United States Department of Labor
Employees' Compensation Appeals Board

JOE T. LATHAM, Appellant	)	
and	)	**Docket No. 04-2169**
	)	**Issued: January 31, 2005**
TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL PLANT, Drakesboro, KY, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On September 2, 2004 appellant filed a timely appeal of the June 7, 2004 merit decision of the Office of Workers' Compensation Programs, which denied his claim for an employment-related pulmonary condition. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant established that his claimed pneumoconiosis and chronic obstructive lung disease are related to his accepted employment exposure.

FACTUAL HISTORY

On June 25, 2002 appellant, then a 68-year-old retired machinist, filed an occupational disease claim for pneumoconiosis and chronic obstructive lung disease. He identified April 24,

2001 as the date he first became aware of his employment-related condition.[1] The employing establishment challenged appellant's claim noting, among other things, that he had a 45-year smoking history and minimal coal dust exposure.[2]

Dr. William C. Houser, a Board-certified pulmonologist, examined appellant on May 29, 2002. He reported a smoking history of 15 cigarettes a day from age 12 to 57 and a 26-year work history with the employing establishment, where appellant was regularly exposed to coal dust. Dr. Houser also reported occupational exposure to asbestos, welding fumes and other dust, smoke and fumes. He interpreted a May 29, 2002 pulmonary function study as revealing a mild restrictive ventilatory defect and a mild obstructive pulmonary impairment. Dr. Houser also read a January 25, 2001 x-ray as positive for pneumoconiosis, with a profusion of 1/0. Regarding appellant's pulmonary condition, Dr. Houser diagnosed pneumoconiosis, category 1/0, due to mixed exposure, mild chronic obstructive pulmonary disease and chronic bronchitis. He explained that appellant's 26-year occupational exposure and positive x-ray evidence were sufficient for a diagnosis of pneumoconiosis, category 1/0. Dr. Houser also stated that the restrictive changes seen on the pulmonary function study were probably secondary to pneumoconiosis. However, the noted airway obstruction was most likely secondary to cigarette smoking and exposure to dust, smoke and fumes from appellant's employment. Additionally, Dr. Houser stated that appellant's chronic bronchitis was probably secondary to former cigarette smoking and exposure to dust, smoke and fumes.

Dr. Ann S. Roberts, a family practitioner, reviewed certain employment and medical records, including appellant's smoking and employment histories, an undated pulmonary function study and undated x-rays. In her February 7, 2003 report, Dr. Roberts noted that the pulmonary function study showed obstruction, which was compatible with long-term smoking. She also commented that appellant's prior x-rays were normal and that the recent positive x-ray for pneumoconiosis was not interpreted by either a radiologist or a certified B-reader. Dr. Roberts concluded that there was insufficient documentation of dust exposure to cause pneumoconiosis, but there was adequate documentation that the compromised pulmonary function study was related to appellant's long history of smoking.

The Office referred appellant for a second opinion examination with Dr. Kenneth C. Anderson, a Board-certified pulmonologist, who examined him on April 23, 2003 and obtained a chest x-ray and pulmonary function study. Dr. Anderson noted that his x-ray revealed parenchyma abnormalities consistent with pneumoconiosis, category 0/1[3] and he stated that the pulmonary function study revealed minimal obstructive airways disease. In his April 23, 2003 report, Dr. Anderson noted a work history of approximately 26 years with the employing establishment, with mostly coal dust and fly ash exposure and occasional asbestos exposure. He also reported a more than 40-pack-year smoking history ending in 1991. Physical examination of the lungs revealed normal respiratory effort and no expiratory wheeze or rhonci.

[1] Appellant retired July 1, 1992. He stated that he first learned he had an occupational lung disease on April 24, 2001 when he saw a chest x-ray report from Dr. Glen R. Baker, Jr., a Board-certified pulmonologist.

[2] Appellant acknowledged that he smoked ¾ of a pack of cigarettes per day from age 12 until he quit at age 57.

[3] On the April 23, 2003 x-ray form report Dr. Anderson identified himself as a B-reader.

