

**United States Department of Labor
Employees' Compensation Appeals Board**

J.B., Appellant)
)
and)
)
TENNESSEE VALLEY AUTHORITY,)
DIVISION OF FOSSIL & HYDRO POWER,)
Drakesboro, KY, Employer)

Docket No. 12-1549
Issued: January 16, 2013

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
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 11, 2012 appellant, through his attorney, filed a timely appeal from the May 7, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for a pulmonary condition. Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 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 met his burden of proof to establish that he sustained a pulmonary condition in the performance of duty.

FACTUAL HISTORY

On April 26, 2011 appellant, then a 59-year-old boilermaker/welder, filed an occupational disease claim alleging a pulmonary condition, including bilateral pleural

¹ 5 U.S.C. §§ 8101-8193.

thickening, due to exposure to asbestos during his federal employment. He stated that on January 25, 2011 he first learned that he had an occupational lung disease after review of a chest x-ray report by Dr. William C. Houser, an attending Board-certified pulmonary physician.²

In a May 13, 2011 letter, OWCP requested that appellant submit additional factual and medical evidence in support of his claim.

In a March 9, 2011 report, Dr. Houser stated that appellant reported working intermittently as a boilermaker from 1970 to 2003 and was exposed to asbestos on a frequent basis during the early years of his employment. Appellant also had a history of bronchitis and pneumonia as well as dyspneic while walking. Dr. Houser indicated that testing showed evidence of diffuse bilateral pleural thickening with face-on thickening on the left. He diagnosed diffuse bilateral pleural thickening, most likely related to prior asbestos exposure, bronchial asthma, obesity, diabetes mellitus, hypertension and history of congenital heart disease, status post open heart surgery at age 15. Dr. Houser stated, “[Appellant] has sufficient occupational exposure (up to 33 years) and chest roentgenographic findings appropriate for the diagnosis of diffuse bilateral pleural thickening most likely related to prior asbestos exposure. This at least in part appears to be related to exposure which occurred while working at [the employing establishment].” The record contains a pulmonary function testing report from March 9, 2011 which was obtained by Dr. Houser.

In an undated statement received on May 31, 2011, appellant listed a history that from 1970 until the late 1980s he periodically worked as a boilermaker and was exposed to asbestos dust and smoke fumes for up to 40 hours a week.³ He noted that occasionally he would wear a paper mask at work. Appellant noted that he could see the dust and it would get on his clothes.

In July 2011, OWCP referred appellant to Dr. Peter Rosario, a Board-certified pulmonologist, for an examination and opinion on whether he sustained a pulmonary condition in the performance of duty. It directed the physician to perform various pulmonary function studies. In an attached statement of accepted facts, OWCP listed appellant’s intermittent exposure to asbestos and other harmful substances for about four years.

In a September 29, 2011 report, Dr. Rosario described appellant’s medical history and his exposure to asbestos in connection with his federal employment. He reported the findings of his examination and of various diagnostic tests. Dr. Rosario stated that a chest x-ray from September 29, 2011 showed some platelike atelectasis changes on the left or possibly a small focal area of chronic scarring. He stated that asbestosis was not evident based on the chest x-ray but noted that there was a “significant possibility of asbestos-related pleural disease.” Dr. Rosario diagnosed multi-factorial shortness of breath, mild hypoxemia, restrictive lung disease related primarily to obesity, toxic effect of asbestos with pleural plaques evident and findings very weak for asbestosis, bronchospasm with significant improvement on pulmonary function studies, mild hypoxemia, obstructive sleep apnea, obesity, hypertension, seizure

² Appellant submitted medical reports regarding the treatment of several medical conditions. He had retired from the employing establishment in 2003.

³ Appellant indicated that he intermittently worked for the employing establishment for four years.

disorder, chest pain -- less likely cardiogenic in origin despite an abnormal electrocardiogram, hyperlipidemia and diabetes mellitus, Type 2. He noted that appellant's shortness of breath was related to multiple factors. These included but were not limited to a restrictive ventilatory defect, obesity, deconditioning, mild hypoxemia, mild scarring and/or atelectasis of the lungs, asbestos-related pleural disease, bronchospasm (asthma) and possible coronary artery disease. Dr. Rosario noted that the presence of asbestos-related pleural disease was contributing to appellant's shortness of breath but was not a major contributor. He stated, "Nor are the minor parenchymal changes noted on chest x-ray which most likely represent atelectasis and chronic scarring. These parenchymal lung changes in my estimation do not represent asbestosis." Dr. Rosario discussed the various diagnosed conditions and stated, "There is greater than 50 percent probability that the pleural thickening noted on chest x-ray is related to his exposure to asbestos. There is less than 50 percent probability that asbestosis (pulmonary fibrosis) is present."

In an October 17, 2011 report, Dr. Eric Puestow, a Board-certified internist serving as an OWCP medical adviser, reviewed the September 29, 2011 report of Dr. Rosario, who found that there was no firm medical evidence that appellant had asbestosis. He noted that the physical examination showed that appellant's lungs were clear and that there was no examination evidence of heart or lung disease. Dr. Puestow noted that chest x-ray testing demonstrated right pleural thickening but no parenchymal disease. He stated:

"[Dr. Rosario] stated that 'Asbestosis is not evident based on this chest x-ray....' Pulmonary function studies were minimally abnormal.

