# United States Department of Labor
# Employees' Compensation Appeals Board

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| **S.G., Appellant** | ) | |
| **and** | ) | **Docket No. 22-0014** |
| | ) | **Issued: November 3, 2022** |
| **U.S. POSTAL SERVICE, POST OFFICE, New Orleans, LA, Employer** | ) | |

*Appearances:*
*Bradley Lance Person, Esq.*, for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

### ***JURISDICTION***

On October 4, 2021 appellant, through counsel, filed a timely appeal from a June 16, 2021 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 has met her burden of proof to establish that she developed a cardiac or respiratory condition in the performance of duty, as alleged.

## ***FACTUAL HISTORY***

On October 13, 2019 appellant, then a 51-year-old regular rural letter carrier, filed an occupational disease claim (Form CA-2) alleging that she developed heart and lung conditions causally related to factors of her federal employment, including exposure to mold. She indicated that she initially developed pneumonia in May 2018, that she observed visible mold in her workplace after a flood two years prior, and that eventually the facility was closed. Appellant noted that she first became aware of her condition on May 17, 2018 and realized that it was caused or aggravated by her federal employment on September 23, 2019. She stopped work on November 23, 2018.

In a statement dated October 23, 2019, appellant asserted that, after a flood at work, she noticed a musty odor in the building and eventually observed visible mold in the bathroom and in the area where she sorted mail for her route. She related that she has had asthma her entire life, but she believed that her exposure to mold at work caused her breathing and heart problems to progressively worsen until she was unable to work. Appellant also related that she was coughing during the week leading up to May 17, 2018 and she sought treatment in the emergency room after experiencing tingling in her legs and difficulty breathing. She noted that she underwent a right heart catheterization on September 11, 2018 and her physician, Dr. Stacy A. Mandras a Board-certified cardiovascular disease and transplant specialist, prescribed oxygen and recommended a lung transplant. Appellant further related that, prior to the mold exposure, she worked 20 years without difficulty, but after the exposure she could not engage in any physical activities. Her last day of work was November 21, 2018, and the facility where she worked was closed due to mold issues on September 23, 2019.

In an April 30, 2020 development letter, OWCP informed appellant of the deficiencies of her claim. It advised her of the type of factual and medical evidence necessary to establish her claim and provided a questionnaire for her completion. In a separate development letter of even date, OWCP requested that the employing establishment provide additional information regarding appellant's exposure to mold, and comments from a knowledgeable supervisor regarding the accuracy of her statements. It afforded both parties 30 days to respond.

In an undated response to OWCP's questionnaire, the employing establishment indicated that appellant's job duties were physically demanding, but she was performing them until she became sick. It further noted that it vacated the building where she worked due to mold issues.

On May 18, 2018 appellant was treated in the emergency room by Dr. Andy G. Quebedeaux, a hospitalist and family medicine specialist, who noted a history of moderate shortness of breath at rest and bilateral lower extremity numbness for one week. On examination, Dr. Quebedeaux noted scattered rhonchi, wheezes, coughing, and low oxygen saturation. He diagnosed dyspnea and ordered a chest x-ray, laboratory work, and medications.

Reports dated November 20, 2018 outlined the results of a pulmonary stress test, complete metabolic panel, and complete blood count.

A report of computerized tomography (CT) scan of the chest dated December 6, 2018 noted the possibility of nonspecific interstitial pneumonia, unusual appearance of usual interstitial pneumonia, or hypersensitivity pneumonia.

On January 1, 2019 appellant was treated in the emergency room by Dr. Christopher C. Landry, a Board-certified internist, who noted that she related worsening shortness of breath and a productive cough for the past two days. She was admitted to the hospital and underwent laboratory work, cultures, x-rays, and a transthoracic echocardiogram. Appellant was discharged on January 5, 2019 by Dr. Shema Abraham, a Board-certified internist, who diagnosed acute bronchitis, hypoxemic respiratory failure, community acquired pneumonia, diabetes, hypertension, hyperglycemia, mixed connected tissue disease, pulmonary artery hypoplasia, pulmonary edema and hypertension, severe sepsis, shortness of breath, and an unspecified disorder of the circulatory system.

In a progress note dated March 6, 2019, Dr. Mandras noted that appellant denied chest pain, shortness of breath, dyspnea with exertion, palpitations or claudication and that appellant was using oxygen regularly and that the edema in her lower extremities had completely resolved.

Appellant underwent additional laboratory work and pulmonary function testing on July 10 and September 17, 2019. Fungal precipitins testing for hypersensitivity pneumonitis collected on September 17, 2019 detected the presence of A fumigatus no. 1.

