United States Department of Labor
Employees' Compensation Appeals Board

R.F., Appellant	)	
and	)	**Docket No. 13-1918**
	)	**Issued: February 18, 2014**
TENNESSEE VALLEY AUTHORITY, Chattanooga, TN, 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, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 19, 2013 appellant, through his attorney, filed a timely appeal from a May 24, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for compensation. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish he sustained asbestosis caused or aggravated by factors of his federal employment.

FACTUAL HISTORY

On May 20, 2004 appellant, then a 58-year-old retired assistant unit operator, filed an occupational disease claim alleging that his employment caused pneumoconiosis and asbestosis. On March 2, 2004 he learned he had an occupational lung disease when reviewing the chest x-

[1] 5 U.S.C. § 8101 *et seq.*

ray report of Dr. Glen R. Baker, a Board-certified pulmonary specialist. On May 20, 2004 appellant also filed a claim for a schedule award. He stated that he was a regular smoker from his twenties through the filing of the claim, having smoked a half pack to a quarter pack a day. The record indicates that appellant worked at the employing establishment in various positions from approximately 1975 until his retirement in 1999. He was briefly rehired in 2000.

In a March 27, 2004 report, Dr. Baker noted the history of appellant's employment and diagnosed bronchitis based on history; and occupational pneumoconiosis with coal workers' pneumoconiosis and x-ray changes consistent with pulmonary asbestosis, category 1/0 based on March 27, 2004 chest x-ray and 2000 ILO Classification. He indicated that appellant's pre and postbronchodilator and pulmonary function studies were within normal limits. However, Dr. Baker opined that appellant had a Class 1 impairment.

In an August 6, 2004 letter, the employing establishment controverted the claim, noting that appellant's exposure was within OSHA limits for coal dust and asbestos and that his physician found both the pre and post pulmonary function studies within normal limits. It also noted that his job as assistant unit operator would not normally place him in areas where coal dust would be at elevated levels.

In an April 28, 2006 report, Dr. Stephen Adams, a Board-certified family practitioner, reviewed appellant's medical records from the employing establishment and Dr. Baker's report. The records showed no evidence of chronic lung disease except an inconsistent finding of a mild obstructive ventilator defect. Dr. Baker's examination recorded no physical findings consistent with pneumoconiosis and appellant's pulmonary function testing was normal. Dr. Adams stated that, given the lack of evidence of excessive exposure in this case and the subjectiveness interpretation of chest x-ray abnormalities, further medical evaluation of appellant was necessary.

In a November 16, 2006 report, Dr. Michael E. Niedermeyer, a Board-certified pulmonary disease specialist, reviewed the results of appellant's pulmonary testing on that date. He found at least a moderate obstructive ventilator defect with mild decrease in corrected diffusion capacity compatible with significant chronic obstructive pulmonary disease and improvement following bronchodilatory and no associated restrictive defect. Oxygen saturation was within normal limits and arterial blood gases showed mild decrease in oxygen level for age. Clinical correlation was suggested.

In September 2006, OWCP referred appellant, together with the medical record, a statement of accepted facts and a list of questions, to Dr. James J. Coleman, Board-certified in pulmonary disease, for a second opinion evaluation. In a November 17, 2006 report, Dr. Coleman reviewed the history of injury and set forth findings on physical examination. Chest x-ray was normal except for changes of pulmonary hyperinflation. No evidence of pleural thickening or pleural plaque formation was found. Pulmonary function studies revealed moderate obstructive impairment with significant improvement following aerosolized bronchodilator medication. Dr. Coleman advised that appellant has reactive airway disease or asthma demonstrated by his response to bronchodilator medication during his pulmonary function studies clearly showed this. The only abnormal finding on appellant's chest x-ray was that of pulmonary hyperinflation, a finding also characteristic of asthma. There was no evidence

of a restrictive impairment and nothing in his pulmonary function studies, physical examination or chest x-ray suggested the presence of asbestosis or any type of pneumoconiosis related to his work exposure. Dr. Coleman opined that appellant's history of occupational exposure to coal dust and asbestos while working at the employment establishment was not related to his current impairment in terms of causation or acceleration.

By decision dated February 21, 2007, OWCP denied the claim, including appellant's schedule award claim. It found that the medical evidence, as denoted by Dr. Coleman's second opinion report, did not demonstrate that the claimed medical condition was related to the established work-related events.

In a January 20, 2009 letter, appellant, through counsel, requested an oral hearing. By decision dated February 9, 2009, OWCP denied the hearing request as untimely and found the issue could be equally addressed by requesting reconsideration. However, based on evidence that appellant had timely requested an oral hearing on March 1, 2007, it held a telephonic hearing on March 18, 2013.

