United States Department of Labor
Employees' Compensation Appeals Board

J.A., Appellant	)	
and	)	**Docket No. 10-94**
	)	**Issued: November 30, 2010**
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:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 13, 2009 appellant, through his representative, timely appealed the August 13, 2009 merit decision of the Office of Workers' Compensation Programs which denied his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant's pneumoconiosis and chronic obstructive pulmonary disease are causally related to his federal employment.

FACTUAL HISTORY

Appellant, a 65-year-old retired conveyor car dumper operator, filed an April 29, 2008 occupational disease claim (Form CA-2) for pneumoconiosis and chronic obstructive pulmonary disease (COPD), which allegedly arose on or about November 29, 2007.[1] He began work for the

[1] Appellant's last reported employment exposure was November 6, 2006. He retired effective November 14, 2006.

employing establishment in 1978.[2] Personnel records reveal that he was employed in March 1980 as a sheet metal worker. Appellant alleged that he was exposed to coal dust and welding fumes on a daily basis. He also reported occasional exposure to asbestos. After more than a decade as a sheet metal worker, appellant transferred to the coal yard in November 1991 where he worked as a conveyor car dumper operator. He remained there through December 1994, at which point he left the employing establishment. In December 2000, appellant resumed work as a conveyor car dumper operator until he retired in November 2006.

In support of his claim, appellant submitted a March 24, 2008 report from Dr. William C. Houser, a Board-certified internist with a subspecialty in pulmonary disease. Dr. Houser reviewed a September 27, 2007 chest x-ray, which he interpreted as positive for pneumoconiosis. He also interpreted a March 24, 2008 pulmonary function study as demonstrating a mild airway obstruction. Dr. Houser noted that appellant complained of dyspnea, which occurred while walking about one mile on level ground or while mowing his lawn or working in the garden. He listed a history of a single episode of pneumonia that was treated on an outpatient basis and no known history of bronchitis. Dr. Houser advised that appellant had a negative tuberculin skin test and no known exposure to tuberculosis. There were no known hospitalizations or emergency room visits solely for respiratory-related problems. Appellant's symptoms were reportedly aggravated by exposure to cold, smoke and fumes. Dr. Houser noted a five- to six-year smoking history of one-half pack per day that reportedly ended 35 years prior. Appellant's occupational history included 25 years with the employing establishment through November 2006. Dr. Houser advised that appellant had performed sheet metal work, and for approximately 15 years he worked the yard, primarily in maintenance. The remainder of the time appellant operated the belt line, which conveyed coal from the yard to the powerhouse. Dr. Houser noted that appellant was exposed to coal dust on a daily basis.

On physical examination, appellant's chest was clear to percussion and auscultation; there were no rales or wheezing and no ronchi, pleural rub or bronchial breath sounds. Dr. Houser noted that appellant's September 27, 2007 chest x-ray was positive for pneumoconiosis, category 1/0 and his recent pulmonary studies showed mild airway obstruction, primarily involving the small airways. He diagnosed pneumoconiosis primarily due to coal dust exposure and mild chronic obstructive pulmonary disease.[3] Dr. Houser advised that appellant had sufficient occupational exposure and chest x-ray findings appropriate for the diagnosis of pneumoconiosis, category 1/0. Based on appellant's occupational history of being regularly exposed to coal dust, such exposure was the most likely cause of his pneumoconiosis. With respect to appellant's mild obstructive disease, Dr. Houser stated that the etiology was primarily secondary to the inhalation of coal dust. He noted that appellant smoked briefly, but quit several years prior. Because of appellant's pneumoconiosis, Dr. Houser recommended that he avoid additional exposure to coal dust or other respirable dust. Due to his chronic obstructive pulmonary disease, it was recommended that appellant avoid exposure to smoke and fumes. Dr. Houser explained that additional exposures increased the likelihood of episodes of acute exacerbation and progression of the disease process.

