United States Department of Labor
Employees' Compensation Appeals Board

S.W., Appellant	)	
	)	**Docket No. 23-1026**
and	)	**Issued: October 21, 2024**
DEPARTMENT OF VETERANS AFFAIRS, JOHN J. PERSHING VA MEDICAL CENTER, Poplar Bluff, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On July 2, 2023 appellant filed a timely appeal from a June 30, 2023 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]

ISSUE

The issue is whether appellant has met his burden of proof to establish a medical condition causally related to the accepted employment exposure.

[1] 5 U.S.C. § 8101 *et seq*.

[2] The Board notes that following the June 30, 2023 decision, appellant submitted additional evidence to OWCP. 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*.

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 January 13, 2019 appellant, then a 47-year-old medical technologist, filed an occupational disease claim (Form CA-2) alleging that he developed an allergic reaction, shortness of breath, confusion, fatigue, and blurred vision due to exposure to mold while in the performance of duty.[4] He indicated that while on duty he noticed black particles coming out of the vents and onto the desk areas at work. Appellant noted that he first became aware of his condition on March 1, 1990 and realized its relation to factors of his federal employment on February 1, 2015.

Appellant submitted reports dated November 25, 2014 through July 22, 2015 by Robert Haldeman Jr., and Melissa Keith, both nurse practitioners, who indicated that appellant was evaluated for complaints of intermittent episodes of urticaria/pruritis of unknown origin, joint pain, gastrointestinal distress, general malaise, shortness of breath, dizziness, skin irritation, rash, and headaches. Ms. Keith noted that appellant had brought allergy testing results, which indicated that he was allergic to trees and mold.

In a report dated January 23, 2016, Dr. Muhammad Saleem, a Board-certified internist, noted that appellant was evaluated for complaints of sinus pressure, sinus condition, and dry cough for over a week. He provided examination findings and diagnosed acute sinusitis with mild bronchitis.

In a report dated August 25, 2017, Dr. Roderick O. Baz, an internist, related that appellant was evaluated in the emergency department complaining about an allergic reaction that started around 9:00 a.m. He diagnosed allergic reaction.

In a January 23, 2019 development letter, OWCP informed appellant of the deficiencies of his claim. It advised him of the type of evidence needed and provided a questionnaire for his completion. In a separate letter of even date, OWCP requested that the employing establishment address the accuracy of appellant's allegations, describe his exposure to harmful substances, and provide the results of any air sample testing. It afforded both parties 30 days to respond.

Appellant submitted a report dated January 22, 2015 by Dr. Shahid K. Choudhary, a Board-certified internist specializing in nephrology, who related that appellant had struggled

[3] *Order Remanding Case*, Docket No. 21-1395 (issued December 2, 2022).

[4] OWCP assigned the present claim OWCP File No. xxxxxx158. Appellant subsequently filed a traumatic injury claim (Form CA-1) on January 17, 2019 alleging that on January 14, 2019 he sustained brain, body, and facial swelling and difficulty breathing when he was exposed to mold while in the performance of duty. OWCP assigned that claim OWCP File No. xxxxxx215. Appellant also filed another Form CA-2 on March 5, 2019 alleging that he sustained an emotional condition due to harassment by coworkers and disciplinary actions by supervisors in relation to his complaints of mold exposure. OWCP assigned that claim OWCP File No. xxxxxx970. Appellant further filed a Form CA-1 on January 9, 2023 alleging that on January 3, 2023 he experienced an allergic reaction and asthma attack due to exposure to mold while in the performance of duty. OWCP assigned that claim OWCP File No. xxxxxx275. Appellant's claims have been administratively combined, with OWCP File No. xxxxxx158 serving as the master file.

with multiple symptoms of headaches, blurred vision, memory loss, fatigue, and problems with his right shoulder for the past five years. Dr. Choudhary reviewed appellant's history and conducted an examination. He reported that appellant had no neurological deficits to suggest intracranial abnormality or vestibular dysfunction.

