United States Department of Labor
Employees' Compensation Appeals Board

D.N., Appellant	)	
	)	
and	)	**Docket No. 10-1762**
	)	**Issued: May 10, 2011**
DEPARTMENT OF VETERANS AFFAIRS,	)	
LOUIS STOKES MEDICAL CENTER,	)	
Brecksville, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 22, 2010 appellant, through his representative, filed a timely appeal from the June 3, 2010 merit decision of the Office of Workers' Compensation Programs, which denied his pulmonary injury claim. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant's occupational exposure to mold on March 7, 2006 caused a pulmonary injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

In the first appeal of this case,[2] the Board noted that there was no dispute that appellant was exposed to mold on March 7, 2006 in the course of his employment.[3] The Board found, however, that the medical opinion evidence failed to show how this exposure caused an injury to his lungs. Appellant's pulmonary specialist did not review the May 23, 2005 mold assessment in Room H27, which stood as the best evidence of the nature of appellant's exposure.[4] The Board noted that sound medical reasoning was particularly important where he had a history of pneumonia, where others at work appeared to have the flu when he began to feel ill and where he was diagnosed with and aggressively treated for pneumonia.[5]

In the second appeal,[6] the Board found that the medical opinion evidence continued to be insufficient to establish causal relationship. The Board stated that a specialist in pulmonary diseases should review the May 23, 2005 mold assessment in Room H27 and account for appellant's activity in the room and the duration of his exposure.[7] The specialist, the Board stated, must soundly explain, with medical reasoning sufficient to convince a lay adjudicator, that appellant's time in Room H27 caused an injury to his lungs. He must explain the nature of that injury and must cite the factual and medical evidence that logically supports causal relationship. The relevant facts of this case, as they appeared in the record at the time of the Board's prior decision, are hereby incorporated by reference.

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[2] Docket No. 07-921 (issued July 26, 2007).

[3] Appellant, a 52-year-old criminal investigator, filed a claim alleging that he sustained an injury to his lungs on March 7, 2006 when he was exposed to mold or fungus in the performance of duty. He entered a records room and noticed what appeared to be mold on the files and other surfaces. Appellant was in the room for approximately 15 minutes and the following week, he stated that he was coughing and felt like he had the flu.

[4] Another mold assessment was conducted in early December 2006.

[5] Appellant last smoked cigarettes in 1973. On January 31, 2001 he saw an internist following urgent care for a productive cough, which he thought was pneumonia. Appellant was treated with medication for bronchitis. He saw an internist on October 8, 2003 for, among other things, coughing up blood. The past medical history noted "pneumonia 1983." The diagnosis included hemoptysis, rule out pneumonia. Appellant sought urgent care the next day and complained of coughing up greenish phlegm. An x-ray showed a minimal collapse of the left lung base with no focal mass or infiltrate. Appellant's diagnosis was upper respiratory infection, most likely viral. He slowly improved but had a persistent, dry, hacking cough intermittently with coughing jags lasting two to three minutes, causing shortness of breath. Appellant began sleeping sitting up and awoke hourly with the cough. He was diagnosed with post viral hyperreactive airway. A pulmonary function study was obtained on March 16, 2004. On March 3, 2005 appellant had a swab sample taken of his pharynx for a viral culture. On April 15, 2005 when he was treated for low blood sugar and vagal reaction, he reported that he had been in recent good health but for a "prolonged influenza," making him real sick and off and on dizzy. On March 17, 2006 10 days after his exposure in Room H27, appellant provided a history of upper respiratory infection followed by shortness of breath "increasing over last several weeks."

[6] Docket No. 09-67 (issued May 22, 2009).

[7] Appellant told the Occupational Health & Safety Specialist that he was in Room H27 for approximately 15 minutes. On November 7, 2006 he testified that he left the room as soon as he confirmed the presence of mold.

