United States Department of Labor
Employees' Compensation Appeals Board

S.L., Appellant	)	
and	)	**Docket No. 21-0079**
	)	**Issued: January 25, 2022**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, New York, 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:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On October 25, 2020 appellant, through counsel, filed a timely appeal from a June 8, 2020 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 his burden of proof to establish an occupational disease causally related to the accepted employment exposure.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances as set forth in the Board's prior order are incorporated herein by reference. The relevant facts are as follows.

On July 28, 2009 appellant, then a 40-year-old special agent, filed an occupational disease claim (Form CA-2) alleging that he sustained hearing loss, tinnitus in the right ear, bronchitis, dizziness, nausea, vomiting, inflammation of the nose and face, lesions, and insomnia causally related to factors of his federal employment, including the exposure to mold. He did not stop work.

Appellant submitted mold analysis reports dated January 30, March 9, and April 8, 2009 from samples obtained at his work location. The results showed unusual mold growth associated with excess moisture. An Environmental Relative Moldiness Index (ERMI) report dated June 4, 2009 provided a list of each type of mold found at appellant's work location and the spore count.

In a report dated July 9, 2009, Dr. Jonathan E. Gage, a Board-certified internist and cardiologist, noted that he had treated appellant for Meniere's disease for several years and discussed his treatment to remove toxins. He diagnosed an abnormal echocardiogram, shortness of breath, chronic fatigue syndrome, and dizziness.

In a statement received by OWCP on August 10, 2009, appellant related that the ductwork in his building had not been cleaned even though it had been "engulfed by the debris" from Ground Zero. In April 2004 he began experiencing tinnitus, hearing loss, inflammation on the right side of his face and nose, and lesions on his right thigh. In 2005 appellant experienced dizziness and vertigo, and in May 2006 he began vomiting uncontrollably at work. He realized in January 2009 that the vents in his office were covered with black mold, which was confirmed by lab testing.

In a development letter dated August 14, 2009, OWCP advised appellant that the evidence currently was insufficient to show that he had sustained an occupational injury. It notified him of the type of additional evidence needed, including a reasoned report from his attending physician addressing the causal relationship between any diagnosed condition and factors of his federal employment. OWCP afforded appellant 30 days to submit the requested evidence.

In a December 23, 2009 development letter, OWCP requested that the employing establishment provide comments from a knowledgeable supervisor regarding whether appellant had been exposed to black mold or other harmful substances at work. It further requested a copy of any available air samples or, if not available, a description of the ventilation and air circulation in his work area.

[3] *Order Granting Remand and Cancelling Oral Argument*, Docket No. 14-2062 (issued June 19, 2015).

By decision dated January 22, 2010, OWCP denied appellant's occupational disease claim. It noted that the employing establishment had not responded to its request for information regarding his exposure to mold, and thus it had accepted his statement regarding mold exposure as factual. OWCP found, however, that the medical evidence of record was insufficient to establish a medical condition causally related to the accepted exposure.

In a report dated December 20, 2010, Dr. Ritchie C. Shoemaker, who specializes in family medicine, discussed his treatment of appellant from May to October 2009. He advised that lab work had revealed compounds in his blood that were linked to water-damaged buildings. Dr. Shoemaker diagnosed chronic inflammatory response syndrome (CIRS) due to workplace exposure. He advised that ERMI testing had confirmed fungal growth at appellant's work location, including stachybotrys. Dr. Shoemaker related that appellant's illness resulted from "a rapidly developing injury caused by exposure to toxigenic organisms, including, but not limited to, toxigenic fungi and inflammagens" found in his work location.

On January 13, 2011 appellant requested reconsideration.[4]

OWCP, on June 21, 2011, referred appellant to Dr. Howard Kaplan, an internist, for a second opinion examination.