In a note dated January 18, 2019, Dr. Chun Kar Hung, a Board-certified internist specializing in hematology, indicated that appellant was seen in urgent care for a work excuse note. He related appellant's complaint of exposure to mold, provided examination findings, and diagnosed history of mold allergy.

In a progress note dated January 23, 2019, Dr. Stephen Nagy, a Board-certified internist, indicated that appellant presented in his office to discuss his allergy to mold after he was exposed at his workplace since May 4, 2014. He related that over the past five years, appellant had been to the emergency room numerous times due to dyspnea and had been on multiple rounds of steroids. Dr. Nagy described appellant's symptoms, conducted an examination, and diagnosed allergy to mold, allergic dermatitis, and nonseasonal allergic rhinitis due to fungal spores.

In a work status note dated January 24, 2019, Nancy Tompkins, a nurse practitioner, indicated that appellant was seen in their office on January 23, 2019 and recommended that appellant be excused from work for one week due to needing to avoid mold exposure.

In a report dated January 29, 2019, Dr. Victor Lawrinenko, a Board-certified internist specializing in gastroenterology, reviewed a computerized tomography (CT) scan of appellant's abdomen and noted findings of probable gastritis. He related that appellant stated that he had a history of mold exposure, specifically aspergillus, at work, which suggested a possible environmental cause of clinical symptoms. Dr. Lawrinenko indicated that appellant had informed him that his abdominal pain had improved after not working for two weeks, which also suggested a possible environmental cause.

Appellant submitted a December 4, 2014 report by Dr. Dorothy Jean Cline, a dermatologist, who indicated that appellant had welts on his neck and different rashes on different parts of the body for six months. Dr. Cline noted that appellant had an appointment with an allergist/immunologist.

In a January 30, 2019 report, Dr. Nagy indicated that appellant was seen to discuss his workers' compensation claim regarding mold exposure. He related that the mold testing was positive for apergillus and was coming out of the air vents at his work. Dr. Nagy noted that appellant had been diagnosed with allergy to fungal spores. He opined that appellant's recurrent rashes, dyspnea, congestion, and cough were directly related to the exposure to aspergillus at work due to the mold being in the air vents and spraying directly in his work environment, including his desk. Dr. Nagy reported that since appellant had been off work for two weeks, his symptoms had resolved other than his memory problems. He also pointed out that appellant had tested outside sources of possible mold exposure, and it had all tested negative. Dr. Nagy provided examination findings and concluded that appellant's symptoms were made worse by the exposure to aspergillus that had been found in his work environment.

OWCP received a February 11, 2019 Indoor Air Quality Survey for the employing establishment workplace demonstrating the presence of Cladosporium mold, Alternaria spores, hyphal fragments, and Cladosporium spores.

In work excuse notes dated February 14 through 26, 2019, Dr. Nagy indicated that appellant was seen in his office on January 23, 2019. He requested that appellant be excused from work from January 23 through February 19, 2019 due to environmental exposure to mold.

OWCP received a pulmonary consultation report dated December 3, 2014 from Larry Wertenberger, a certified respiratory therapist, who indicated that pulmonary function test (PFT) results showed mild obstructive/restrictive function. Mr. Wertenberger related that appellant informed him that he was exposed to asbestos while in the Navy and felt that this exposure was bad for his lungs.

In a report dated March 9, 2019, Dr. Hung indicated that appellant was treated in urgent care for complaints of shortness of breath, headache, and diarrhea after he was exposed to mold while having a magnetic resonance imaging (MRI) scan yesterday. Physical examination showed occasional wheezing in both lung fields. Dr. Hung reported that appellant was known to have an allergy to mold.

In a March 12, 2019 work status note, Tina Moe, a nurse practitioner, indicated that appellant was seen on that date and could return to work on March 15, 2019.

By decision dated March 18, 2019, OWCP denied appellant's occupational disease claim, finding that the evidence was insufficient to establish that he sustained a medical condition causally related to the accepted employment exposure to mold. Therefore, it concluded that the requirements had not been met to establish an injury as defined by FECA.