Appellant requested reconsideration and submitted the April 6, 2010 report of Dr. Ernest P. Chiodo, Board-certified in internal and occupational medicine and as well as public health and general preventative medicine, who is also a certified industrial hygienist. Dr. Chiodo noted that appellant had no history of any pulmonary disease other than a possible episode of "walking pneumonia" in the mid-1980s, which, if it did exist, resolved without treatment. He stated that appellant was called upon to investigate a medical records storage vault that had been closed after a flood a number of years previously. Appellant spent a relatively short time investigating the storage vault, which was heavily contaminated with mold. The black mold covered the walls, floor and file storage cabinets. Appellant stated that the mold contamination on the floor was about one inch in depth and he walked over the mold-covered floor without respiratory protection.

Dr. Chiodo stated that, approximately one week later, appellant developed flu-like symptoms, including shortness of breath and cough productive of greenish sputum, which then became brownish. Symptoms continued over the course of about one week. Appellant finally had an episode of near loss of consciousness at work, which led to an evaluation showing a pneumonic process. He was hospitalized and ultimately had a lung biopsy demonstrating focal chronic interstitial pneumonia consistent with hypersensitivity pneumonia.

Dr. Chiodo described his physical examination of appellant. Findings included marked Velcro crackles in the lung bases on inspiration. He noted that peer-reviewed literature supported the assertion that allergic disease may be caused by mold antigen exposure, though the quotation he cited stated that pathogenesis of all hypersensitivity disease involves repeated antigen exposure and that time is required for the body to develop an immunological sensitization: "Therefore, latency (absence of response or disease on first contact) is characteristic of all hypersensitivity diseases." Dr. Chiodo offered his opinion on causal relationship:

> "It is my opinion to a reasonable degree of medical and scientific certainty as both a physician and a Certified Industrial Hygienist that [appellant's] interstitial lung disease in the form of hypersensitivity pneumonitis was cause[d] by his mold exposure in the Cleveland Veterans Administration Medical Center. [Appellant] clearly had a massive exposure to mold spores that would be released by his walking without respiratory protection in a one inch deep 'carpet' of mold on the floor of the storage vault. His onset of disease shortly after entering into the heavily mold contaminated storage vault is a classic presentation of mold[-]induced hypersensitivity pneumonitis."

On June 3, 2010 the Office reviewed the merits of appellant's claim but denied modification of its September 19, 2008 decision. It found that Dr. Chiodo's opinion failed to establish causal relationship.

On appeal, appellant's representative contends that, although the medical evidence may or may not be sufficient to meet appellant's burden of proof, it raises an uncontroverted inference of causal relationship and is sufficient to require further development. He argues that the Office should further develop the factual or medical evidence including appellant's possible exposure to mold in the subbasement of Building 2 on the Brecksville Campus earlier on March 7, 2006.

LEGAL PRECEDENT

The Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of his duty.[8] An employee seeking benefits under the Act has the burden of proof to establish the essential elements of his claim. When an employee claims that he sustained an injury in the performance of duty, he must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. He must also establish that such event, incident or exposure caused an injury.[9]

Causal relationship is a medical issue[10] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[11] must be one of reasonable medical certainty[12] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[13]

ANALYSIS

Dr. Chiodo, an internist, described heavy mold contamination in the medical records storage vault. He stated that black-colored mold covered the walls, floor and file storage cabinets. Dr. Chiodo noted that the mold contamination on the floor was about one inch in depth and that appellant walked over this "carpet" of black mold without respiratory protection, thereby causing a massive exposure to mold spores.

The problem with this history is that it is does not find good support in the record. A visual inspection in February 2005 noted that the floors in one area of Room H27 showed quite a bit of debris had accumulated. What kind of debris is unknown. The memorandum stated that "disturbing this debris could possibly disturb moulds [sic] that are at rest in the debris." What mold, if any, was at rest in the debris is also unknown.

