United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 18-1522**
	)	**Issued: April 22, 2019**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, BROOKLYN HEALTH & HUMAN SERVICES, Brooklyn, NY, Employer	)	

Appearances:
Thomas S. Harkins, Esq., for the appellant[1]
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 August 3, 2018 appellant, through counsel, filed a timely appeal from a February 12, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the

[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.

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.[3]

ISSUE

The issue is whether appellant has met his burden of proof to establish that his reactive airway disease (RAD), allergic rhinitis, and bronchial asthma were caused or aggravated by the accepted June 4, 2014 employment incident.

FACTUAL HISTORY

On June 20, 2014 appellant, then a 32-year-old staff pharmacist, filed a traumatic injury claim (Form CA-1) alleging that on June 4, 2014 he experienced shortness of breath, difficulty breathing, chest tightness, cough, dizziness, and clogged nose while in the performance of duty. He attributed his symptoms to chemicals and fumes used to clean and wax the floors in his work area that day. Appellant did not stop work.

Appellant was treated in the employing establishment emergency room on June 4, 2014 by Dr. Hasmatul M. Islam, an emergency medicine physician, who diagnosed a hypersensitivity reaction and provided bronchodilator therapy.

In a July 23, 2014 note, Dr. Magdi S. Sourour, a Board-certified internist and pulmonologist, reported that appellant was exposed to cleaning chemicals on June 4, 2014 while at work. He provided an impression of cough variant asthma/status post chemical bronchitis "most likely" due to exposure to cleaning chemicals in the pharmacy. The July 23, 2014 spirometry report indicated a mild restriction, premedication.

Several reports with accompanying spirometry test results were received from Dr. Alan J. Schecter, a Board-certified pulmonologist. In a July 31, 2014 report, Dr. Schecter noted the history of the June 4, 2014 chemical exposure incident and that appellant's symptoms (a chronic cough) returned after he completed his prescribed medication. Appellant was noted as being both a lifetime nonsmoker and a current every day smoker. Dr. Schecter indicated that the July 31, 2014 pulmonary function study suggested mild asthma. He assessed appellant "likely with" mild asthma induced by chemical burn cough and nasal congestion "likely" also related to chemical burn.

In a September 4, 2014 report, Dr. Schecter noted that a pulmonary function study showed normal function with slight decline from previous study. Appellant was noted to be an every day smoker. Dr. Schecter provided an assessment of possible asthma, though it was not clear if his symptoms were typical, and a diagnosis of intrinsic asthma, unspecified. In October 6 and November 3, 2014 reports, he diagnosed asthma. Dr. Schecter noted that appellant was never a

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that, following the February 12, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

smoker and that appellant's pulmonary function studies were normal. He also indicated, in his October 6, 2014 report, that appellant's cough may not be related to asthma. In a February 5, 2015 report, Dr. Schecter reported that appellant had probable asthma though his pulmonary functions had always been near normal. He diagnosed asthma, mild persistent, with acute exacerbation. A copy of a February 5, 2015 spirometry report was provided.

Several reports with accompanying spirometry testing were received from Dr. Sourour. In May 11 and August 28, 2015 treatment reports, he reported a date of injury of June 4, 2014, noted examination findings and provided an impression of occupational asthmatic cough due to chemical exposure. Both of the May 11 and August 28, 2015 spirometry tests revealed normal results premedication. In October 21 and November 16, 2015 reports, Dr. Sourour diagnosed occupational exposure -- recurrent bronchial asthma. The October 21, 2015 spirometry test revealed normal results premedication.

In a November 18, 2015 report, Dr. Sourour noted appellant's persistent cough and wheezing started on June 4, 2014 after he was exposed to chemical cleaning agent on the floor of the pharmacy where he worked. Appellant was given bronchodilator therapy in the emergency room and discharged. Dr. Sourour indicated that appellant's past medical history was negative for bronchial asthma, allergic rhinitis, and diabetes mellitus and that he never smoked or drank. He summarized appellant's visits, noting that his physical examinations were consistent with recurrent bronchospasms. Dr. Sourour indicated that appellant's condition most likely would last several years and that he needed to be followed up on a regular basis as he developed a secondary bacterial infection. He opined that the final diagnosis was reactive airway distress syndrome, occupational asthma, secondary to exposure to chemical fumes from cleaning agents he was exposed to at his workplace on June 4, 2014. Appellant also diagnosed chronic recurrent sinusitis and chronic reactive tracho-bronchitis with bronchospasm.

In a January 21, 2016 letter, counsel argued that Dr. Sourour's November 18, 2015 report established appellant's claim.