[2] Appellant submitted an undated response to Form CA-35F (Evidence Required in Support of a Claim for Work-Related Pulmonary Illness), which the Office received on June 3, 2008. He briefly described his military service, employment history, smoking history, previous pulmonary condition(s), occupational exposure and the development of his current pulmonary condition.

[3] Additional nonrespiratory diagnoses included diabetes mellitus, obesity and status post right rotator cuff repair.

The employer submitted appellant's medical records, including periodic physical examination reports dated March 18, 1980 to July 12, 1994 and an undated report at age 56 (2001). On March 18, 1980 a childhood history of pneumonia was noted; however, appellant's chest x-ray was reported to be within normal limits. The June 28, 1982 examination also revealed appellant's chest x-ray to be within normal limits. A March 27, 1985 physical examination report noted a childhood history of asthma. The May 13, 1987 examination revealed some wheezing and shortness of breath with coal dust and welding fumes. It also listed a smoking history of one-half pack of cigarettes a day from age 18 to 28 and that appellant was allergic to pollen. Although appellant's chest x-ray was normal, he had an abnormal chest examination that revealed sibilant rales on inspiration and expiration throughout both lung fields, bilaterally. Appellant was diagnosed with asthma by history. The July 5, 1989 physical examination noted asthma, occasionally due to dust and smoke. Appellant had been off work two to three days in 1987 due to pneumonia. The July 12, 1994 physical examination noted a history of asthma and a cigarette smoking history of one-half pack a day from age 18 to 30. Appellant was diagnosed with chronic obstructive pulmonary disease.

A June 5, 1986 dispensary note listed a history of asthma and bronchitis during childhood, but no significant symptoms for years. Appellant reported that it was humid that day and the dust "hadn't helped much." He felt able to do his job, but was coughing up small amounts of thick phlegm. It was also noted that appellant was a nonsmoker. Appellant was diagnosed with asthma and bronchitis. On July 2, 1986 he reported a recent episode of shortness of breath and asthmatic-type wheezing. Appellant was advised to wear a respiratory protector at all times while in dusty areas. On January 5 and December 14, 1987 he was treated for an upper respiratory infection and sinusitis. The latter report noted a history of bronchitis.

Appellant was seen on four occasions in January 1988 for respiratory problems. There was a reported history of bronchitis and asthma. The January 8, 1988 entry noted that appellant had walking pneumonia two years prior. He was advised of the potential for pneumonitis or early pneumonia based on his prior history. On January 11, 1988 appellant was sent home and advised not to return to work until he was released by his private physician. After missing work for two days, he returned with a complaint of a burning sensation when breathing. Appellant's private physician reportedly diagnosed walking pneumonia and released him to return to work. He was advised to avoid exposure to outside weather. The employing establishment was unable to accommodate the restrictions and, therefore, appellant was sent home and advised to follow up on January 15, 1988. Appellant returned on January 19, 1998 and was released to resume his regular work. He was identified as status post pneumonia and advised to wear a dust mask to protect against irritants. On April 11, 1988 appellant was again treated for an upper respiratory infection and sinusitis. He complained of a sore throat, head congestion and a cough. Appellant's symptoms had just begun, but he did not want to wait until they worsened given his history of bronchitis and asthma.

Pulmonary function and other diagnostic studies were submitted to the record. Appellant's March 27, 1985 study revealed forced vital capacity (FVC) and forced expiratory volume (FEV) values that were 73 and 75 percent of predicted normal, respectively. The June 11, 1985 study computer printout was not entirely legible. Some of the reported test values were obscured, but the narrative indicated a mild coexisting obstruction and restriction. The July 12, 1994 study similarly listed a mild coexisting obstruction and restriction. Although

appellant's effort was "good," the July 12, 1994 study failed to meet repeatability criteria. His May 13, 1987 and July 12, 1994 electrocardiograms were both reported as normal.

In a May 21, 2008 report, Mike Bradford, an employing establishment industrial hygienist, reviewed air sampling data from 1986 to 1997. He advised that it revealed that 95 percent of the time exposure to respirable dust was well below current permissible exposure limits.