In a report dated July 7, 2011, Dr. Kaplan noted that Dr. Shoemaker had diagnosed CIRS after evaluating appellant for hearing loss, tinnitus, bronchitis, dizziness, nausea, inflammation of the nose, and sleep issues. He advised that CRIS was "not a codeable medical diagnosis but it is an accepted medical syndrome that is normally seen after exposure to various mold and/or toxins and inflammatory components." Dr. Kaplan attributed appellant's medical condition "not only to mold but other inflammatory components related to mold to which he was exposed" at his work location. He attributed his dizziness and hearing loss on the right side directly related to mold exposure at work, noting that the records showed high levels of mold and toxins in the samples taken. In a July 28, 2011 addendum, Dr. Kaplan provided the applicable diagnosis codes for the conditions of accidental poisoning, contact with hazardous substances, and contact with and exposure to mold. In response to OWCP's request for clarification of the diagnoses, on September 8, 2011, he diagnosed cough, tinnitus, hearing loss not otherwise specified, and nausea.

On September 22, 2011 OWCP referred appellant to Dr. Varshapriya Iyer, a Board-certified internist, for a second opinion examination. In a report dated November 1, 2011, Dr. Iyer indicated that CIRS was not a recognized condition. She advised that appellant's "auditory and vestibular symptoms cannot be ascribed to mold exposure."

OWCP noted that Dr. Iyer had not provided a narrative report. It thus referred appellant to Dr. Alan Kaufman, Board-certified in allergy and immunology, for a second opinion examination.

In a report dated December 27, 2011, Dr. Kaufman advised that he was unaware of the diagnosis of CIRS. He further opined that causation between appellant's hearing loss and mold

[4] Appellant submitted additional lab reports dated November 2009.

exposure was not established. Dr. Kaufman indicated that there were "no other medical conditions attributed to mold exposure that have been diagnosed in the claimant."

By decision dated January 11, 2012, OWCP denied modification of its January 22, 2010 decision.

In a report dated May 27, 2012, Dr. Shoemaker asserted that acute sensorineural hearing loss was a "known complication of an inflammatory illness…." He advised that CIRS was a chronic form of systemic inflammatory response syndrome (SIRS), which had a diagnosis code.

On December 27, 2012 appellant requested reconsideration.

On March 12, 2013 OWCP again referred appellant to Dr. Kaufman for a second opinion examination.

In a report dated March 26, 2013, Dr. Kaufman opined that the etiology of Meniere disease was unknown and unconnected to mold exposure. He asserted that recent studies showed no adverse effects from mold exposure at work.

By decision dated April 22, 2013, OWCP denied modification of its January 11, 2012 decision.

In a report dated December 31, 2013, Dr. John Santilli, Board-certified in allergy and immunology, discussed appellant's symptoms of dizziness, tinnitus, hearing loss, fatigue, difficulty with memory and focusing, anxiety, and depression beginning in 2003 after he was transferred to a new work location. He noted that appellant's symptoms temporarily improved in 2006 when he took medication. In October 2009 appellant's symptoms resolved when he relocated to a new work location. In June 2010 he returned to the former location and again experienced dizziness, nausea, and vomiting. Dr. Santilli advised that allergy testing performed November 25, 2013 was positive for seven types of mold. He found that environmental testing at appellant's work location had revealed mold associated with excess moisture. Dr. Santilli noted that he continued to experience nasal congestion, postnasal drip, ear pain, tinnitus, hearing loss, fatigue, and difficulty with memory and focus. He related that appellant "suffers from symptoms associated with allergic rhinitis, chronic sinusitis, and cognitive problems secondary to indoor mold exposure" at the implicated work location. Dr. Santilli indicated that tinnitus, associated hearing loss, vertigo, and Meniere's disease had been associated with allergies.

On February 4, 2014 appellant requested reconsideration.

By decision dated May 1, 2014, OWCP denied modification of its April 22, 2013 decision.

Appellant appealed to the Board. By order dated June 19, 2015, the Board granted the Director of OWCP's motion to set aside the May 1, 2014 decision.[5] The Board noted that the Director asserted that a conflict existed between Dr. Shoemaker and Dr. Santilli, appellant's physicians, and Dr. Kaufman, the referral physician, regarding whether he had sustained a

[5] *Supra* note 3.

diagnosed condition due to his accepted mold exposure in the course of his federal employment and that, on remand, OWCP would refer him to an impartial medical examiner for resolution of the conflict.

