United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 20-1252**
	)	**Issued: February 5, 2021**
DEPARTMENT OF VETERANS AFFAIRS, VA MONTANA HEALTHCARE SYSTEM, BOZEMAN VA CLINIC, Bozeman, MT, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 3, 2020 appellant filed a timely appeal from a May 12, 2020 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the May 12, 2020 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.*

ISSUE

The issue is whether appellant has met his burden of proof to establish that he sustained a respiratory condition in the performance of duty, as alleged.

FACTUAL HISTORY

On March 25, 2020 appellant, then a 46-year-old nurse, filed an occupational disease claim (Form CA-2) alleging that he experienced an allergic respiratory reaction causally related to factors of his federal employment, including exposure to four types of mold identified in the clinic where he worked. He noted that he first became aware of his condition on June 1, 2019 and realized that it was caused or aggravated by his federal employment on March 23, 2020. Appellant indicated that, after taking 10 days off, he returned to work and experienced increased respiratory symptoms and was treated in the emergency room. He stopped work on March 24, 2020. On the reverse side of the claim form appellant's supervisor indicated that on March 30, 2020 he was scheduled to return to work at another employing establishment facility.

Appellant submitted a copy of a report detailing the March 3, 2020 testing of bioaerosol samples at the employing establishment. The testing, completed by a private company, revealed results suggestive of a possible indoor source of mold. It indicated that two fungal types were recovered indoors that were not detected in the out-of-doors sample, suggesting a possible indoor source. The study further indicated that Stachybotrys, a type of mold that can produce potent mycotoxins and is associated with significant health symptoms, was detected in a sample taken in office seven. This concentration was sufficient to contribute to poor indoor air quality. The study revealed that these spores are not easily aerosolized and industry experts agree that any airborne Stachybotrys indoors should trigger investigative action and thorough remediation of the mold source. It further noted that Chaetomium was observed in samples taken in office 47 and 48. The report indicated that this fungal type is allergenic and can produce various mycotoxins as well as opportunistic infections in immune compromised individuals. It further indicated that Chaetomium is found in cellulose materials and requires similar environmental conditions for growth and it is often found in conjunction with Stachybotrys. The study recommended that the mold sources be identified and corrective action be undertaken to avoid potentially severe symptoms and reduce exposure to building occupants. It further recommended that with fungal material at this level, and because of the presence of two target fungal types, remediation efforts should be conducted.

In an April 7, 2020 development letter, OWCP informed appellant that it had received no evidence in support of his occupational disease claim. It advised him of the type of factual and medical evidence necessary to establish his claim and provided a questionnaire for his completion. In a separate development letter of even date, OWCP requested that the employing establishment provide additional information regarding appellant's exposure to potentially harmful substances, and comments from a knowledgeable supervisor regarding the accuracy of his statements. It afforded both parties 30 days to respond.

On March 24, 2020 appellant was treated in the emergency room by Dr. Eric G. Lowe, a Board-certified emergency room physician, for shortness of breath. He reported that after taking 10 days off he returned to work and had a return of respiratory symptoms. Appellant noted that

his workplace was under investigation for mold exposure, which was being remediated that week. Dr. Lowe diagnosed acute respiratory failure with hypercapnia, environmental and seasonal allergies, and gastroesophageal reflux disease. He opined that there was evidence of environmental exposure as the source for appellant's symptoms and removed him from work for one week. Dr. Lowe prescribed epinephrine with almost immediate resolution of symptoms.

On April 14, 2020 Dr. Elizabeth A. Steiz, an osteopath, treated appellant by telephone for occupational exposure to mold. She indicated that the employing establishment had known mold contamination and was currently undergoing mold remediation. Appellant provided reports documenting positive mold tests at the facility. He reported chronic and recurrent symptoms of respiratory disease since June 2019 with cough, congestion, and shortness of breath. Appellant was hospitalized from September 30 through October 2, 2019 for acute hypoxic and hypercapnic respiratory failure, severe obstructive lung disease, staph aureus bronchitis, and hyper eosinophilia. He also reported two emergency room visits in September 2019 with symptoms of shortness of breath, coughing, and wheezing. Dr. Steiz noted that appellant had 10 days off work with improvement in his symptoms and, upon returning to work on March 23, 2020, he experienced shortness of breath and was treated in the emergency room. She diagnosed mold exposure, work-related injury, and reactive airway disease that was not asthma. Appellant indicated that his employing establishment moved him off site to another facility and he experienced improvement in his symptoms.