"[Dr. Rosario] concluded that claimant has multi-factorial shortness of breath, restrictive lung disease due to obesity and that 'findings are very weak for asbestosis.' He further stated that the asbestos[-]related pleural disease is not a major contributor to claimant's shortness of breath and that '[t]hese parenchymal lung changes in my estimation do not represent asbestosis.'

"As claimant does not have firm medical evidence supporting the diagnosis of asbestosis, calculation of a [s]cheduled [a]ward is not appropriate in this case."

In an October 20, 2011 decision, OWCP denied appellant's claim on the grounds that he did not submit sufficient medical evidence to establish that he sustained a pulmonary condition in the performance of duty. It noted that Dr. Rosario showed that appellant did not have work-related asbestosis.

Appellant requested a hearing before an OWCP hearing representative. At the February 17, 2012 hearing, he was represented by counsel. Appellant explained that the claim was not filed for asbestosis but rather for bilateral pleural thickening as a result of the asbestos exposure. Counsel noted that Dr. Rosario's report established appellant's claim as he noted there was a significant possibility of asbestos-related pleural disease. Dr. Rosario stated that pleural plaques were evident and that the pleural thickening was related to asbestos exposure. Counsel argued that there was a conflict in medical opinion between Dr. Rosario and OWCP's medical adviser.

In a March 23, 2012 letter, the employing establishment asserted that appellant only worked for its organization for a total of two years and four months between 1970 to 1988.

In a May 7, 2012 decision, OWCP's hearing representative affirmed the October 20, 2011 decision denying appellant's claim for a work-related pulmonary condition.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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 FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and specific condition for which compensation is claimed are causally related to the employment injury.⁴ These are the essential elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.⁵

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 differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.⁶

⁴ *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

⁵ See *Delores C. Ellyett*, 41 ECAB 992, 994 (1990); *Ruthie M. Evans*, 41 ECAB 416, 423-25 (1990). A traumatic injury refers to injury caused by a specific event or incident or series of incidents occurring within a single workday or work shift whereas an occupational disease refers to an injury produced by employment factors which occur or are present over a period longer than a single workday or work shift. 20 C.F.R. § 10.5(ee), (q); *Brady L. Fowler*, 44 ECAB 343, 351 (1992).

⁶ See *Donna Faye Cardwell*, 41 ECAB 730, 741-42 (1990).

It is well established that proceedings under FECA are not adversarial in nature and while the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.⁷

ANALYSIS

On April 16, 2011 appellant filed an occupational disease claim alleging that he sustained a pulmonary condition, including bilateral pleural thickening, due to exposure to asbestos during his federal employment. In July 2011, OWCP referred him to Dr. Rosario, a Board-certified pulmonologist, for an examination and opinion on whether he sustained a pulmonary condition in the performance of duty. It based its denial of appellant's claim for a work-related pulmonary condition on the report of Dr. Rosario and on an October 17, 2011 report of Dr. Puestow, a Board-certified internist who served as an OWCP medical adviser.

The Board finds that the September 29, 2011 report of Dr. Rosario is generally supportive that appellant sustained a work-related pulmonary condition. The case will be remanded to OWCP for further development of the medical evidence in this regard.

Dr. Rosario noted that a chest x-ray from September 29, 2011 showed some platelike atelectasis changes on the left or possibly a small focal area of chronic scarring. He stated that asbestosis was not evident based on this chest x-ray but noted that there was a "significant possibility of asbestos-related pleural disease." Dr. Rosario listed a number of diagnoses including toxic effect of asbestos with pleural plaques evident and findings very weak for asbestosis. He noted that appellant's shortness of breath was related to multiple factors, including mild scarring and/or atelectasis of the lungs and asbestos-related pleural disease. Dr. Rosario noted that the presence of asbestos-related pleural disease was contributing to appellant's shortness of breath but was not a major contributor. He stated, "Nor are the minor parenchymal changes noted on chest x-ray which most likely represent atelectasis and chronic scarring. These parenchymal lung changes in my estimation do not represent asbestosis." Dr. Rosario individually discussed the various diagnosed conditions and further stated, "There is greater than 50 percent probability that the pleural thickening noted on chest x-ray is related to his exposure to asbestos. There is less than 50 percent probability that asbestosis (pulmonary fibrosis) is present."

While Dr. Rosario indicated that appellant probably did not have the condition of asbestosis, his report suggested that appellant had some other form of a work-related asbestos-related pleural disease or pleural thickening. Given these findings, the case should be remanded to OWCP for the purpose of obtaining additional clarification of Dr. Rosario's opinion that appellant sustained some form of work-related pulmonary condition.⁸ After such development as it deems necessary, OWCP should issue an appropriate decision regarding appellant's claim that he sustained a pulmonary condition in the performance of duty.

⁷ *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

⁸ *See supra* note 7. OWCP should produce an updated statement of accepted facts which clarifies the extent to which appellant was exposed to asbestos and other harmful substances during his federal employment.

CONCLUSION

The Board finds that the case is not in posture for decision regarding whether appellant met his burden of proof to establish that he sustained a pulmonary condition in the performance of duty. The case is remanded to OWCP for further development of the evidence.

ORDER

IT IS HEREBY ORDERED THAT the May 7, 2012 decision of the Office of Workers' Compensation Programs is set aside and the case remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: January 16, 2013
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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