The employing establishment also submitted a June 23, 2008 report from Dr. Stephen Adams, a Board-certified family practitioner, who reviewed the medical record at the employer's request. Dr. Adams noted that appellant worked from 1980 to 1994 and from 2000 to 2006. During appellant's last nine years of employment, he worked as a conveyor car dumper operator. Dr. Adams stated that appellant claimed to have developed shortness of breath over the last several years and currently had a slight cough.[4] He noted that Dr. Houser's report did not mention any lung problems other than the recent problems appellant mentioned in his complaint. Dr. Adams referenced Dr. Houser's positive x-ray interpretation (pneumoconiosis, category 1/0) and the recent pulmonary function studies that showed mild airway obstruction, but disagreed with Dr. Houser's opinion regarding the etiology of appellant's condition.

Dr. Adams explained that appellant's medical records provided important additional evidence that Dr. Houser did not discuss. He characterized appellant as having a lifelong history of asthma, which Dr. Houser did not mention in his report. Dr. Adams noted that appellant's initial employee physical examination did not include a diagnosis of asthma; however, it was listed on subsequent examination. He noted that appellant was treated several times over the years by employing establishment physicians for asthma. Appellant's pulmonary function testing consistently showed findings similar to those obtained by Dr. Houser. Dr. Adams stated that the current FVC results were better than in 1985, which was proof that appellant did not develop obstructive lung disease as a result of coal exposure during the years 1991 to 1994 and 2000 to 2006.[5] He commented that the study obtained by Dr. Houser showed obstructive lung disease with reversibility primarily affecting the small airways, which was a textbook description of asthma.[6] Dr. Adams stated that it was understandable that Dr. Houser would think appellant's lung disease was due to work-related exposure because he did not know of the preexisting asthma.

Dr. Adams stated that appellant had always had asthma and his relatively stable pulmonary function testing over a 23-year period established that his obstructive lung disease

[4] Dr. Adams appears to be referencing appellant's undated Form CA-35F, which reads as follows: "I have had shortness of breath gradually develop over the last couple of years. I have a slight cough." Appellant also reported smoking "one-half pack of cigarettes a day for about 5-6 years," and having quit smoking 35 years ago. He further noted that about 15 years ago he had pneumonia, which did not require hospitalization.

[5] Dr. Adams did not specifically address appellant's reported occupational exposure as a sheet metal/maintenance worker between 1980 and 1991.

[6] The March 24, 2008 pulmonary function study (PFS) Dr. Houser obtained indicated that postbronchodilator testing failed to demonstrate a significant change in FVC, FEV_1 or forced expiratory flow (FEF) 25 to 75. The prebronchodilator FEF 25 to 75 value was 44 percent of predicted and there was no measurable change after bronchodilator therapy was administered. While the FEV_1 and FVC postbronchodilator values improved 11 and 14 percent, respectively, they were still only 74 and 87 percent of the predicted values.

predated his work as a dump operator. He also noted that the industrial hygienist's report documented safe exposure levels. Dr. Adams advised there was a significant rate of "false positive" diagnoses on plain x-ray. Citing a 2002 article from the *Journal of Thoracic Imaging*, he explained that 20 percent of coal workers with x-rays interpreted as positive for pneumoconiosis were found to be completely normal when tested with high resolution computerized tomography (CT) scanning and 42 percent had only minimal abnormalities. Dr. Adams stated that appellant's x-ray results were questionable given the lack of evidence of excessive exposure and proof that appellant's lung disease had not worsened significantly in 23 years.

In a report dated August 1, 2008, Dr. Augustus E. Anderson, Jr., an Office medical adviser, reviewed the medical evidence of record. He noted that Dr. Adams diagnosed asthma and mild chronic obstructive pulmonary disease, both of which preexisted appellant's exposure to coal dust in his federal employment. Moreover, the pulmonary function studies as interpreted by Dr. Adams had been stable for 23 years. Dr. Anderson found that the opinion of Dr. Adams was well reasoned and established that the minimal chest x-ray changes were due to asthma and mild obstructive disease and not pneumoconiosis as found by Dr. Houser.

