United States Department of Labor
Employees' Compensation Appeals Board

T.F., Appellant	)	
and	)	**Docket No. 19-1900**
	)	**Issued: October 27, 2020**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, Denver, CO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 15, 2019 appellant filed a timely appeal from a September 11, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met her burden of proof to establish respiratory conditions, bronchitis, and headaches causally related to the accepted employment exposure.

FACTUAL HISTORY

On February 4, 2019 appellant, then a 49-year-old special agent, filed an occupational disease claim (Form CA-2) for respiratory issues/bronchitis, loss of voice, and

[1] 5 U.S.C. § 8101 *et seq.*

headaches/migraines that she attributed to exposure to bacteria in the ventilation system when working from January to December 2018 in the Cyber Squad offices. She indicated that she first became aware of her condition on January 17, 2018 and first realized its relation to factors of her federal employment on December 20, 2018.

In a narrative statement dated January 17, 2019, appellant indicated that she had moved her workspace into newly-remodeled office space on December 21, 2017. Starting in early January 2018, she began suffering from daily migraines, usually starting in the afternoon. Appellant reported that she had suffered from migraines for years, but her prior headaches rarely started in the afternoon and were never at such regularity or severity. She noted that on January 21, 2018 she was sick and was diagnosed with bronchitis and thereafter remained on leave for 22 days. Appellant continued to work from February 26 to March 30, 2018, but continued to feel ill and she indicated that she had lost her voice and that the afternoon headaches/migraines continued. She attributed the cause of her illness and migraines to stresses at the workplace and had not considered that it could have been the office space itself until after her numerous physician's visits.

In a February 19, 2018 report, Dr. Judy Lane, a Board certified neurologist, diagnosed chronic migraine without aura, intractable, with status migrainosus; cervicalgia of occipito-atlanto-axial region; medication overuse headache; and primary insomnia. She noted that appellant had reported headaches over the prior 15 years with increased frequency, duration, and severity causing moderate-to-significant dysfunction.

On February 21, 2018 Dr. Marsha M. Manning, a Board-certified internist, indicated that appellant had been ill for approximately three to four weeks and first had significant myalgia and a severe acute bronchitis, as well as a severe cough and severe hoarseness with almost no voice, which could have been pertussis. She diagnosed migraine headaches, which appellant had for multiple years and significant insomnia.

A computerized tomography (CT) scan of the maxillofacial/sinuses performed on December 6, 2018 was unremarkable. A CT of the chest performed on December 11, 2018 showed a benign five-millimeter right lower lobe calcified granuloma, but was otherwise unremarkable. A pulmonary function report dated December 11, 2018 demonstrated normal spirometric values indicating the absence of any significant degree of obstructive pulmonary impairment and/or restrictive ventilator defect.

In reports dated December 11 and 20, 2018, Dr. David L. Goodman, a Board-certified allergist and immunologist, diagnosed cough, dermatographic urticarial, dyspnea, and chronic rhinitis. He indicated that appellant had been ill since September 2018 and had reported a persistent cough for most of the year, with no response to numerous courses of oral and inhaled medications, including steroids and antibiotics. Appellant missed 12 weeks of work and she tended to worsen shortly after going back to the office and ascribed it to voice strain. A cough and fever tended to accompany her return to work, as well. Dr. Goodman noted that appellant was office-based when at work, but also worked from home at other times. He opined that there was evidence of past exposure to a known vector of hypersensitivity pneumonitis, with temporal correlation of evanescent symptom intensity to workplace exposures. Dr. Goodman noted that there had been a pre-illness renovation of appellant's workplace and she had been subjected to

work exposures as an agent involving raids in buildings with suspect hygiene and "[Heating Ventilation and Air Conditioning (HVAC)]/mold exposure statuses."

