Board has held that an opinion that

[10] *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley*, 55 ECAB 206 (2004).

[11] *D.S.*, Docket No. 15-1930 (issued January 30, 2016).

[12] *S.E.*, Docket No. 08-2214 (issued May 6, 2009); *T.M.*, Docket No. 08-0975 (issued February 6, 2009).

[13] *Deborah L. Beatty*, 54 ECAB 340 (2003) (where the board found that in the absence of a medical report providing a diagnosed condition and a reasoned opinion on causal relationship with the employment incident, appellant did not meet her burden of proof).

a condition is causally related because the employee was asymptomatic before the injury is insufficient, without sufficient rationale, to establish causal relationship.[14]

Dr. Fitzgerald, in a January 14, 2016 progress note, found that appellant had an allergic reaction and vascular headache, but failed to offer a medical opinion addressing whether the diagnosed conditions were caused or aggravated by the accepted employment incident. The Board has found 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.[15]

Dr. Hazen, in a February 4, 2016 progress note, reported appellant's complaints of fever, chills, syncope, chest pain, or any other concern and prescribed short-term medications. He did not provide a firm diagnosis of a particular medical condition,[16] provide a history of injury,[17] or offer a specific opinion as to whether the accepted January 14, 2016 employment incident caused or aggravated appellant's condition.[18] The Board finds, therefore, that Dr. Hazen's progress note is insufficient to establish her claim.

The progress note and report from a physician assistant found that appellant had a reaction to items burning/overheating in a building elevator on January 14, 2016. This evidence does not constitute competent medical evidence because physician assistants are not considered physicians as defined under FECA.[19] As such, this evidence is also insufficient to meet appellant's burden of proof. Ms. Atma's February 8, 2016 report on behalf of Dr. Matthews is also of no probative medical value. There is no indication that she is a physician and, therefore, she does not qualify as a physician within the meaning of FECA.[20] Diagnostic test reports of record are of limited probative value on causal relationship as they do not contain a physician's opinion addressing

[14] *K.P.*, Docket No. 17-1145 (issued November 15, 2017); *T.M., supra* note 12; *Michael S. Mina*, 57 ECAB 379 (2006).

[15] *See C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[16] *See supra* note 13.

[17] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history have little probative value).

[18] *Supra* note 14.

[19] 5 U.S.C. § 8101 (2); *Roy L. Humphrey*, 57 ECAB 238 (2005). Section 8102(2) of FECA provides that 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. *See also Sean O'Connell*, 56 ECAB 195 (2004) (physician assistants are not considered physicians as defined under FECA); *Gloria J. McPherson*, 51 ECAB 441 (2000); *Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (a medical issue such as causal relationship can only be resolved through the submission of probative medical evidence from a physician).

[20] 5 U.S.C. § 8101(2); *Sharon A. Marshall*, Docket No. 02-0308 (issued June 21, 2002); *Sheila G. Peckenschneider*, 49 ECAB 430, 432 (1998); *Arnold A. Alley*, 44 ECAB 920-21 (1993).

whether any diagnosed condition is causally related to the January 14, 2016 employment incident.[21]

The Board finds that appellant has failed to submit rationalized, probative medical evidence sufficient to establish that her accepted work exposure on January 14, 2016 caused or aggravated a diagnosed medical condition.

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.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof to establish an allergic reaction causally related to the accepted January 14, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the May 8, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 4, 2018
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

[21] *See supra* note 14.