In a January 10, 2013 report, Dr. Sanjay Chavda, a Board-certified pulmonary disease specialist, interpreted the January 10, 2013 pulmonary function study as showing moderate obstructive airway disease.

By decision dated May 24, 2013, an OWCP hearing representative affirmed the denial of appellant's claim. She also found that appellant overstated his work-related exposure according to his employer and provided no proof of greater exposure than what the employing establishment monitoring supported.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish 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 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.[2] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[3]

OWCP's regulations define the term occupational disease or illness as a condition produced by the work environment over a period longer than a single workday or shift.[4] 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

[2] *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Bonnie A. Contreras*, 57 ECAB 364 (2006).

[3] *S.P.*, 59 ECAB 184 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[4] 20 C.F.R. § 10.5(ee).

occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical opinion 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.[5]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[6] 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 employee.[7] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[8]

ANALYSIS

OWCP has determined that appellant was exposed to coal dust and asbestos within OSHA limits for exposure. The Board finds that he did not meet his burden of proof to establish that he sustained asbestosis or pneumoconiosis caused by his accepted exposure during federal employment. The medical evidence is insufficient to establish causal relationship.

The diagnostic studies, including x-rays and pulmonary function tests, do not provide a cause of any diagnosed condition. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[9]

In a March 27, 2004 report, Dr. Baker diagnosed occupational pneumoconiosis based on x-rays. His finding that the pulmonary function studies were within normal limits, contradicts a diagnosis of pneumoconiosis, which is a restrictive disease. Dr. Baker also did not provide any explanation as to how the diagnosed occupational pneumoconiosis was a valid diagnosis since the absence of any clinically significant restrictive disease excludes the diagnosis of pneumoconiosis. Given his lack of explanation and finding that the pulmonary function studies were normal, his opinion that appellant has occupational pneumoconiosis is not well rationalized

[5] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[6] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[7] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[8] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[9] *Willie M. Miller*, 53 ECAB 697 (2002).

and has little probative value to establish that he sustained pneumoconiosis causally related to his federal employment.[10]

In an April 28, 2006 report, Dr. Adams reviewed appellant's medical record and found no evidence of chronic lung disease beyond the inconsistent finding of a mild obstructive ventilator defect. He also noted that Dr. Baker's examination did not provide any physical findings consistent with pneumoconiosis; however, Dr. Adams offered no opinion on the issue of causal relationship. Medical evidence that offers no opinion regarding the cause of an employee's condition is of diminished probative value and insufficient to meet appellant's burden of proof on causal relationship.[11]

In a November 17, 2006 report, Dr. Coleman noted the history of injury and reported physical findings as well as findings from diagnostic testing. He opined that appellant has reactive airway disease or asthma and explained that such diagnosis was supported by his response to bronchodilator medication during his pulmonary function study and the pulmonary hyperinflation found on chest x-ray. Dr. Coleman ruled out any asbestosis or pneumoconiosis related to work exposure as there was no evidence of a restrictive impairment on either the pulmonary function studies, physical examination or chest x-ray.

The Board finds that Dr. Coleman had a full and accurate history of the relevant facts and evaluated appellant's condition. Dr. Coleman provided a review of the records, diagnostic tests and performed a thorough physical examination. He addressed his own examination findings as well as the medical records to reach a reasoned conclusion regarding appellant's condition.[12] Dr. Coleman found no basis to support that appellant had any asbestosis or pneumoconiosis related to work exposure. His opinion as set forth in his November 17, 2006 report is found to be probative and reliable. Furthermore, the Board notes that neither the November 16, 2006 nor January 10, 2013 spirometry reports showed evidence of asbestosis or occupational pneumoconiosis. The Board finds that Dr. Coleman's opinion constitutes the weight of the medical evidence that appellant does not have any asbestosis or pneumoconiosis related to work exposure.

On appeal, appellant's counsel contends that a conflict in medical evidence exists between Dr. Baker and Dr. Coleman regarding pneumoconiosis related to work exposure. The medical evidence, as represented by Dr. Coleman's referral opinion, however, does not support the existence of any pneumoconiosis related to work exposure. Furthermore, Dr. Baker's opinion is of little probative value.

[10] *See T.M.*, Docket No. 08-975 (issued February 6, 2009); *Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006); *William C. Thomas*, 45 ECAB 591 (1994) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[11] *A.F.*, 59 ECAB 714 (2008); *Ellen L. Noble*, 55 ECAB 530 (2004); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[12] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion are facts which determine the weight to be given to each individual report).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that he sustained asbestosis or pneumoconiosis causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the May 24, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 18, 2014
Washington, DC

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

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

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