On March 14, 2016 OWCP referred appellant to Dr. Richard J. Lee, Board-certified in allergy and immunology, for an independent medical evaluation.

In a report dated May 2, 2016, Dr. Lee discussed appellant's symptoms of tinnitus, dizziness, hearing loss, depression, anxiety, and fatigue when he was exposed to mold at his work location, and his continued complaints of sinus congestion, hearing loss on one side, and tinnitus. He diagnosed chronic rhinitis and tinnitus. Dr. Lee disagreed that appellant had chronic systemic inflammatory syndrome, but found that his exposure to mold at work had caused "the development of a chronic allergic condition." He noted that 2013 mold testing by Dr. Santilli showed a "strong positive skin responses to molds. This test was repeated at this visit and confirms those finding[s] with a strong positive test to aspergillus." Dr. Lee found that appellant had "documented IgE disease to the mold and this is mostly likely secondary to the high level of exposure at the job site."

On November 7, 2016 OWCP referred appellant to Dr. Stanley Goldstein, Board-certified in allergy and immunology, for an impartial medical examination. The statement of accepted facts (SOAF) indicated that appellant had filed an occupational disease claim alleging mold exposure at his work location and that mold testing had been performed at his building in 2009.

In a report dated August 28, 2018, Dr. Goldstein advised that CIRS was not a recognized medical condition. He opined that tinnitus, hearing loss, Meniere's disease, cognitive problems, and chronic fatigue syndrome were unrelated to mold exposure. Dr. Goldstein found that exposure to mold could contribute to the development of allergic rhinitis. He determined, however, that appellant had no symptoms of allergic rhinitis at the time of his examination and advised that skin testing performed on that date showed a negative response to mold. Dr. Goldstein further found that a review of the medical evidence failed to establish that he had chronic rhinosinusitis and thus determined that his mold exposure had not caused or aggravated the condition.

By decision dated January 31, 2019, OWCP again denied appellant's occupational disease claim, finding that he had not established a medical condition causally related to his accepted employment-related mold exposure.

In a report dated August 27, 2019, Dr. Santilli noted his treatment of appellant from 2013 to 2018. He advised that appellant had positive skin test results to the molds alternaria, aspergillus, cloadosporium, fusarium, mucor, phycomycetes, penicillium, and rhizopus. Dr. Santilli challenged Dr. Goldstein's assertion that exposure to mold did not contribute to Meniere's disease, hearing loss, or chronic fatigue syndrome, noting that it was currently unknown whether mold was a factor in these conditions and that it thus could not be eliminated as a cause. He opined that mold exposure had triggered appellant's allergic rhinitis. Dr. Santilli related, "All of Dr. Goldstein's conclusions that mold exposure does not cause any medical problems are not backed up by any medical references, and are, therefore, only his opinion and are not medically backed by current research." He diagnosed allergic rhinitis, chronic sinusitis, and reactive airways disease due to appellant's mold exposure at work. Dr. Santilli advised that skin tests supported his findings.

On January 10, 2020 appellant, through counsel, requested reconsideration. He advised that photographs supported that appellant had a positive skin reaction to the allergy tests performed by Dr. Goldstein, and that consequently Dr. Goldstein's opinion was based on an inaccurate medical history. Counsel also argued that Dr. Santilli was more qualified than Dr. Goldstein as he was an expert in reactions to environmental pathogens.

By decision dated June 8, 2020, OWCP denied modification of its January 31, 2019 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[6] 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 filed within the applicable time limitation period of FECA,[7] 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 employment injury.[8] 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.[9]

In an occupational disease claim, appellant's burden of proof requires submission of 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 employment factors identified by the employee.[10]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[11] 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.[12]

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[6] *Supra* note 2.

[7] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[8] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[9] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[10] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[11] *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388 (2008).

[12] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008).

Section 8123(a) of FECA provides, in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[13] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[14] Where a case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[15]

ANALYSIS

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

OWCP determined that a conflict arose between appellant's physicians, Dr. Shoemaker and Dr. Santilli, and OWCP's referral physician, Dr. Kaufman, regarding whether appellant had sustained a diagnosed condition due to his accepted employment-related mold exposure. In order to resolve the conflict, it properly referred him, pursuant to section 8123(a) of FECA, to Dr. Goldstein, a Board-certified allergist, for an impartial medical examination.

