United States Department of Labor
Employees' Compensation Appeals Board

B.S., Appellant	)	
and	)	**Docket No. 09-563**
	)	**Issued: October 6, 2009**
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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 23, 2008 appellant, through his attorney, filed a timely appeal from February 15 and September 25, 2008 merit decisions of the Office of Workers' Compensation Programs denying his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that he sustained a pulmonary condition causally related to factors of his federal employment.

On appeal, counsel argues that the hearing representative erred in relying on the Office referral physician instead of appellant's attending physician. Alternatively, he contends that there is a conflict in medical opinion.

FACTUAL HISTORY

On January 15, 2004 appellant, then a 60-year-old retired senior instrument mechanic, filed an occupational disease claim alleging that he sustained occupational pneumoconiosis and probable asbestosis causally related to factors of his federal employment. He retired on July 26, 2002.[1] Appellant related that from 1980 to 1993 he was exposed to coal dust, asbestos and mercury performing maintenance on electronic instrumentation. He denied any history of cigarette smoking.

On May 6, 2004 the employing establishment controverted the claim. It indicated that it had not measured appellant's specific exposure to coal dust or asbestos but noted that employees in similar positions were exposed to around 0.3 to 0.7 milligrams per cubic meter of air of coal dust "calculated as an [eight]-hour time weighted average." The employing establishment indicated that appellant was not exposed to asbestos above the safety levels set by the Occupational Safety and Health Administration (OSHA).

In a report dated December 30, 2002, Dr. Glen Baker, a Board-certified internist with a subspecialty in pulmonary disease, discussed appellant's work exposure to coal dust, asbestos and some mercury. He described symptoms of coughing, wheezing and difficulty breathing, especially with exertion. Dr. Baker noted that appellant had no smoking history. He interpreted an x-ray as revealing occupational pneumoconiosis, category 1/1 by x-ray and noted "with [appellant's] history of asbestos exposure, with both lower bases having irregular opacities, this is suggestive of pulmonary asbestosis as the primary type of occupational pneumoconiosis." Dr. Baker found that pulmonary function tests (PFT) revealed a mild or minimal obstructive deficit. He diagnosed occupational pneumoconiosis with probable pulmonary asbestosis and a mild or minimal obstructive defect. Dr. Baker opined that appellant was disabled from any work in a dusty environment.

By letter dated January 13, 2004, the employing establishment controverted appellant's claim, noting that he suffered from severe allergies and possible asthma.[2] Appellant was also "exposed to fumes and smoke from his mobile home catching on fire in which the entire home was destroyed." The employing establishment disputed that he was exposed to mercury. It reiterated that it did not have specific monitoring information for coal dust or asbestos but asserted that it was within established safety parameters.

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[1] Appellant related that he learned from a physician that he had an occupational lung disease on December 13, 2002.

[2] On April 21, 2004 Dr. Anne Roberts, Board-certified in preventive medicine, reviewed the medical evidence on behalf of the employing establishment. She noted that there was no evidence that appellant was exposed to coal dust or asbestos at levels that exceeded occupational safety standards set by OSHA. Dr. Roberts reviewed Dr. Baker's finding and concluded that there was "no evidence of impairment of pulmonary function" based on PFT and noted that appellant was "diagnosed with pulmonary fibrosis at the time he was hired by [the employing establishment] based on an x-ray taking at the time of his preemployment physical examination. Therefore, this condition was not the result of appellant's duties at [the employing establishment]."

By decision dated November 1, 2004, the Office denied appellant's claim on the grounds that he did not establish a medical condition due to the accepted work factors. On November 16, 2004 appellant requested an oral hearing. Following a preliminary review of the record, the hearing representative vacated the November 1, 2004 decision. He directed the Office to prepare a statement of accepted facts identifying the accepted exposure to coal dust and asbestos and refer appellant for a second opinion examination.