By decision dated June 5, 2020, OWCP denied appellant's claim, finding that the evidence of record was insufficient to establish a medical diagnosis in connection with the accepted factors of appellant's federal employment. It concluded, therefore, that she had not met the requirements to establish an injury as defined by FECA.

OWCP thereafter received additional records pertaining to appellant's May 18, 2018 hospital admission, including a chest CT which showed an enlarged heart and bilateral pulmonary infiltrates. Dr. Quebedeaux reviewed the CT and diagnosed acute on chronic respiratory failure with a history of asthma with hypoxia, bilateral pneumonia, hypertension, and diabetes. In a report of even date, Dr. Robert Menuet, II, a Board-certified internist and cardiovascular specialist, diagnosed dyspnea with hypoxia due to bilateral pneumonia, elevated B-type natriuretic peptide bilateral lower extremity edema, hypertension, and diabetes. A discharge summary dated May 19, 2018 documented that appellant related that her shortness of breath had greatly improved. She was discharged with prescribed medications and a nebulizer machine.

In a report of right heart catheterization dated September 11, 2018, Dr. David Homan, an interventional cardiologist, diagnosed severe pulmonary hypertension.

In a May 21, 2019 medical report, Dr. Mandras diagnosed pulmonary hypertension, chronic respiratory failure with hypoxia, obstructive sleep apnea, interstitial lung disease, diabetes, obesity, mixed hyperlipidemia, essential hypertension, and chronic deep vein thrombosis of the right lower extremity. She recommended a right heart catheterization to remeasure the blood pressure in appellant's lungs.

A report of a nasopharyngeal respiratory infection panel dated September 17, 2019 was negative.

On June 8, 2020 appellant, through counsel, requested review of the written record by a representative of OWCP's Branch of Hearings and Review.

Following a preliminary review, by decision dated September 25, 2020, OWCP's hearing representative vacated the June 5, 2020 decision and remanded the case to OWCP for further development, noting that the factual and medical development was incomplete and finding that it must consider additional records which addressed the alleged exposure.

OWCP thereafter received employing establishment facility work orders for appellant's worksite, including a request dated March 29, 2017 which indicated that a safety specialist had observed standing water, six inches deep, in the basement. An entry dated April 4, 2017 noted that the location's sump pump had burst, water was running out, and it needed to be replaced. A January 25, 2018 entry indicated that a mold assessment had confirmed mold in multiple locations.

OWCP also received copies of correspondence from the employing establishment, including: an August 24, 2017 e-mail indicating that the sump pump was not able to keep up with heavy rains and that it was necessary to spray mildew and mold killer on the walls in the basement; an August 19, 2019 e-mail from T.F., a supervisor at appellant's worksite, requesting an air quality test; a September 6, 2019 e-mail from T.F. noting that multiple employees reported illness due to breathing issues; September 20, 2019 e-mails noting that a facility environmental specialist had concluded that the facility was not a healthy air space for employees to work longer than eight hours; the employing establishment's September 23, 2019 press release regarding the closure of appellant's worksite; and an October 29, 2019 e-mail from T.F. indicating that he observed seven to eight inches of water in the basement. It also received material safety data sheets for various cleaning agents, weed killers, and pesticides.

An October 10, 2019 limited structural evaluation report noted that mold had developed from a previous water leak in the basement, but the evaluation was put on hold in February 2018 pending water intrusion repairs. It further indicated that on September 19, 2019 the employing establishment requested an emergency mold assessment after receiving several employee complaints of health concerns. The report also noted that several areas of possible water intrusion and visible mold were found on September 30, 2019.

On May 4, 2021 OWCP referred appellant, along with a statement of accepted facts (SOAF), the medical record, and a set of questions, to Dr. Bogdan L. Nowakowski, a Board-certified pulmonary disease specialist, for a second opinion evaluation to determine whether a work exposure to mold caused or contributed to her breathing problems.

In a report dated June 9, 2021, Dr. Nowakowski diagnosed chronic hypoxic respiratory disease secondary to mixed collagen vascular disease, pulmonary hypertension, and asthma. He opined that appellant's conditions were not related to the claimed work injury.

By decision dated June 16, 2021, OWCP denied appellant's claim, finding that the evidence of record was insufficient to establish the implicated employment factors. It concluded,

therefore, that she had not met the requirements to establish that she sustained an injury as defined by FECA.

## ***LEGAL PRECEDENT***

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including 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 of FECA,[4] 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 to the employment injury.[5] 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.[6]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (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.[7]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[8] 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.[9] 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.[10]

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[3] *Id*.