In a February 10, 2016 treatment note, Dr. Sourour reported new reactivation of RAD. A February 10, 2016 spirometry indicated mild restriction premedication. In a July 13, 2016 note, Dr. Sourour diagnosed status post RAD syndrome, obstructive lung disease, chronic trachecitis, and allergic rhinitis. The July 13, 2015 spirometry report indicated normal spirometry results premedication.

By development letter dated October 12, 2016, OWCP advised appellant that he initially filed a claim for a traumatic injury which originally appeared to be for a minor injury resulting in minimal or no lost time. It advised him that his claim was reopened because the medical bills exceeded $1,500.00. OWCP advised appellant that exposure alone was insufficient to establish a work-related medical condition and that the medial evidence did not substantiate the diagnoses provided. It informed him of the type of factual and medical evidence needed to support his claim, and provided a questionnaire for his completion. OWCP afforded appellant 30 days to submit the requested evidence.

In a November 8, 2016 statement, appellant responded to OWCP's development letter. He noted that the June 4, 2014 work incident was a onetime event when the floors of the pharmacy were stripped and waxed. Appellant indicated that he had inhaled the fumes of the toxic chemicals

for five hours as he was the only person on duty and could not leave the pharmacy unattended. He also asserted that he never smoked. A Safety Data Sheet for the chemicals involved in the cleaning agents used was provided.

By decision dated November 18, 2016, OWCP denied appellant's claim, finding that it was insufficient to establish an injury causally related to the accepted employment incident. It noted that there was conflicting factual and medical evidence regarding whether he was a smoker and if smoking could be a factor in the development of the diagnosed conditions.

OWCP continued to receive additional evidence. In February 24 and October 10, 2016 reports, Dr. Sourour diagnosed RAD after exposure to cleaning agent, and bronchial asthma. In his October 10, 2016 report, he also noted "severe irritating secondary to exposure to cleaning material and detergents and chlorine base." October 10, 2016 spirometry testing was within normal limits. In a December 14, 2016 report, Dr. Sourour noted that appellant was seen for RAD, allergic rhinitis, and bronchial asthma.

On November 10, 2017 appellant, through counsel, requested reconsideration and provided a December 29, 2016 report from Dr. Schecter who indicated that an error was made in appellant's electronic medical records dated July 31 and September 4, 2014, which documented appellant as a current smoker. He contended that, since appellant's first office visit, he had indicated that appellant did not smoke. Counsel argued that Dr. Schecter's December 29, 2016 report confirmed that appellant was not a smoker.

OWCP received additional reports from Dr. Sourour. In an October 11, 2017 report, Dr. Sourour indicated that spirometry premedication indicated moderate obstruction possible concomitant restrictive defect. He provided an impression of RAD secondary to chemical and dust exposure and allergic rhinitis. A copy of the October 11, 2017 spirometry report was provided. In a January 26, 2018 report, Dr. Sourour diagnosed RAD secondary to chemical exposure, allergic rhinitis, and bronchial asthma. He noted that the spirometry indicated mild restriction premedication.

By decision dated February 12, 2018, OWCP denied modification of its November 18, 2016 decision. It found that, while the evidence indicated that appellant was not a smoker, there was no well-reasoned medical opinion which explained how his chemical/dust exposure on one day either caused or aggravated the diagnosed conditions of RAD, allergic rhinitis, and bronchial asthma.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] has the burden of proof to establish 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 filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the

[4] *Supra* note 2.

employment injury.[5] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[6]

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. There are two components involved in establishing 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]

To establish causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence sufficient to establish such 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

The Board finds that appellant has not established that his RAD, allergic rhinitis, and bronchial asthma conditions were causally related to the accepted June 4, 2014 employment incident.

In a June 4, 2014 emergency room report, Dr. Islam initially noted appellant's symptoms after the employing establishment floor was cleaned. While he diagnosed a hypersensitivity reaction, he did not provide a firm diagnosis of a particular medical condition[10] or offer a specific opinion as to whether the accepted June 4, 2014 employment incident caused or aggravated appellant's condition.[11] Thus, Dr. Islam's report is insufficient to meet appellant's burden of proof.

[5] *T.H.*, Docket No. 17-747 (issued May 14, 2018); *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[6] *T.H., id.; S.P.*, 59 ECAB 184 (2007); *Victor J. Woodhams*, 41 ECAB 345 (1989); *Joe D. Cameron*, 41 ECAB 153 (1989).