In a progress note dated March 21, 2019, Dr. Nagy indicated that appellant was evaluated for continued wheezing and cough after having an MRI scan. He reviewed appellant's history and noted examination findings of cough, shortness of breath, and wheezing. Dr. Nagy diagnosed mild persistent asthma without complication, mild cognitive impairment, and allergic rhinitis.

In a March 26, 2019 work status note, Cara Dillinger, a nurse practitioner, excused appellant from work for that date.

On April 4, 2019 appellant requested reconsideration.

In a letter dated March 28, 2019, Dr. Jennifer Sellman, an osteopathic physician, noted that appellant was seen for health issues affected by mold. She indicated that while performing his work duties as a medical technologist in a laboratory, appellant came into direct contact with mold identified as Cladosporium and Alternaria at high levels that had directly affected his physical health. Dr. Sellman reported that appellant had asthma, and the direct contact and exposure has contributed to recurrent upper respiratory tract infections, recurrent sinusitis, and asthma exacerbations. She also explained that due to repeated exposures to high mold counts of Cladosporium and Alternaria affecting his health, appellant had missed several periods of work due to exacerbations of asthma.

In a request for accommodation form dated April 27, 2019, Ms. Keith indicated that appellant should work in an area free of mold. She noted that appellant's work environment had been found to have mold, which exacerbated his allergy and asthma symptoms.

By decision dated June 27, 2019, OWCP denied modification of the March 18, 2019 decision.

In a report dated May 23, 2019, Dr. Mohanad Alfaqih, a Board-certified internist specializing in pulmonary disease, indicated that appellant was referred to him for asthma. Appellant related that there was mold in his workplace and that he was experiencing episodes of shortness of breath, cough, chest tightness, and fatigue. Dr. Alfaqih noted that appellant worked as a lab technologist at the employing establishment and was exposed to mold through the vents at the facility where he worked. He related that appellant's symptoms of cough, shortness of breath, and chest tightness had improved since he moved to a different department. On physical examination, Dr. Alfaqih observed good air entry bilaterally and no wheezing or crackles in appellant's lungs. Neurologic examination demonstrated normal gait and station. Dr. Alfaqih indicated that appellant's current symptoms appeared to be consistent clinically with asthma.

On July 24, 2019 appellant requested reconsideration.

In a report dated July 16, 2019, Dr. Choudhary related that appellant did not work in the laboratory anymore and that his symptoms had improved since he left the laboratory. On examination, he reported intact sensation to touch and pinprick and intact extraocular movement. Appellant indicated that he was doing better now that he was not exposed to mold. Dr. Choudhary opined that it was "possible" that appellant's headaches were associated with more exposure.

In a July 25, 2019 progress report, Dr. Alfaqih indicated that appellant was evaluated for follow-up for asthma. He related that appellant informed him that his shortness of breath had improved after starting on a higher dose of medication. Dr. Alfaqih noted that appellant left his old job on January 18, 2019 and did not experience any more episodes until March 2019 when he was exposed to mold in the MRI scan area. He conducted an examination and diagnosed asthma. Dr. Alfaqih indicated that appellant was diagnosed with asthma while he was in the military and that his current symptoms were consistent with underlying asthma. He noted that appellant's symptoms were worse when he was at work and testing had shown the presence of high levels of Cladosporium and Alternaria spores. Dr. Alfaqih reported that exposure to mold can aggravate underlying asthma. He pointed out that appellant experienced improved symptoms when he was moved to a new department because there was no exposure to mold. Dr. Alfaqih recommended that appellant avoid exposure to allergens that might exacerbate his underlying asthma.

Appellant also submitted various e-mails dated April 12 through 17, 2019; handwritten treatment notes dated May 22, 1990 through January 21, 1992; a PFT report dated July 1, 2019; and a July 31, 2019 audiological progress report.

By decision dated September 27, 2019, OWCP denied modification of the June 27, 2019 decision.

On September 30, 2019 appellant requested reconsideration.