On December 28, 2018 Dr. Goodman reiterated his opinion that appellant's recent airway issues with cough and respiratory distress were related to episodic exposures to thermophilic actinomycetes bacteria, a known cause of lung hypersensitivity reactions, which may be found in HVAC systems. He noted that serologic evidence of exposure did not, by itself, prove causation, but explained that there was circumstantial evidence that asymptomatic sensitization to this actinomycetes family grain positive rod, a known vector of HP, followed by a respiratory viral pathogen eliciting bronchial symptoms, could lead to an acute, or subacute, HP presentation. Dr. Goodman found that appellant's chest CT scan was absent signs of interstitial lung processes and her spirometry was normal, after recent prednisone courses in treatment of her acute respiratory symptoms. He recommended that she not be reexposed to the environment, as progressive interstitial lung disease and fibrosis could result.

In a development letter dated February 7, 2019, OWCP informed appellant that the evidence of record was insufficient to establish her claim. It advised her of the type of medical and factual evidence required and provided a questionnaire for her completion. OWCP afforded appellant 30 days to submit the requested information. It sent a similar letter requesting additional information from the employing establishment.

In response, appellant submitted a narrative statement dated February 12, 2019 reiterating the factual and medical history of her claim.

In a pulmonary visit note dated February 15, 2018, Dr. Dominic John Titone, a Board-certified internist, pulmonologist, and critical care specialist, diagnosed bronchitis, possible mild intermittent asthma, and history of hives.

In a report dated November 28, 2018, Dr. Brent W. Wieland, a Board-certified infectious disease specialist, diagnosed chronic bronchitis and fever. He indicated that appellant presented for an evaluation of recurrent upper respiratory tract infections. Dr. Wieland reported that she had a history of chronic urticarial, allergic rhinitis, migraines, frequent upper respiratory infections, and recurrent bronchitis. He reported that appellant had been unable to work for the past few months due to her illness and had reported several episodes of recurrent bronchitis over the past few years. Appellant believed that the episodes were occurring more frequently and reported feeling ill on three separate prolonged courses in 2018.

On December 5, 2018 appellant had followed up with Dr. Wieland for a lab review and he found that her initial workup was largely unremarkable, with negative infectious testing for mononucleosis, normal immunoglobulin levels, and normal routine labs. She presented with sinus congestion, as well as low-grade fevers, sore throat, hoarse voice, and cough.

In a December 11, 2018 report, Dr. Goodman indicated that appellant's C-reactive protein (CRP) testing was markedly elevated, but she had had milder CRP elevations in the past.

In a telephone encounter note dated December 17, 2018, Dr. Goodman indicated that appellant's labs were significant for "Micropolyspora faeni (A HYPERSENSITIVITY PNEUMONITIS trigger)." He noted that her work area had been subdivided and renovated

months ago and indicated that he would be sending pertinent literature citations and the lab results to her by mail, and that she would be pursuing an indoor air quality evaluation at her office in Denver, Colorado. On February 19, 2018 Dr. Goodman indicated that in the standard, nonindustrial, nonhazardous commercial/government administrative office environment in which the exposures to thermophilic actinomyces bacteria, no requirement for protective equipment (respirator, mask) would be stipulated. This was a post-construction exposure that would be totally unpredictable in a remodeled office build out and hygienically prepared for occupancy under applicable OSHA rules. Dr. Goodman opined that appellant's claimed exposure or contact occurred during the performance of duties in what was presumed to be an environment that had been successfully remodeled for nonhazardous use. He indicated that no "precautions to take," nor "hazards of use" would have been typical for reoccupation of such a space.

In a hospital report dated February 18, 2019, Dr. Christopher Brian Mawn, a Board certified plastic surgeon and otolaryngologist, diagnosed conditions including hoarseness of voice and fatigue. On March 5, 2018 he diagnosed vocal cord dysfunction, following chronic bronchitis in January 2018.

In a January 17, 2019 narrative statement, appellant reiterated the factual and medical history of her claim and submitted a blood panel dated November 1, 2018.

On December 11, 2018 Dr. Goodman indicated that appellant had a very challenging health year in 2018, with a persistent cough for most of the year, and opined that, in the face of a negative allergy evaluation, her history was most suggestive of a postviral process.