[7] *See K.R.*, Docket No. 18-1388 (issued January 9, 2019); *V.J.*, Docket No. 18-0452 (issued July 3, 2018); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

[8] *Id.*

[9] *T.H.*, Docket No. 18-1736 (issued March 13, 2019); *I.J.*, 59 ECAB 408 (2008).

[10] *Deborah L. Beatty*, 54 ECAB 340 (2003) (in the absence of a medical report providing a diagnosed condition and a reasoned opinion on causal relationship, appellant has not met her burden of proof).

[11] *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

OWCP received a series of reports from Dr. Sourour. In a July 23, 2014 report, Dr. Sourour reported that appellant was exposed to cleaning chemicals on June 4, 2014 while at work and that the spirometry report indicated a mild restrictions premedication. He provided an impression of cough variant asthma/status post chemical bronchitis "most likely" due to exposure to cleaning chemicals in the pharmacy. As he couched his impression in terms as "most likely," Dr. Sourour's 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.[12] Additionally, Dr. Sourour did not explain why or how exposure to cleaning chemicals would have caused or contributed to appellant's diagnosed condition. 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.[13] Thus, Dr. Sourour's report is of limited probative value and is insufficient to establish appellant's claim.

In reports from May 11, 2015 through November 16, 2016, Dr. Sourour provided impressions of occupational asthmatic cough and recurrent bronchial asthma due to occupational exposure, although the spirometry tests taken on those dates were within normal limits. In his November 18, 2015 report, he indicated that appellant's persistent cough and wheezing started on June 4, 2014 after his exposure to chemical cleaning agents at the employing establishment. Dr. Sourour opined that appellant's diagnoses of reactive airway distress syndrome, occupational asthma, were secondary to exposure to chemical fumes from cleaning agents he was exposed to at his workplace on June 4, 2014. In so far as his opinion regarding causal relationship appears to be based on the fact that appellant's past medical history was negative for the diagnosed conditions, the Board has held that an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without sufficient rationale, to establish causal relationship.[14]

In subsequent reports Dr. Sourour reiterated appellant's diagnoses, but did not explain the reasons how appellant's diagnosed conditions were caused by the June 4, 2014 employment incident.[15] The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.[16] Therefore, these reports of Dr. Sourour are insufficient to establish appellant's claim.

OWCP also received reports from Dr. Schecter. In his initial report of July 31, 2014, Dr. Schecter noted the history of appellant's June 4, 2014 chemical exposure and that his July 31, 2014 pulmonary function study suggested mild asthma. He assessed appellant "likely with" mild asthma induced by chemical burn, as well as cough and nasal congestion "likely" also related to

[12] *See V.B.*, Docket No. 17-1847 (issued April 4, 2018); *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley*, 55 ECAB 206 (2004).

[13] *See V.B., id; S.E.*, Docket No. 08-2214 (issued May 6, 2009); *T.M.*, Docket No. 08-0975 (issued February 6, 2009).

[14] *K.P.*, Docket No. 17-1145 (issued November 15, 2017); *T.M., id.*

[15] *See G.G.*, Docket No. 13-0573 (issued May 17, 2013).

[16] *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017).

chemical burn. However, this opinion is again speculative in nature.[17] Dr. Schecter did not explain with certainty how or why the employment-related chemical exposure would have resulted in a chemical burn, or otherwise caused or contributed to appellant's diagnosed conditions.[18] For these reasons, his report is insufficient to meet appellant's burden of proof.

In his other reports, Dr. Schecter either assessed probable asthma, asthma, or intrinsic asthma, unspecified. However, he 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 an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[19]

The spirometry tests of record are also insufficient to establish appellant's claim. The Board has held that reports of diagnostic tests lack probative value as they do not provide an opinion on causal relationship between his employment duties and a diagnosed condition.[20]

The Board finds that appellant has not submitted rationalized, probative medical evidence sufficient to establish that his diagnosed RAD, allergic rhinitis, and bronchial asthma conditions were causally related to the accepted employment incident. As such, appellant has not met his burden of proof.

As appellant has not submitted rationalized medical evidence establishing that his RAD, allergic rhinitis, and bronchial asthma were caused or aggravated by the accepted June 4, 2014 employment incident, the Board finds that he has not met his burden of proof.

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 not met his burden of proof to establish that his RAD, allergic rhinitis, and bronchial asthma were causally related to the accepted June 4, 2014 employment incident.

[17] *See supra* note 13.

[18] *See supra* note 14.

[19] *See supra* note 11.

[20] *See K.V.*, Docket No. 18-0723 (issued November 9, 2016).

ORDER

IT IS HEREBY ORDERED THAT the February 12, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 22, 2019
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