The Board notes that the SOAF provided to Dr. Goldstein was deficient in that it indicated only that appellant claimed that he was exposed to mold at work. The SOAF did not specify that OWCP had accepted his mold exposure or provide any exposure data, both of which are essential elements of the SOAF under OWCP's procedures.[16]

Further, when a case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[17] The Board finds, however, that Dr. Goldstein's report is insufficiently rationalized to constitute the special weight of the evidence.

In a report dated August 28, 2018, Dr. Goldstein found that CIRS was not a recognized diagnosed medical condition. He asserted tinnitus, hearing loss, Meniere's disease, cognitive problems, and chronic fatigue syndrome were unrelated to mold exposure. Dr. Goldstein further found that appellant had no symptoms of allergic rhinitis at the time of his examination. He noted that skin testing performed on that date had demonstrated a negative response to mold. Dr. Goldstein opined that the medical evidence failed to support the diagnosis of chronic rhinosinusitis. The Board notes, however, that his opinion is conclusory in nature.[18] The Board has held that to be entitled to special weight, the opinion of the impartial medical examiner (IME)

[13] 5 U.S.C. § 8123(a).

[14] *C.W.*, Docket No. 18-1536 (issued June 24, 2019).

[15] *V.K.*, Docket No. 18-1005 (issued February 1, 2019).

[16] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statement of Accepted Facts*, Chapter 2.809.5(f) (September 2009).

[17] *Id*.

[18] *See G.B.*, Docket No. 19-1510 (issued February 12, 2020).

must contain clear, persuasive rationale on the critical issue in the claim.[19] Dr. Goldstein failed to provide rationale for his opinion other than to note that appellant did not have positive mold test results or symptoms of rhinitis at the time of his examination.[20] He did not explain the discrepancy between the negative mold testing results he obtained and the positive skin tests for mold found in 2013 by Dr. Santilli and in 2016 by Dr. Lee, an OWCP referral physician. The Board has found that, when an IME fails to provide medical reasoning to support his or her conclusions about a claimant's condition, the opinion is insufficient to resolve a conflict in medical evidence.[21] Thus, the Board finds that Dr. Goldstein's opinion is of insufficient probative value to carry the special weight of the evidence.[22]

The Board has held that, when OWCP obtains an opinion from an IME for the purpose of resolving a conflict in the medical evidence and the IME's opinion requires clarification or elaboration, it must secure a supplemental report to correct the defect in his or her original report.[23] Upon return of the case record, OWCP shall prepare a SOAF setting forth appellant's accepted mold exposure in accordance with its procedures and obtain a supplemental report from Dr. Goldstein clarifying whether appellant sustained a diagnosed condition due to his accepted mold exposure. If the IME is unable to clarify or elaborate on his original report, or if the supplemental report is also vague, speculative, or lacking in rationale, OWCP must submit the case record and a detailed SOAF to another IME for the purpose of obtaining a rationalized medical opinion on the issue.[24] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.[25]

CONCLUSION

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

[19] *C.T.*, Docket No. 19-0508 (issued September 5, 2019); *A.R.*, Docket No. 17-1358 (issued February 1, 2018).

[20] *See T.S.*, Docket No. 18-1702 (issued October 4, 2019).

[21] *B.J.*, Docket No. 18-1186 (issued July 9, 2019); *A.R.*, Docket No. 12-0443 (issued October 2, 2012).

[22] *S.A.*, Docket No. 18-1353 (issued May 22, 2020).

[23] *R.O.*, Docket No. 19-0885 (issued November 4, 2019); *Talmadge Miller*, 47 ECAB 673 (1996); *see also supra* note 6 at Part 2 -- Claims, *Developing and Evaluation Medical Evidence*, Chapter 2.810.11(c)(1)-(2) (September 2010).

[24] *Id*.

[25] *V.K.*, Docket No. 19-0422 (issued June 10, 2020); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

ORDER

IT IS HEREBY ORDERED THAT the June 8, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: January 25, 2022
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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