Appellant submitted additional progress notes dated March 21 through June 13, 2019 by Ms. Tompkins and Ms. Moe, who provided examination findings and diagnosed gastroesophageal reflux disease without esophagitis (GERD).

OWCP received a progress note dated January 14, 2019 by Dr. Baz who recounted that appellant was evaluated in urgent care requesting a steroid shot due to an allergic reaction. Dr. Baz noted that appellant experienced swelling of his face and shortness of breath.

In a report dated September 25, 2019, Dr. Alexandros Georgolios, a Board-certified neurologist, indicated that appellant was evaluated for complaints of recurrent sinus problems, ear infections, hearing loss, and sore throat with onset of 1990. Appellant also complained of chronic, severe watery rhinorrhea, and perennial, associated with his exposure to mold at work. Dr. Georgolios noted that appellant's symptoms had worsened over the past few years. He provided examination findings and diagnosed sinusitis, deviated nasal septum, incompetence of nasal valve, binaural sensorineural hearing loss, allergic rhinitis and turbinate hyperthrophy.

In a progress report dated November 7, 2019, Dr. Alfaqih reviewed appellant's history and diagnosed asthma. He related that appellant informed him that recent allergy testing revealed that he was allergic to aspergillus fumigatus and that testing of the air at his workplace had tested positive for aspergillus. Appellant reported that when he was moved to an office that tested negative for aspergillus, his symptoms improved. Dr. Alfaqih recommended that appellant avoid allergens that exacerbate his symptoms.

Appellant submitted narrative statements, contending that he had established his claim.

By decision dated February 26, 2020, OWCP denied modification of the September 27, 2019 decision.

On October 2, 2020 appellant, through his then-counsel, requested reconsideration.

Appellant submitted a September 23, 2020 report, wherein Dr. Natasha Ware, a family medicine specialist, indicated that she had treated appellant since April 2014 for a myriad of symptoms, including upper respiratory illnesses, asthma/reactive airway disease, dyspnea, allergies, pharyngitis, allergic conjunctivitis, pruritic skin manifestations, dizziness, fatigue and malaise, memory problems, blurred vision, migrating joint pain, muscle weakness and headaches. Dr. Ware related that appellant had informed her that testing found mold growth in his work environment, notably Aspergillus and Cladosporium, and environmental air quality testing noted mold from the vent, musty-malodorous air from vents, and issues with humidity and temperature. She reported that allergy testing revealed that appellant was highly sensitive to aspergillus. Dr. Ware explained that these findings showed that appellant likely suffered repeated, prolonged exposure of the offending antigen, aspergillus. She reported that the "exposure to mold in the work environment clearly exacerbated his underlying asthma with episodes of flare occurring at work and none while he was at home or off work for a period of time." Dr. Ware opined that given the evidence provided by appellant, appellant's claims regarding mold exposure are substantiated and has had a significant negative impact on his health and well-being.

By decision dated January 8, 2021, OWCP denied appellant's request for reconsideration of the merits of the claim, pursuant to 5 U.S.C. § 8128(a).

On February 1, 2021 appellant, through his then-counsel, requested reconsideration of the February 26, 2020 decision and submitted additional evidence.

In a January 20, 2021 progress note, Ms. Keith indicated that appellant was evaluated for monitoring of chronic conditions of allergic rhinitis and asthma symptoms thought to be related to toxic mold. She noted that appellant's symptoms were stable as long as he was outside his work environment where he was exposed to mold. Ms. Keith provided examination findings and diagnosed history of reactive airway disease (RAD)/allergic rhinitis and asthma.

In a letter dated January 21, 2021, Dr. Ware explained that she had personally reviewed the extensive case file for appellant. She indicated that reviews of attestations, office visits, laboratory testing(s), consultations to various specialists, and other communications all indicate that appellant "does have validity in his statements." Dr. Ware noted that she agreed with the statements of Ms. Keith, who had treated appellant for several years.