On September 26, 2005 the Office referred appellant to Dr. Kenneth Anderson, an internist with a subspecialty in pulmonary disease, for a second opinion examination.[3] In a report dated November 8, 2005, Dr. Anderson diagnosed a "[c]ough consistent with chronic bronchitis with dyspnea on exertion. Pulmonary function tests are normal and chest radiograph demonstrates abnormal findings. However, profusion is only 1/0, nondiagnostic." Dr. Anderson indicated that appellant's symptoms may be due to nonemployment-related sleep apnea or a cardiac condition. He found that appellant had a zero percent impairment based on the PFTs. Dr. Anderson advised appellant to limit further exposure to offending agents because of his abnormal chest x-ray.

By decision dated January 25, 2006, the Office found that appellant had not established that he sustained a pulmonary condition due to his federal employment. On February 2, 2006 appellant requested an oral hearing. After a preliminary review, in a decision dated December 20, 2006 a hearing representative set aside the January 25, 2006 decision. He found that the statement of accepted facts provided to Dr. Anderson was deficient as it did not provide appellant's history of exposure to smoke in a house fire and his preexisting fibrosis. The hearing representative further found that Dr. Anderson's report was insufficiently rationalized.

In a supplemental report dated April 24, 2007, Dr. Anderson noted that an April 2, 2007 PFT showed an obstructive defect "more consistent with asthma." He found that an x-ray showed small opacities, 1/0 in the middle and lower lung zones. Dr. Anderson diagnosed dyspnea with recent PFTs suggesting an asthmatic component most likely unrelated to appellant's employment. He also diagnosed a cough consistent with chronic bronchitis or due to angiogenesis converting enzyme (ACE) inhibitors. Dr. Anderson found that the chest x-ray was most likely "an insignificant finding because a diagnosis of asbestosis cannot be made without abnormal pulmonary function tests."

On May 16, 2007 the Office requested that Dr. Anderson address Dr. Baker's findings. In a May 31, 2007 response, Dr. Anderson noted that appellant had abnormal findings on chest x-ray suggestive of asbestosis but no functional abnormality. He opined that he did not believe that appellant "has a progressive interstitial lung disease based on [the] relative stability of his pulmonary function tests." Dr. Anderson noted that a high-resolution computerized tomography (CT) scan could clarify the issue of the abnormal chest x-ray.

[3] On April 3, 2005 Dr. Brent D. Brandon, a Board-certified radiologist and B-reader, interpreted the December 21, 2002 x-ray as showing parenchymal abnormalities consistent with pneumoconiosis and 1/2 small opacities. He noted a prominence on the right and advised that appellant should rule out cancer.

By decision dated June 7, 2007, the Office denied appellant's claim for an employment-related pulmonary condition. On June 14, 2007 appellant, through his attorney, requested an oral hearing. After a preliminary review of the record, the hearing representative set aside the June 7, 2007 decision and remanded the case for the Office to refer appellant for a supplemental report from Dr. Anderson following a high-resolution CT scan.

A high resolution CT scan of appellant's chest, obtained on December 5, 2007, was unremarkable. In a report dated December 23, 2007, Dr. Anderson indicated that a CT scan of the chest showed no interstitial lung disease or pleural calcifications. He concluded that appellant had no impairment based on the CT scan or pulmonary function studies.

By decision dated February 15, 2008, the Office denied appellant's claim on the grounds that the evidence was insufficient to show that he sustained an employment-related pulmonary condition. On March 4, 2008 appellant, through his attorney, requested an oral hearing. At the hearing, held on July 30, 2008, counsel argued that Dr. Anderson concluded that he had no impairment rather than no occupational disease. He also questioned the usefulness of CT scans in pneumoconiosis or occupational lung disease.