[4] *F.H.*, Docket No.18-0869 (issued January 29, 2020); *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *J.H.*, Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *P.A.*, Docket No. 18-0559 (issued January 29, 2020); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *T.W.*, Docket No. 20-0767 (issued January 13, 2021); *L.D.*, Docket No. 19-1301 (issued January 29, 2020); *S.C.*, Docket No. 18-1242 (issued March 13, 2019).

[8] *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).

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

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

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.[11]

## ***ANALYSIS***

The Board finds that appellant has met her burden of proof to establish that exposure to mold occurred while in the performance of duty, as alleged.

Appellant filed a claim alleging that she developed heart and lung conditions caused by exposure to mold while working at the employing establishment. The record establishes that in 2017, the sump pump at her worksite burst, causing flooding, and as of January 2018, an environmental assessment confirmed mold in multiple locations. Appellant presented to the emergency room on May 8, 2018 with respiratory symptoms and was diagnosed with bilateral pneumonia. She continued to work until November 2018, and a CT scan of the chest dated December 6, 2018 was suggestive of nonspecific interstitial pneumonia, unusual appearance of usual interstitial pneumonia, or hypersensitivity pneumonia. On January 1, 2019 appellant was again treated in the emergency room with complaints of worsening shortness of breath and a productive cough. Employing establishment communications in August and September 2019 noted that other employees reported breathing-related illnesses, and the facility was closed due to unsafe air quality and mold on September 23, 2019. The Board finds that this evidence establishes that the exposure to mold occurred, as alleged.[12]

As appellant has established the claimed occupational exposure, the question becomes whether this exposure caused an injury.[13] It is well established that proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares the responsibility in the development of the evidence to see that justice is done.[14] Once it undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[15]

OWCP's procedures dictate that, when an OWCP medical adviser, second opinion specialist, or impartial medical examiner renders a medical opinion based on a SOAF, which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion,

[11] *E.W.*, Docket No. 19-1393 (issued January 29, 2020); *Gary L. Fowler*, 45 ECAB 365 (1994).

[12] *See J.H.*, Docket No. 20-1252 (issued February 5, 2021); *J.C.*, Docket No. 18-1803 (issued April 19, 2019); *M.C.*, Docket No. 18-1278 (issued March 7, 2019); *M.M.*, Docket No. 17-1522 (issued April 25, 2018).

[13] *See N.B.*, Docket No. 13-0513 (issued August 27, 2017).

[14] *J.R.*, Docket No. 19-1321 (issued February 7, 2020); *S.S.*, Docket No. 18-0397 (issued January 15, 2019).

[15] *Id.*; *see also R.M.*, Docket No. 16-0147 (issued June 17, 2016).

the probative value of the opinion is seriously diminished or negated altogether.[16] The Board finds that OWCP provided Dr. Nowakowski a deficient SOAF, which did not specify the nature and extent of appellant's exposure to mold. Therefore, the probative value of Dr. Nowakowski's opinion is diminished.[17] Accordingly, the Board finds that the case must be remanded to OWCP.[18]

On remand OWCP shall clarify the accepted employment factors, including the nature and extent of appellant's exposure to mold in the workplace, and prepare an updated SOAF. It shall then refer the case record, together with the updated SOAF, to Dr. Nowakowski for a reasoned opinion regarding whether the accepted mold exposure contributed to a diagnosed condition or caused an aggravation of a preexisting condition.[19] If Dr. Nowakowski is unable to clarify or elaborate on his original report, or if his supplemental report is vague, speculative, or lacking in rationale, OWCP shall refer appellant to a new second opinion physician.[20] After this and other such further development as deemed necessary, it shall issue a *de novo* decision.

## ***CONCLUSION***

The Board finds that appellant has met her burden of proof to establish exposure to mold in the performance of duty, as alleged. The Board further finds that the case is not in posture for decision with regard to whether she has established a respiratory or other medical condition causally related to the accepted employment exposure.

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990); *see S.C.*, Docket No. 18-1011 (issued March 23, 2020).

[17] *See P.C.*, Docket No. 20-0935 (issued February 19, 2021).

[18] *Supra* note 14; *J.T.*, Docket No. 18-1300 (issued March 22, 2019).

[19] *See G.T.*, Docket No. 21-0170 (issued September 29, 2021); *P.S.*, Docket No. 17-0802 (issued August 18, 2017).

[20] *G.T., id.*; *see also D.L.*, Docket No. 20-0886 (issued November 9, 2021).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the June 16, 2021 decision of the Office of Workers' Compensation Programs is reversed in part and set aside in part; the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 3, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board