In a letter dated February 27, 2019, the employing establishment indicated that appellant moved to a new office on January 7, 2019 after working in an area of new construction which she believed to be the cause of her medical conditions. It further indicated that, air quality testing of, her workspace was conducted on February 4 and 11, 2019 and found to be within recommended guidelines on the dates of testing, but complaints of a respiratory irritant were made by two separate special agents, D.W. and R.W., neither of whom had knowledge of appellant's illness. The employing establishment noted that appellant did not wear a mask or respirator to conduct her daily activities in the office and after her physician provided information and a diagnosis on her condition and possible exposure to a respiratory irritant, she moved offices to reduce her exposure. It submitted a position description and the Limited Indoor Air Quality Assessment dated February 20, 2019.

In a February 28, 2019 report, Dr. Manning indicated that Dr. Goodman's diagnosis was made based on blood test results showing exposure to Saccharopolyspora rectivirgula (formerly Micropolyspora faeni) bacteria/organism. Since moving to a different office space in another building in January 2019, appellant had not shown a recurrence of prior symptoms which included significant respiratory issues including bronchitis, laryngitis, fatigue, insomnia, and migraine headaches, according to Dr. Manning. Dr. Manning explained that given that appellant had shown recovery since appellant was no longer exposed to her former office space environment and given the diagnosis made by Dr. Goodman, that the former office space was the source of appellant's illness.

By decision dated March 12, 2019, OWCP denied appellant's claim. It accepted that she was working in a newly remodeled office space as described, but denied her claim finding that the medical evidence of record failed to establish causal relationship between the accepted employment exposure and a diagnosed condition. OWCP concluded therefore that the requirements had not been met to establish an injury as defined by FECA.

On June 13, 2019 appellant requested reconsideration and submitted a narrative statement indicating that the symptoms she experienced from January to December 2018 completely disappeared after her removal from the renovated office space in early January 2019. In addition, since her retirement in May 2019, appellant had been in her residence daily and had experienced none of her prior symptoms. In support of her claim, she also submitted an article on the topic of actinomycetes and mycobacteria and an e-mail correspondence dated June 3, 2019 from M.H. indicating that a separate sampling would be needed to detect thermophilic actinomycetes organisms.

In a report dated May 20, 2019, Dr. Goodman indicated that the February 20, 2019 air quality testing was a limited observational assessment of a functional workspace, and thus did not specifically address the microbiological environment within that workspace. He opined that appellant presented with a symptom complex quite typical of cluster 1 acute/subacute hypersensitivity pneumonitis and had recurrent/remitting with avoidance/relapsing symptoms of malaise, chills, and cough, accompanied by a normal chest imaging and serologic evidence of sensitization to Saccharopolyspora rectivirgula. Dr. Goodman concluded that absent incontrovertible bacteriologic evidence to the contrary, her condition was work related.

By decision dated September 11, 2019, OWCP denied modification of its prior March 12, 2019 decision finding that the medical evidence of record was insufficient to establish causal relationship between appellant's diagnosed conditions and the accepted factors of her federal employment. It noted that she had been working in a newly renovated office space and had been exposed to a contaminated HVAC system, but she had been exposed to many airborne substances on a daily basis and the medical evidence did not provide enough probative and substantial evidence to support that her condition(s) resulted from being exposed to the newly remodeled workspace, in general, or the HVAC system, in particular.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] 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 timely filed within the applicable time limitation period of FECA,[3] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related

[2] *Id*.

[3] *E.W.*, Docket No. 19-1393 (issued January 29, 2020); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

to the employment injury.[4] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.[6]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[7] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[8] Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[9]

In a case in which a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[10]

ANALYSIS

The Board finds that this case is not in posture for decision.