The mold assessment of Room H27 on May 23, 2005 -- nine months before appellant entered the room -- mentioned nothing about the floor. Medical files located in the northeast corner of the room contained visible mold contamination. Surface samples collected on those medical files indicated numerous counts of *Aspergillus/Penicillium*, *Botrytis* and *Hyphal*

[8] 5 U.S.C. § 8102(a).

[9] *E.g., John J. Carlone*, 41 ECAB 354 (1989).

[10] *Mary J. Briggs*, 37 ECAB 578 (1986).

[11] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[12] *Morris Scanlon*, 11 ECAB 384, 385 (1960).

[13] *William E. Enright*, 31 ECAB 426, 430 (1980).

fragments. Air samples indicated elevated levels of *Aspergillus/Penicillium* and *Stachybotrys*. The walk-through evaluation describes the visual inspection of the room with no mention of any mold contamination on the floor.

On June 9, 2006 appellant described what happened on March 7, 2006. It appears he entered the room at the mezzanine level and walked down the side ramp to the file room. As appellant looked between the shelving units for evidence of anyone sleeping in the area, he saw what appeared to be mold on a few of the files. The more he looked, the more he thought he saw. After going back up the ramp and turning on some of the lights, appellant went back down to check if, in fact, there was mold on the files. There was and it looked like there was mold on other surfaces as well. Appellant left and determined that there were no signs that anyone had been using the area for sleeping.

This was appellant's most contemporaneous and most detailed description of what he did and what he saw on March 7, 2006. He made no mention of the floor. However, when appellant testified before an Office hearing representative on November 7, 2006, he stated that there was mold everywhere: on the files, on the walls, on the ceiling and on the floor.

The mold assessment in early December 2006 -- nine months after appellant's exposure -- showed a higher concentration of mold in the air outside the medical center than in Room H27 or the mezzanine. A December 13, 2006 memorandum from the Occupational Health & Safety specialist explained: "The heavy mold concentrations are on the records -- if not disturbed by handling, it will not go airborne." This is consistent with the June 28, 2006 report of the employer's injury compensation specialist that the mold in Room H27 was confined predominantly to the file cabinets themselves and, according to Occupational Health & Safety, very few spores would have been circulating in the air. She added: "The employee acknowledges that [appellant] did not open or touch any cabinets or files."

On August 20, 2008 appellant stated that he was told that his exposure came from the spores that had fallen off the files to the floor. His account of what happened on March 7, 2006 now included walking through dust that was a quarter-inch to a half-inch deep, which caused spores and dust to become airborne. Appellant stated that breathing this spore-containing dust caused his illness. He stated that his physicians told him that only one spore could cause his illness.

In April 2010, appellant told Dr. Chiodo that he had spent his time in the medical records room walking on a one-inch carpet of black mold. It was on that basis factual history, that Dr. Chiodo described the room as heavily contaminated with mold and described appellant as massively exposed to mold spores. The Board finds that this is not a proper foundation for an opinion on causal relationship. Dr. Chiodo should have reviewed the mold assessments obtained in May 2005 and December 2006. This was the most objective evidence of appellant's exposure. Dr. Chiodo should have reviewed appellant's June 9, 2006 statement. This was the most contemporaneous and most reliable description of what he did and what he saw in Room H27.

Medical conclusions based on inaccurate or incomplete histories are of diminished probative value.[14]

There is no basis in the factual record for Dr. Chiodo's history that appellant became massively exposed to mold spores when he walked without respiratory protection on a one-inch deep carpet of black mold. Indeed, the Board can find no reliable evidence that appellant disturbed any mold while walking in Room H27. The February 2005 memorandum speculated that disturbing debris in one area of the room could possibly disturb molds at rest. Those who conducted the mold assessments also walked about the room and were keenly aware of the mold contamination. For them any mold on the floor was not an issue.