In a January 22, 2021 progress note, Dr. Ware related that appellant's continued complaints of RAD, allergic rhinitis, and asthma in part to toxic mold. She indicated that appellant's symptoms were stable "as long as he is outside his work environment where he is exposed to mold." Dr. Ware noted her examination findings and a history of "strong allergy to mold which he has been exposed to in his work environment." In an attached January 22, 2021 addendum to her September 23, 2020 report, she noted that new evidence was provided, including documents by an industrial hygienist which indicated that there was amplification of Hyphal fragments noted in the hematology labs. Dr. Ware explained that the presence of Hyphal fragments was generally indicative of nearby mold growths as opposed to only settled spores from the outdoors. She also noted that filtration and humidity HVAC issues were reported leading to potential mold growth. Dr. Ware reported that this information certainly lent itself to the claim that laboratory air quality negatively affected appellant's asthma. She referred to information from government agencies regarding work-related asthma exposure. Dr. Ware opined that "[t]his evidence would further support and substantiate the claim that air quality, inhalation of mold and environment was a clear contributor of worsening asthma and allergy symptoms."

By decision dated March 29, 2021, OWCP denied modification of the February 26, 2020 decision.

On June 21, 2021 appellant requested reconsideration and submitted additional evidence.

By decision dated September 15, 2021, OWCP denied modification of the March 29, 2021 decision.

On September 22, 2021 appellant filed an appeal before the Board. By order dated December 2, 2022, the Board set aside the March 29 and September 15, 2021 decisions and remanded the case for OWCP to administratively combine OWCP File Nos. xxxxxx158, xxxxxx215, and xxxxxx970 as these claims all involved appellant's complaints of workplace exposure to mold. OWCP subsequently administratively combined OWCP File Nos. xxxxxx158, xxxxxx215, xxxxxx970, and xxxxxx275, with File No. xxxxxx158 serving as the master file.

In an attending physicians report (Form CA-20) dated February 7, 2023, Dr. Ware noted a date of injury of January 3, 2023. She described that appellant experienced congestion and difficulty breathing during union duties. Dr. Ware noted that appellant had a history of mold, asthma attacks, and sinusitis noted in the laboratory and MRI scan room. She diagnosed acute recurrent sinusitis. Dr. Ware checked a box marked "Yes" indicating that appellant's medical condition was caused by the described employment activity. She explained that exposure to mold at the employing establishment workplace triggered allergies resulting in sinusitis.

In a March 10, 2023 note, Dr. Ware related that mold spore counts collected on January 3, 2023 revealed mold spore counts over three times the amount observed. She explained that when appellant inhaled these elevated indoor mold spores, it caused inflammation of his sinuses, which caused his acute sinusitis and increased sensitivity to molds. Dr. Ware also noted that a February 17, 2023 report prepared by an industrial hygienist company revealed that building occupants in rooms 105, 108, 152, and 111 had experienced dry eyes, headaches, and sore throat and that indoor mold concentrations were 2.5 to 3 times higher than outdoor mold spore counts. She concluded that these reports, the building occupant's testimony, and physical assessment substantiate that the elevated mold spores aggravated appellant's medical conditions at the employing establishment workplace.

In a duty status report (Form CA-17) dated April 26, 2023, Ms. Keith noted a diagnosis of chronic allergies, fatigue, and recurrent sinusitis. She indicated that appellant could return to work with restrictions.

By decision dated June 30, 2023, OWCP denied appellant's claim, finding that the medical evidence of record was insufficient to establish that his diagnosed conditions were causally related to the accepted employment exposure to mold.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] 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,[6] 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.[7] 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.[8]

[5] *Supra* note 1.

[6] *D.D.*, Docket No. 19-1715 (issued December 3, 2020); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[7] *Y.G.*, Docket No. 20-0688 (issued November 13, 2020); *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[8] *C.H.*, Docket No. 19-1781 (issued November 13, 2020); *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).