In support of her claim, appellant submitted a series of medical reports from her attending physician, Dr. Goodman. In his reports, Dr. Goodman provided a proper factual and medical history of injury, noting that there had been a pre-illness renovation of her workplace and she had been subjected to work exposures as an agent involving raids in buildings with suspect hygiene

[4] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[5] 20 C.F.R. § 10.115; *E.S.*, Docket No. 18-1580 (issued January 23, 2020); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[6] *See T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[7] *J.F.*, Docket No. 18-0492 (issued January 16, 2020); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[8] *A.M.*, Docket No. 18-0562 (issued January 23, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[9] *E.W.*, *supra* note 3; *Gary L. Fowler*, 45 ECAB 365 (1994).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013). *See R.D.*, Docket No. 18-1551 (issued March 1, 2019).

and HVAC/mold exposure statuses. On December 28, 2018 he reiterated his opinion that appellant's recent airway issues with cough and respiratory distress were related to episodic exposures to thermophilic actinomycetes bacteria, and he explained that such bacteria are a known cause of lung hypersensitivity reactions. Dr. Goodman indicated that the bacteria can be found in HVAC systems. In his May 20, 2019 report, he cited to the February 20, 2019 air quality testing and opined that he presented with a symptom complex quite typical of cluster 1 acute/subacute hypersensitivity pneumonitis and had recurrent/remitting with avoidance/relapsing symptoms of malaise, chills, and cough, accompanied by a normal chest imaging and serologic evidence of sensitization to Saccharopolyspora rectivirgula. Dr. Goodman also indicated that while serologic evidence of exposure did not, by itself, prove causation, he opined that there was circumstantial evidence that asymptomatic sensitization to this actinomycetes family grain positive rod, a known vector of HP, followed by a respiratory viral pathogen eliciting bronchial symptoms, could lead to an acute, or subacute, HP presentation. He clarified that the blood test results were consistent with the noted exposures. Based on his medical findings, Dr. Goodman concluded that appellant's workplace air exposures were the cause of her diagnosed conditions.

The Board finds that the reports from Dr. Goodman are sufficient to require further development of the medical evidence in this claim. Dr. Goodman is a physician in the appropriate field of medicine and is therefore qualified to render rationalized opinions on the issue of causal relationship and he exhibited a comprehensive understanding of the medical record and case history. His reports provide a rationalized explanation as to how appellant's exposures to contaminants in her renovated office space at work resulted in her diagnosed respiratory conditions including bronchitis and headaches. The Board has long held that it is unnecessary that the evidence of record in a case be so conclusive as to suggest causal connection beyond all possible doubt. Rather, the evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound, and logical.[11] Thus, Dr. Goodman's medical opinions as set forth in his series of reports are found to be rationalized and logical and are sufficient to require further development of appellant's claim.[12]

It is well established that proceedings under FECA are not adversarial in nature and, while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[13] OWCP has an obligation to see that justice is done.[14]

[11] *W.M.*, Docket No. 17-1244 (issued November 7, 2017); *E.M.*, Docket No. 11-1106 (issued December 28, 2011); *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983).

[12] *J.H.*, Docket No. 18-1637 (issued January 29, 2020); *D.S.*, Docket No. 17-1359 (issued May 3, 2019); *X.V.*, Docket No. 18-1360 (issued April 12, 2019); *C.M.*, Docket No. 17-1977 (issued January 29, 2019); *William J. Cantrell*, 34 ECAB 1223 (1983).

[13] *See id. See also A.P.*, Docket No. 17-0813 (issued January 3, 2018); *Jimmy A. Hammons*, 51 ECAB 219, 223 (1999).

[14] *See B.C.*, Docket No. 15-1853 (issued January 19, 2016); *E.J.*, Docket No. 09-1481 (issued February 19, 2010); *John J. Carlone*, 41 ECAB 354 (1989).

On remand OWCP shall refer appellant, a statement of accepted facts, and the medical record to an appropriate respiratory specialist. The chosen physician shall provide a rationalized opinion as to whether the diagnosed conditions are causally related to the accepted factors of appellant's federal employment. If the physician opines that the diagnosed conditions are not causally related to the accepted employment exposure, he or she must explain, with rationale, how or why the opinion differs from that of Dr. Goodman. Following this and other such other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the September 11, 2019 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: October 27, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board