In an August 11, 2008 decision, the Office denied appellant's occupational disease claim. It found that the weight of medical opinion established that appellant's pulmonary condition was due to asthma and unrelated to his federal occupational exposure.

Appellant requested an oral hearing, which was held on June 12, 2009.

By decision dated August 13, 2009, an Office hearing representative affirmed the August 11, 2008 decision. She found that the medical evidence was insufficient to establish that appellant's pulmonary condition was causally related to his accepted work exposure.

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[7] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[8]

To establish that an injury was sustained in the performance of duty, a claimant must submit: (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

[7] 5 U.S.C. §§ 8101-8193.

[8] 20 C.F.R. § 10.115(e), (f) (2009); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's 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.*

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 identified employment factors.[9]

The Act provide that if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.[10]

ANALYSIS

Appellant filed a claim for pneumoconiosis and chronic obstructive pulmonary disease that he attributed to exposure to coal dust and welding fumes in his federal employment. The Office accepted that appellant established his exposure as alleged. The Board finds that the case is not in posture for decision due to a conflict in medical opinion.

Appellant submitted the report of Dr. Houser, a Board-certified specialist in pulmonary disease, who reviewed appellant's history and obtained diagnostic tests. Dr. Houser noted that pulmonary function studies revealed a mild airway obstruction and listed findings on physical examination. He diagnosed pneumoconiosis category 1/0 which was due to appellant's history of occupational exposure to coal dust. Dr. Houser noted that the diagnosis was consistent with the findings on diagnostic study and chest x-rays.

The employer submitted records for review by Dr. Adams, who diagnosed asthma and a mild chronic obstructive pulmonary disease which he found was not related to appellant's history of exposure in his federal employment. Dr. Adams determined that appellant had a preexisting pulmonary condition with reversibility, primarily affecting the small airways which were a textbook description of asthma. He indicated that appellant's lung disease was not caused or contributed to by his occupational exposure as the pulmonary studies revealed that his lung disease had not worsened over 23 years.

Dr. Anderson, the Office medical adviser, reviewed the medical records and agreed with the opinion of Dr. Adams, noting that appellant's asthma and chronic obstructive pulmonary disease were preexisting conditions that had been stable for 23 years. He determined that appellant's condition was not due to pneumoconiosis as diagnosed by Dr. Houser.

In *Donald E. Ewals*,[11] the Board noted that a physician contracted by the federal employer may not be considered a second opinion specialist.[12] For this reason, the report of Dr. Adams is not sufficient to create a conflict in medical opinion with that of Dr. Houser in this case. However, it is also well established that the opinion of an Office medical adviser may give

[9] *Victor J. Woodhams, supra* note 8.

[10] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[11] 51 ECAB 428 (2000).

[12] *Id*. at 434. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.9(b) (June 2002), revised at Chapter 2.810.4(a) (September 2010). *See also Mary L. Barragy*, 47 ECAB 285 (1996).

rise to a conflict under section 8123(a).[13] Dr. Anderson, the Office medical adviser, reviewed and incorporated the medical opinion and findings of Dr. Adams and recommended to the Office that it represented the weight of medical opinion. The Board finds that a conflict in medical opinion arose between Dr. Houser, for appellant, and Dr. Anderson, the Office medical adviser, for the government as to whether appellant's lung disease was caused or aggravated by his federal employment. Due to this unresolved conflict in medical opinion, the case will be remanded to the Office for further development and referral of appellant to an impartial medical specialist. After such further development of the case as the Office deems necessary, a *de novo* decision shall by issued.

CONCLUSION

The case is not in posture for decision due to an unresolved conflict in medical opinion between appellant's physician and the Office medical adviser.

ORDER

IT IS HEREBY ORDERED THAT the August 13, 2009 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further action consistent with this decision.

Issued: November 30, 2010
Washington, DC

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

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

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

[13] *See Elaine Sneed*, 56 ECAB 373 (2005); 20 C.F.R. § 10.321(b).