United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant **and** **TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL PLANT, Drakesboro, KY, Employer**	**Docket No. 14-452** **Issued: June 18, 2014**

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, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 27, 2013 appellant, through his attorney, filed a timely appeal of a November 27, 2013 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 to consider the merits of the case.

ISSUE

The issue is whether appellant met his burden of proof to establish a lung condition due to factors of his federal employment.

On appeal counsel argued that the report of his pulmonologist was entitled to the weight of the medical evidence as he is a B reader. In the alternative, there is an unresolved conflict of medical evidence.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On October 19, 2012 appellant, then a 55-year-old laborer, filed an occupational disease claim alleging that he first became aware of his occupational pneumoconiosis on August 31, 2012 and attributed his condition to his employment on that date.

In a letter dated November 13, 2012, OWCP requested additional factual and medical evidence in support of appellant's claim. The employing establishment responded on November 5, 2012. It submitted an August 31, 2012 report stating that appellant worked as a laborer for 106 months or approximately 9 years. Air quality studies found that currently at the employing establishment background levels of asbestos were 80 to 90 percent below the established Occupational Safety and Health Administration (OSHA) limits for schools and public buildings. Furthermore, exposure to respirable dust was found to be consistently under the limit set by OSHA.

Appellant stated that he was exposed to coal dust on a daily basis and asbestos when insulation would be blown off pipes or break off pipes. He stated that he had dust on his skin and clothing at work on a daily basis. Appellant noted that he was exposed to flue gas and rock dust and wore a paper mask.

Dr. Glen Baker, a Board-certified pulmonologist and B reader, completed a report on September 21, 2012 noting that appellant worked as a laborer with exposure to coal dust and asbestos. He stated that appellant worked for 10 years at the employing establishment consistently and that he worked there periodically for another 20 years. Dr. Baker noted appellant's statement that he had exposure to coal dust primarily, but that he was also exposed to asbestos fibers. He reported that appellant had shortness of breath with dyspnea on exertion and a cough. Appellant stated that his breathing was worse with exertion, damp or dust. Dr. Baker examined appellant's chest x-ray dated July 6, 2012 and found evidence of occupational pneumoconiosis, category 1/0. Appellant's pulmonary function studies were within normal limits. Dr. Baker diagnosed occupational pneumoconiosis with a history of exposure to coal dust and asbestos fibers in the work environment, mild bronchitis, obstructive sleep apnea, diabetes mellitus and hyperlipidemia. He stated that appellant had 23.3 years of dust exposure including coal dust and periodic asbestos exposure. Dr. Baker found that appellant had x-ray changes with irregular opacities primarily in the lower lobes of his lungs which were consistent with pulmonary asbestosis as coal workers' pneumoconiosis primarily caused rounded opacities. He concluded that appellant had no impairment based on his pulmonary function studies and did not currently require treatment.

In a letter dated December 10, 2012, the employing establishment noted that appellant began his federal employment on June 16, 2003 and retired on August 10, 2012. It could neither confirm nor deny his statement of exposure. The employing establishment provided a list of appellant's health records.

On March 14, 2013 OWCP referred appellant for a second opinion examination with Dr. Harold Dale Haller, Jr., a Board-certified pulmonologist. It prepared a statement of accepted facts listing appellant's daily exposure to coal dust and occasional exposure to asbestos. In a report dated April 25, 2013, Dr. Haller requested a high resolution computerized tomography (CT) scan. On examination appellant's pulmonary function tests were normal. Dr. Haller stated that he did not see evidence for asbestosis or pneumoconiosis and found that appellant's chest

x-ray was normal. He attributed appellant's symptoms to his morbid obesity and found no evidence of asbestosis or pneumoconiosis. Due to the disagreement with Dr. Baker on chest x-ray interpretation, Dr. Haller recommended a high resolution CT scan of appellant's chest. The CT scan dated April 29, 2013 demonstrated bilateral noncalcified pulmonary nodules which may be postinfectious or inflammatory with a possibility of metastatic disease to be correlated with a history of malignancy or a follow-up CT scan. The scan demonstrated no evidence of pulmonary fibrosis. Dr. Haller reviewed the CT scan on May 3, 2013 and found no evidence of fibrosis or interstitial lung disease with no bronchiectasis or peribronchial thickening. He opined that appellant's pulmonary nodules were most likely postinflammatory due to histoplasmosis. Dr. Haller further stated that appellant's work exposures did not cause his dyspnea or cough. He found that appellant had no pulmonary limitations.

By decision dated May 24, 2013, OWCP denied appellant's occupational disease claim finding that Dr. Haller represented the weight of medical opinion. It noted that Dr. Baker's report was based on an inaccurate history of injury as he found that appellant had exposures of 23 rather than 9 years. OWCP further found that Dr. Baker failed to provide sufficient medical rationale regarding the relationship of the employment exposure versus other work exposures and medical conditions.