Dr. Chiodo also based his opinion on an incomplete medical history. He stated that appellant had no history of any pulmonary disease other than a possible episode of walking pneumonia in the mid-1980s, which he seemed to doubt. Dr. Chiodo found that appellant had no significant pulmonary history prior to his exposure on March 7, 2006, but the record shows otherwise. As noted, appellant had a significant pulmonary history: smoking, pneumonia, bronchitis, hemoptysis rule out pneumonia, post viral hyperreactivity airway and an apparently "prolonged influenza" in 2005.[15] Not to be overlooked is the history appellant provided on March 17, 2006, stating that he had an upper respiratory infection followed by shortness of breath "increasing over last several weeks." This indicated that he had begun to experience pulmonary symptoms before he entered Room H27 on March 7, 2006.

Any physician providing an opinion on whether appellant's workplace exposure on March 7, 2006 caused his pulmonary disease has an obligation to review the medical record, address his history and treatment and explain the relationships, if any, on his pulmonary condition after March 7, 2006. Dr. Chiodo offered his opinion on causal relationship with essentially no discussion of appellant's past medical history. He made no mention of the fact that, when appellant began to feel ill, others at work appeared to have the flu.

The Board also finds that Dr. Chiodo's medical reasoning is of diminished probative value. Dr. Chiodo noted that, one lung biopsy -- there were several, the results of which he should address -- showed focal chronic interstitial pneumonia, consistent with hypersensitivity pneumonia. Given appellant's massive exposure from walking on a one-inch carpet of black mold, followed quite shortly by the onset of disease, Dr. Chiodo concluded that appellant's exposure had caused this interstitial lung disease.

Before he offered this opinion, Dr. Chiodo quoted a 1999 publication from the American Conference of Governmental Industrial Hygienists, which he described as a reliable authority. He stated that citations from this publication were reflective of recognized and generally accepted methodology by the medical and scientific community. This publication, Dr. Chiodo stated, supported the assertion that allergic disease may be caused by mold antigen exposure.

[14] *James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little diminished probative value because the history was both inaccurate and incomplete). *See generally Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

[15] *See supra* note 5.

According to the quotation Dr. Chiodo selected, the pathogenesis of all hypersensitivity disease involves repeated antigen exposure and an immunological sensitization of a host to an antigen. This sensitization requires time to develop in the body, so latency or the absence of response or disease on first contact, is characteristic of all hypersensitivity diseases. Dr. Chiodo did not explain how this pathogenesis was consistent with his opinion that appellant's one-time exposure on March 7, 2006 caused disease only days later. The repeated antigen exposure and the absence of response on first contact do not appear to be present in this case. Dr. Chiodo did not fully reconcile his opinion with the passage he quoted. Apart from the incomplete and inaccurate factual and medical history, his opinion lacks sufficient medical rationale to establish the critical element of causal relationship.[16]

The Board finds that appellant has not met his burden of proof. The medical opinion evidence he submitted to support his request for reconsideration was based on an incomplete and inaccurate factual history as well as a lack of sound medical reasoning. The Board will therefore affirm the Office's June 3, 2001 decision denying appellant's injury claim.

Appellant's representative stresses the importance of a careful recitation and review of the facts. The Board finds that Dr. Chiodo's opinion is of diminished probative value for the reasons stated. The representative also argues that, although the medical evidence may or may not be sufficient to meet appellant's burden of proof, it raises an uncontroverted inference of causal relationship and is sufficient to require further development. The Board does not find Dr. Chiodo's opinion sufficiently supportive of appellant's claim to raise an inference of causal relationship or to warrant setting aside the denial of compensation for further development. Dr. Chiodo's opinion is of diminished weight.

CONCLUSION

The Board finds that appellant did not establish that his occupational exposure to mold on March 7, 2006 caused a pulmonary injury. The medical opinion evidence does not establish the critical element of causal relationship.

[16] Medical conclusions unsupported by rationale are of little probative value. *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

ORDER

IT IS HEREBY ORDERED THAT the June 3, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 10, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board