In a report dated August 19, 2008, Dr. Matthew A. Vuskovich, Board-certified in preventive medicine, noted that there were no standards to evaluate pneumoconiosis by CT scan and thus no way to establish a positive diagnosis. He further stated:

> "X-ray and CT scan image appearances of pneumoconiosis are summation images. This is in contrast to a real image such as a single cancer mass or a foreign body image. The image of a single pneumoconiosis lesion is not projected on the x-ray film. The image on the film represents a summation of the lesions through the three-dimensional depth of the lung tissue, CT scans, especially very thin slice high-resolution CT scans effectively "wash out" the pneumoconiosis lesions because they visualize such a thin slice of the tissue. For that reason the CT scan image 'false negative' rate is prohibitively high. Therefore, a "negative CT" scan interpretation is meaningless."

By decision dated September 26, 2008, the hearing representative affirmed the February 15, 2008 decision.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[4] has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of the Act, that the claim was filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[5] These are the essential

[4] 5 U.S.C. §§ 8101-8193.

[5] *Tracey P. Spillane*, 54 ECAB 608 (2003); *Elaine Pendleton*, 40 ECAB 1143 (1989).

elements of each and every compensation claim regardless of whether the claim is predicated on 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) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed;[7] (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition;[8] and (3) medical evidence establishing the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[9]

The medical evidence required to establish causal relationship generally is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence, which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors.[10] 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] explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[13]

Section 8123(a) provides that, 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.[14] The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[15]

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[6] *See Ellen L. Noble*, 55 ECAB 530 (2004).

[7] *Michael R. Shaffer*, 55 ECAB 386 (2004).

[8] *Marlon Vera*, 54 ECAB 834 (2003); *Roger Williams*, 52 ECAB 468 (2001).

[9] *Beverly A. Spencer*, 55 ECAB 501 (2004).

[10] *Conrad Hightower*, 54 ECAB 796 (2003); *Leslie C. Moore*, 52 ECAB 132 (2000).

[11] *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

[12] *John W. Montoya*, 54 ECAB 306 (2003).

[13] *Judy C. Rogers*, 54 ECAB 693 (2003).

[14] 5 U.S.C. § 8123(a); *see also Richard P. Cortes*, 56 ECAB 200 (2004).

[15] 20 C.F.R. § 10.321.

ANALYSIS

Appellant filed an occupational disease claim alleging that he sustained occupational pneumoconiosis and probable asbestosis due to factors of his federal employment. The Office accepted that he was exposed to coal dust and asbestos in the course of his federal employment. The issue, therefore, is whether the medical evidence establishes a causal relationship between the claimed conditions and the identified employment factors.

Dr. Anderson, an Office referral physician, found that appellant had nondiagnostic-findings on x-ray of 1/0 profusion and a zero percent pulmonary impairment based on a PFT. In a supplemental report dated April 24, 2007, he diagnosed dyspnea and interpreted a PFT as showing asthma most likely unrelated to appellant's employment. Dr. Anderson found no functional abnormality after pulmonary testing and indicated that appellant was unable to render a diagnosis of asbestosis absent an abnormal PFT. He interpreted a high-density CT scan, obtained on December 5, 2007, as showing no interstitial lung disease or pleural calcifications. Dr. Anderson again concluded that appellant had no impairment.

In a report dated December 30, 2002, appellant's physician, Dr. Baker, diagnosed occupational pneumoconiosis by x-ray with probable pulmonary asbestosis. He found a mild or minimal obstructive deficit by PFT. On August 19, 2008 appellant submitted a report from Dr. Vuskovich, who opined that high-density CT scans were of no value in diagnosing pneumoconiosis.

The Board notes that Dr. Anderson, the Office referral physician, and Dr. Baker, appellant's attending physician, disagreed regarding the presence and etiology of the claimed pulmonary conditions. Drs. Anderson and Vuskovich also disagreed regarding the value of a high-density CT scan in diagnosing pneumoconiosis. 5 U.S.C. § 8123 states that 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.[16] The case will be remanded to the Office to refer appellant to an impartial medical examiner to determine whether he sustained pneumoconiosis and/or asbestosis in the performance of duty. After this and such further development as is deemed necessary, the Office shall issue a *de novo* decision.

CONCLUSION

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

[16] 5 U.S.C. § 8123(a); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated September 25 and February 15, 2008 are set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 6, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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