On June 11, 2013 appellant requested an oral hearing before an OWCP hearing representative. In a report dated May 6, 2008, Dr. Matthew V. Vuskovich, a physician Board-certified in preventative medicine and a B reader, stated that B readers did not interpret CT scans for pneumoconiosis as there were no standard images. He further noted that high resolution CT scans effectively "wash out" pneumoconiosis lesions because they visualize a thin slice of tissue and result in prohibitively high false negatives. Dr. Vuskovich stated, "In summary, to establish a positive pneumoconiosis diagnosis and to accurately determine the severity of the disease chest CT scan imaging should not be utilized."

At the oral hearing, appellant testified that his work as a laborer required him to shovel and vacuum coal dust. He noted that pipes insulated with asbestos frequently burst. Appellant stated that he could see asbestos fibers in the air.

By decision dated November 27, 2013, OWCP's hearing representative found that Dr. Haller's report was entitled to the weight of the medical evidence as he discussed appellant's morbid obesity and sleep apnea. She affirmed OWCP's decision.

LEGAL PRECEDENT

OWCP regulations define an occupational disease as "a condition produced by the work environment over a period longer than a single workday or shift."[2] 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; (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 employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated

[2] 20 C.F.R. § 10.5(q).

differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The evidence required to establish causal relationship is rationalized medical opinion evidence, based upon a complete factual and medical background, showing a causal relationship between the claimed condition and identified factors. The belief of a claimant that a condition was caused or aggravated by the employment is not sufficient to establish causal relation.[3]

ANALYSIS

In support of his occupational disease claim, appellant submitted a report dated September 21, 2012 from Dr. Baker, a B reader, diagnosing occupational pneumoconiosis with a history of exposure to coal dust and asbestos fibers in the work environment, mild bronchitis, obstructive sleep apnea, diabetes mellitus and hyperlipidemia. He submitted evidence that he was exposed to coal dust on a daily basis and asbestos when insulation would be blown off pipes or break off pipes.

Dr. Baker reported appellant's employment exposure to coal dust and asbestos for 10 years at the employing establishment as well as additional exposure in other employment. He examined appellant's chest x-ray dated July 6, 2012 and found evidence of occupational pneumoconiosis, category 1/0. Dr. Baker found that appellant had x-ray changes with irregular opacities primarily in the lower lobes of his lungs consistent with pulmonary asbestosis.

OWCP referred appellant for a second opinion evaluation with Dr. Haller who reviewed appellant's chest x-ray and found that it was normal. To resolve his disagreement with Dr. Baker's findings on x-ray, Dr. Haller recommended a high resolution CT scan of appellant's chest. On May 3, 2013 he found no evidence of fibrosis or interstitial lung disease. Dr. Haller noted that the CT scan did not demonstrate bronchiectasis or peribronchial thickening. He opined that appellant's pulmonary nodules were most likely postinflammatory due to histoplasmosis. Dr. Haller opined that appellant's work exposures did not cause his dyspnea or cough.

The Board finds that this case is not in posture for a decision due to an unresolved conflict of medical opinion evidence. Dr. Baker, a certified B reader, examined appellant's chest x-rays and determined that he had 1/0 occupational pneumoconiosis. Dr. Haller disagreed with the finding on x-ray and requested a high resolution CT scan which demonstrated noncalcified lung nodules. He opined that these nodules were postinflammatory due to histoplasmosis. The Board finds that there is disagreement between the two physician's regarding the results of appellant's diagnostic studies. Due to the disagreement on the cause and nature of appellant's findings on diagnostic studies, the Board finds that there is a conflict of medical opinion evidence.

When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which 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

[3] *Lourdes Harris*, 45 ECAB 545, 547 (1994).

an examination and resolve the conflict of medical evidence.[4] 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.[5]

On remand, OWCP should refer appellant a statement of accepted facts, a list of specific questions and his diagnostic studies to an appropriate Board-certified physician and B reader to determine whether appellant has any employment-related lung condition.[6]

CONCLUSION

The Board finds that this case is not in posture for a decision due to an unresolved conflict of medical opinion evidence regarding the interpretation of appellant's chest x-ray.

ORDER

IT IS HEREBY ORDERED THAT the November 27, 2013 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board

Issued: June 18, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[4] 5 U.S.C. §§ 8101-8193, 8123; *B.C.*, 58 ECAB 111 (2006); *M.S.,* 58 ECAB 328 (2007).

[5] *R.C.,* 58 ECAB 238 (2006).

[6] *See e.g., S.T.,* Docket No. 13-1977 (issued March 18, 2014 (the interpretation of a B reader carries more weight when interpreting chest x-rays for evidence of pneumoconiosis).