In an attending physician's report (Form CA-20) dated April 16, 2020, Dr. Steiz noted a history of mold exposure on March 23, 2020 resulting in respiratory symptoms. She diagnosed reactive airway disease and respiratory failure. Dr. Steiz checked a box marked "Yes," indicating that the diagnosed conditions were caused or aggravated by the described employment incident, further noting that appellant's symptoms developed after exposure to mold.

On May 6, 2020 Dr. Mark D. Winton, Board-certified in infectious disease, treated appellant for mold exposure, eosinophilia, and acute recurrent pansinusitis. He diagnosed reactive airway disease that mimics asthma caused by mold exposure at the employing establishment. Dr. Winton noted that studies of the air handling in the building revealed elevated levels of reactive mold. He reported other employees having similar symptoms with a removal from that work space causing a dramatic improvement in symptoms. Dr. Winton ruled out other diseases and environmental causes after reviewing the data from the work environment. He further noted that immune response to mold can produce the same signs and symptoms as a sinus infection.

By decision dated May 12, 2020, OWCP denied appellant's claim, finding that the evidence of record was insufficient to establish the implicated employment factors. It concluded, therefore, that he had not met the requirements to establish that he 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 the fact that the individual is an employee of the

[3] *Supra* note 1.

United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period 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 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.[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]

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]

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[4] *Id.*

[5] *E.W.*, Docket No. 19-1393 (issued January 29, 2020); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989); *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *L.C., id.*; *R.C.*, 59 ECAB 427 (2008); *James E. Chadden*, *id.*

[7] 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).

[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).

[11] *E.W.*, *supra* note 5; *Gary L. Fowler*, 45 ECAB 365 (1994).

ANALYSIS

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

Appellant filed a claim alleging that he developed an allergic respiratory reaction caused by exposure to mold while working at the employing establishment. The record establishes that from June 2019 through March 23, 2020 appellant worked at the employing establishment with exposure to mold. A March 3, 2020 study of bioaerosol samples at the employing establishment revealed two fungal types were recovered indoors. The study noted that Stachybotrys, a type of mold that can produce potent mycotoxins and was associated with significant health symptoms, was detected in a sample taken in office seven. This concentration was sufficient to contribute to poor indoor air quality. The study further noted that Chaetomium was observed in samples taken in office 47 and 48, which is an allergen and can produce various mycotoxins as well as opportunistic infections in immune compromised individuals. The study recommended that the mold sources be identified and remediation efforts be undertaken to avoid potentially severe symptoms and reduce exposure to building occupants. Appellant indicated that, after taking off 10 days, he returned to work and experienced increased congestion and respiratory symptoms.

The employing establishment did not respond to the development questionnaire and did not dispute the findings of this study. On the reverse side of the claim form, appellant's supervisor had indicated that appellant was removed from the employing establishment and scheduled to work from another facility commencing March 30, 2020. Additionally, appellant sought medical care with Dr. Lowe on March 24, 2020, who noted his account of exposure to mold in the workplace and diagnosed acute respiratory failure with hypercapnia, environmental and seasonal allergies. Similarly, on April 14, 2020 Dr. Steiz treated appellant for occupational exposure to mold. She too indicated that the employing establishment had known mold contamination and was currently undergoing mold remediation. Dr. Steiz diagnosed mold exposure, work-related injury, and reactive airway disease that was not asthma. Likewise, on May 6, 2020 Dr. Winton treated appellant for mold exposure, eosinophilia, and acute recurrent pansinusitis. He referenced mold exposure at the employing establishment, specifically that studies of the air handling in the building revealed elevated levels of reactive mold. Dr. Winton diagnosed reactive airway disease caused by mold exposure at the employing establishment.

The claimed respiratory injury is consistent with the facts and circumstances he sets forth, his course of action, and the medical evidence he submitted. The Board finds that this evidence establishes that the alleged 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] As OWCP found that he had not established an employment exposure, it did not evaluate the medical evidence.[14] Thus, the Board will set aside

[12] *See 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] *See A.T.*, Docket No. 16-1787 (issued February 1, 2017).

OWCP's May 12, 2020 decision and remand the case for consideration of the medical evidence of record.[15] After such further development as deemed necessary, OWCP shall issue a *de novo* decision addressing whether appellant has met his burden of proof to establish a respiratory or other medical condition causally related to the accepted employment exposure.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 12, 2020 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: February 5, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

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

[15] *Id.*