Dr. Anderson also stated that appellant's lungs were clear to auscultation, with a very rare end inspiratory crackle. He indicated that the pulmonary function testing was consistent with early obstructive lung disease, peripheral airway dysfunction. Dr. Anderson explained that appellant demonstrated symptoms of chronic bronchitis that could be a residual of his tobacco history. However, pulmonary function tests only demonstrated early obstructive lung disease. He also stated that the chest x-ray was not diagnostic of pneumoconiosis because the abnormalities present were only determined to be a profusion of 0/1. Lastly, Dr. Anderson stated that pulmonary function tests did not support a diagnosis of restrictive lung disease based on occupational exposure. He concluded that it did not appear that the symptoms appellant was experiencing were caused by his exposure history.

In a decision dated June 16, 2003, the Office denied appellant's occupational disease claim. Relying on Dr. Anderson's April 23, 2003 opinion, the Office found that he failed to establish that the claimed medical condition was the result of his established employment exposure.

Appellant requested an oral hearing which was held on May 3, 2004. Additionally, he submitted three x-ray interpretations of a January 25, 2001 film, which the Office received on May 27, 2004. Dr. Brent D. Barndon, a Board-certified radiologist and B-reader, interpreted the film as pneumoconiosis, category 2/1. On October 2, 2003 Dr. Anderson read the January 25, 2001 film as positive for pneumoconiosis, category 1/0. Dr. Baker interpreted the same film as category 0/1 pneumoconiosis.

By decision dated June 7, 2004, the Office hearing representative affirmed the June 16, 2003 decision. He accorded determinative weight to Dr. Anderson's opinion, noting, among other things, that Dr. Anderson unequivocally stated that appellant's chest x-ray was "'not diagnostic of pneumoconiosis'" and that the "'[a]bnormalities present are only determined to be a profusion of 0/1.'"

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[4] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence, including that any specific condition or disability for work for which he claims compensation is causally related to the employment injury.[5]

[4] 5 U.S.C. § 8101 *et seq.*

[5] 20 C.F.R. § 10.115(e), (f) (1999); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question that can generally be resolved only by rationalized medical opinion evidence. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors must be based on a complete factual and medical background of the claimant. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, in order to be considered rationalized, the opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

In an occupational disease claim, to establish that an injury was sustained in the performance of duty, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[6]

ANALYSIS

On appeal counsel for appellant argues that the Office hearing representative neglected to consider the recently submitted x-ray evidence, particularly Dr. Anderson's October 2, 2003 positive x-ray interpretation. The Board's jurisdiction over a case is limited to reviewing the evidence that was before the Office at the time of its final decision.[7] Inasmuch as the Board's decisions are final as to the subject matter appealed, it is crucial that all relevant evidence that was properly submitted to the Office prior to the time of issuance of its final decision be addressed by the Office.[8]

The Office received additional medical evidence on May 27, 2004. The hearing representative proclaimed to have reviewed the "case record in its entirety"; however, the June 7, 2004 decision makes no reference to the x-ray interpretations counsel submitted 11 days prior to the issuance of the decision. The Office's oversight is apparent because the hearing representative quoted Dr. Anderson's April 23, 2003 x-ray findings, but made no mention of his subsequent October 2, 2003 positive interpretation for pneumoconiosis. Had the hearing representative actually reviewed the latter reading, he would have been expected to reconcile Dr. Anderson's differing x-ray interpretations before deferring to the doctor's April 23, 2003 findings.

Whether the Office receives relevant evidence on the date of the decision or several days prior, such evidence must be reviewed by the Office.[9] As the Office failed to address all the relevant evidenced before it at the time of its June 7, 2004 decision, the Board must set aside the Office's decision and remand the case for a proper review of the evidence and issuance of an appropriate final decision.

CONCLUSION

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

[6] *Victor J. Woodhams*, *supra* note 5.

[7] 20 C.F.R. § 501.2(c).

[8] 20 C.F.R. § 501.6(c); *see William A. Couch*, 41 ECAB 548, 553 (1990).

[9] *Willard McKennon*, 51 ECAB 145 (1999).

ORDER

IT IS HEREBY ORDERED THAT the June 7, 2004 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: January 31, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member