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) rationalized medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[9]

To establish causal relationship between the claimed condition and the accepted employment factors, the employee must submit rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 factor(s) identified by the employee.[11] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[12]

In any case where 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.[13]

ANALYSIS

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

In support of his claim, appellant submitted a September 23, 2020 report, wherein Dr. Ware indicated that she had treated appellant since April 2014 for a myriad of symptoms, including upper respiratory illnesses, asthma/reactive airway disease, dyspnea, allergies, pharyngitis, allergic conjunctivitis, pruritic skin manifestations, dizziness, fatigue and malaise, memory problems, blurred vision, migrating joint pain, muscle weakness and headaches. Dr. Ware related that appellant had informed her that environmental air quality testing revealed mold growth in his work environment, notably Aspergillus and Cladosporium. The testing further revealed mold from the vents, musty-malodorous air from vents, and problems with humidity and temperature. Dr. Ware noted that allergy testing revealed that appellant was highly sensitive to aspergillus. She explained that these findings showed that appellant likely suffered repeated, prolonged exposure of "the offending antigen, aspergillus." Dr. Ware reported that the

[9] *T.M.*, Docket No. 20-0712 (issued November 10, 2020); *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[10] *S.A.*, Docket No. 18-0399 (issued October 16, 2018); *Robert G. Morris*, 48 ECAB 238 (1996).

[11] *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[12] *D.R.*, Docket No. 19-0954 (issued October 25, 2019); *James Mack*, 43 ECAB 321 (1991).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

"exposure to mold in the work environment clearly exacerbated his underlying asthma with episodes of flare occurring at work and none while he was at home or off work for a period of time." She opined that given the evidence provided by appellant, appellant's claims regarding mold exposure are substantiated and has had a significant negative impact on his health and well-being. In a January 22, 2021 progress note, Dr. Ware related appellant's continued complaints of RAD, allergic rhinitis, and asthma in part to toxic mold. She indicated that appellant's symptoms were stable "as long as he is outside his work environment where he is exposed to mold." Dr. Ware noted her examination findings and a history of "strong allergy to mold which he has been exposed to in his work environment." In an attached January 22, 2021 addendum to her September 23, 2020 report, she noted that new evidence was provided, including documents by an industrial hygienist which indicated that there was amplification of Hyphal fragments noted in the hematology labs. Dr. Ware explained that the presence of Hyphal fragments was generally indicative of nearby mold growths as opposed to only settled spores from the outdoors. She also noted that filtration and humidity HVAC issues were reported leading to potential mold growth. Dr. Ware reported that this information certainly lent itself to the claim that laboratory air quality negatively affected appellant's asthma. She referred to information from government agencies regarding work-related asthma exposure. Dr. Ware opined that "[t]his evidence would further support and substantiate the claim that air quality, inhalation of mold and environment was a clear contributor of worsening asthma and allergy symptoms." The Board finds that her opinion, while not fully rationalized, is sufficient to require further development of the medical evidence.[14]

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.[15] OWCP has an obligation to see that justice is done.[16]

The case shall, therefore, be remanded for further development of the medical evidence. On remand OWCP shall refer appellant, along with the medical record and a statement of accepted facts, to a specialist in the appropriate field of medicine for a rationalized opinion regarding whether appellant sustained a medical condition causally related to the accepted employment exposure. If the physician opines that the diagnosed conditions are not causally related, he or she must explain with rationale how or why their opinion differs from that of Dr. Ware. Following this, and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[14] *M.S.*, Docket No. 20-1095 (issued March 29, 2022); *B.F.*, Docket No. 20-0990 (issued January 13, 2021); *Y.D.*, Docket No. 19-1200 (issued April 6, 2020); *John J. Carlone*, 41 ECAB 354 (1989).

[15] *See A.D.*, Docket No. 21-0143 (issued November 15, 2021); *see also A.P.*, Docket No. 17-0813 (issued January 3, 2018); *Jimmy A. Hammons*, 51 ECAB 219, 223 (1999).

[16] *Id.*; *see also B.C.*, Docket No. 15-1853 (issued January 19, 2016); *E.J.*, Docket No. 09-1481 (issued February 19, 2010); *John J. Carlone*, *supra* note 14.

ORDER

IT IS HEREBY ORDERED THAT the June 30, 2023 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 21, 2024
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board