United States Department of Labor
Employees' Compensation Appeals Board

M.S., Appellant	)	
and	)	**Docket No. 11-263**
	)	**Issued: September 14, 2011**
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:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 10, 2010 appellant, through his attorney, filed a timely appeal from an October 5, 2010 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 that his lung condition is causally related to factors of his federal employment.

FACTUAL HISTORY

On June 12, 2009 appellant, then a 54-year-old conveyor car dump operator, filed an occupational disease claim alleging that he developed asbestosis and bronchitis due to factors of

[1] 5 U.S.C. § 8101 *et seq.*

his federal employment. He first became aware of his condition on May 12, 2009 and first related the condition to his employment on that date. Appellant stated that Dr. Glen R. Baker, a Board-certified pulmonologist, reviewed x-rays and made the diagnosis. On the reverse of the form, appellant's supervisor stated that he was last exposed on December 31, 2008 when he retired from the employing establishment.

In a letter dated August 17, 2009, OWCP requested factual and medical evidence in support of appellant's claim. It allowed 30 days for a response. Appellant responded that he began working at the employing establishment in 1977 as a laborer for over five years. He was exposed to asbestos while cleaning the facility with air lances as it was used in the insulation that covered pipes. Appellant shoveled the dust which included asbestos, fly ash and coal dust. He stated that the dust was in his noise and throat. In appellant's position as a conveyor car dump operator that he held until December 31, 2008, he was exposed to coal dust on a daily basis. He also stated that asbestos was still present in his workplace.

In a report dated July 11, 2009, Dr. Baker noted appellant's employment history that there were pipes that were wrapped in asbestos as well as asbestos in the walls of his working area. Appellant also had employment-related exposure to coal dust, fly ash and magnate. Dr. Baker stated that appellant had never smoked. He noted complaints of shortness of breath for two years with the primary symptom of sputum production. Dr. Baker stated that appellant's breathing was aggravated by exertion, upper respiratory tract infection and various dusts. He reviewed appellant's chest x-ray dated April 7, 2009 that was consistent with occupational pneumoconiosis. Dr. Baker found that appellant's pulmonary function studies were within normal limits. He diagnosed pulmonary asbestosis based on appellant's history of asbestos exposure for a long period and x-ray changes consistent with pulmonary asbestosis. Dr. Baker also diagnosed bronchitis and mitral insufficiency. He opined that appellant's clinical findings were consistent with significant exposure to asbestos resulting in significant x-ray changes. As appellant's pulmonary function studies were within normal limits, he had no ratable impairment under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2]

The employing establishment responded to OWCP's request for information on October 21, 2009. It stated that data exposures to respirable coal dust specifically for appellant were not available. The employing establishment noted that data on exposures between 1977 and 2008 to respirable coal dust, total dust and asbestos at his duty station were below the permissible exposure limits approximately 87 percent of the time. It stated that exposures to respirable coal dust were consistently under the applicable limit and that this exposure assessment was confirmed by the lack of diagnosis of pneumoconiosis which affects workers exposed to respirable coal dust. The employing establishment stated that measured exposures to asbestos were within the established limit and that appellant's employment as a coal car dump operator for the last 24 years was a position in which he was not exposed to asbestos in his job function.

[2] A.M.A., *Guides* (5th ed. 2001).

OWCP referred appellant for a second opinion evaluation with Dr. William Houser, a Board-certified pulmonologist on December 3, 2009. In his December 17, 2009 report, Dr. Houser noted that appellant reported experiencing respiratory symptoms over the past two years including cough with sputum production. He noted that during appellant's work he was regularly exposed to coal dust and fly ash, flue gas and magnetite. Dr. Houser stated that appellant worked in areas where asbestos was on the pipes and boiler. On physical examination, he found no rales, rhonchi, wheezing, pleural rub or bronchial breath sounds. Dr. Houser reported that appellant's arterial blood gas studies and spirometry studies were within normal limits. He opined that appellant's chest x-ray was within normal limits. Dr. Houser found no evidence of respiratory disease, hypertension and diabetic mellitus.

By decision dated January 22, 2010, OWCP denied appellant's claim. It stated that he filed a timely claim and was exposed to work factors as alleged, but that the medical evidence did not establish asbestosis. OWCP concluded that Dr. Houser's report was entitled to the weight of the medical evidence and established that appellant did not have a respiratory disease.

On February 5, 2010 appellant requested an oral hearing. He testified at the oral hearing on June 17, 2010. Appellant stated that in his initial position as a laborer he used air and water hoses to clean the rooms with coal dust or boiler rooms with ash and shoveled out basements. He stated that he was exposed to pipes with asbestos. Appellant testified that he saw asbestos hanging down from the wall. He stated that after approximately five years his position changed to conveyor car dump operator, which required him to shovel coal dust. Appellant stated that he had difficulties breathing and a productive cough. Counsel argued that Dr. Baker's report should be entitled to special weight as he as a designed B-Reader, a physician with demonstrated proficiency in the classification of chest radiographs for pneumoconiosis. He noted that there was no indication that Dr. Houser was a B-Reader.

By decision dated October 5, 2010, the hearing representative affirmed OWCP's January 22, 2010 decision finding that Dr. Houser's report constituted the weight of the medical evidence.

LEGAL PRECEDENT

Section 10.5(q) of OWCP's regulations define an occupational disease or illness as a condition produced by the work environment over a period longer than a single workday or work shift.[3] To establish that an injury was sustained in the performance of duty in an occupational disease claim, an employee must submit the following: (1) medical evidence establishing the presence or existence of a condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the condition; and (3) medical evidence establishing that the employment factors identified by the employee were the proximate cause of the condition or illness, 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 employee.[4]

[3] 20 C.F.R. § 10.5(q).

[4] *D.D.*, 57 ECAB 734 (2006); *Donna L. Mims*, 53 ECAB 730 (2002).

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[5] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between an employee's diagnosed conditions and the implicated employment factors.[6] 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 conditions and the specific employment factors identified by the employee.

Section 8123(a) of FECA provides in pertinent part: "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."[7] In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[8]

ANALYSIS

Appellant filed an occupational disease claim alleging that he had developed lung disease due to occupational exposures to coal dust and asbestos in the performance of his federal job. The employing establishment substantiated that he had exposure to coal dust and asbestos. Appellant submitted a report from Dr. Baker dated July 11, 2009 in which, Dr. Baker noted appellant's exposure to asbestos, coal dust, fly ash and magnate. He examined an April 7, 2009 chest x-ray and diagnosed occupational pneumoconiosis and pulmonary asbestosis. Dr. Baker opined that appellant's clinical findings were consistent with significant exposure to asbestos over a period of time resulting in significant x-ray changes.

OWCP referred appellant for a second opinion evaluation with Dr. Houser who completed a report on December 17, 2009 and noted that appellant was regularly exposed to coal dust and fly ash, flue gas and magnetite. Dr. Houser made no positive findings on physical examination stating that appellant had no rales, rhonchi, wheezing, pleural rub or bronchial breath sounds. He also found that appellant's chest x-ray, arterial blood gas studies and spirometry studies were within normal limits. Dr. Houser concluded that appellant had no evidence of respiratory disease.

The Board finds that there is an unresolved conflict of medical opinion evidence between appellant's physician, Dr. Baker, and a physician for OWCP, Dr. Houser regarding whether appellant has a diagnosed lung condition and whether this condition is related to his accepted employment exposures. On remand, OWCP shoulder refer appellant, a statement of accepted

[5] *David Apgar*, 57 ECAB 137 (2005); *I.R.*, Docket No. 09-1229 (issued February 24, 2010).

[6] *G.G.*, 58 ECAB 389 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[7] 5 U.S.C. § 8123(a).

[8] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

facts and a list of specific questions to a Board-certified pulmonologist and B-Reader to determine if he has a lung disease and if so, whether this condition is causally related to his accepted employment exposures. After this and such other development as OWCP deems necessary, OWCP should issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision due to an unresolved conflict of medical opinion evidence.

ORDER

IT IS HEREBY ORDERED THAT the October 5, 2010 decision of the Office of Workers' Compensation Programs is set aside and remanded for further development consistent with this decision of the Board.

Issued: September 14, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

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

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