United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 13-2039**
	)	**Issued: March 5, 2014**
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:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 6, 2013 appellant, through counsel, timely appealed the August 2, 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 over the merits of the claim.

ISSUE

The issue is whether appellant sustained an injury in the performance of duty on or about June 14, 2012.

FACTUAL HISTORY

Appellant, a 61-year-old retired maintenance mechanic/steamfitter, filed a claim (Form CA-2) for pneumoconiosis, asbestosis and bronchitis. He attributed his claimed condition to

[1] 5 U.S.C. §§ 8101-8193.

industrial exposure to coal dust and asbestos.[2] Appellant claimed that he first became aware of his condition on June 14, 2012.

Dr. Glen R. Baker, Jr. interpreted a May 2, 2012 chest x-ray as positive for pneumoconiosis.[3] He examined appellant on July 6, 2012 and diagnosed, *inter alia*, mild bronchitis and occupational pneumoconiosis with pulmonary asbestosis, category 1/0.[4] Dr. Baker noted that appellant had been employed for 14½ years as a pipefitter and was exposed to coal dust and asbestos. Many of the pipes he worked on were reportedly wrapped in asbestos. Appellant also had a 41-year smoking history.[5] He complained of shortness of breath, wheezing and a daily cough with variable sputum production. Exertion and exposure to hot and humid weather reportedly aggravated appellant's breathing. He could walk 125 to 150 yards on level ground before having to stop and catch his breath. Dr. Baker commented on appellant's May 2, 2012 positive x-ray findings and also noted that his July 6, 2012 pulmonary function study (PFS) was within normal limits. He attributed appellant's bronchitis and occupational pneumoconiosis to asbestos exposure, as well as other dusts, odors and fumes encountered during his employment. Cigarette smoking was also a contributing factor.

OWCP referred appellant to Dr. H. Dale Haller, Jr., a pulmonary specialist Board-certified in pulmonary disease, who examined appellant on December 13, 2012. He reviewed appellant's more than 30-year employment history as a pipefitter, which included work as a federal civilian employee and as a private-sector contractor. Dr. Haller noted that appellant worked around asbestos-insulated piping, but he was not responsible for removing the insulation. Appellant also reported using asbestos fire blankets which produced some dust. Additionally, he was exposed to flue gas. However, appellant was primarily exposed to coal dust which was reportedly everywhere. He indicated there were days when he was covered in coal dust. Appellant would cough up dust and blow it out of his nose. His industrial exposure was similar during a 15-year stint as a private contract employee at the Paradise facility, which ended in 2010. Dr. Haller also noted a 41-year smoking history of one and a half to two packs of cigarettes per day, with a recent decrease to one pack per day. Appellant reportedly retired two years ago.

On physical examination, Dr. Haller noted dyspnea with exertion. Appellant had fairly minimal exertion at 100 yards on level ground and after 8 to 10 steps he had to stop and catch his breath. Dr. Haller reported no significant cough or wheezing. There was no chest pain or

[2] Appellant was a federal employee from 1977 until October 1994. OWCP accepted that he had been exposed to coal dust, asbestos and flue gas during his federal civilian service. Appellant continued to work as a pipefitter at the Paradise facility from 1995 through October 2010, but as a private contractor/employee. In addition to his industrial exposure, appellant reported a 41-year smoking history of at least one pack of cigarettes per day.

[3] Dr. Baker is a certified B reader (National Institute for Occupational Safety and Health - NIOSH) with a demonstrated proficiency in classifying chest x-rays for pneumoconiosis. He is also Board-certified in both internal medicine and pulmonary disease.

[4] Dr. Baker also diagnosed essential hypertension and ischemic heart disease, and noted a history of cardiac arrhythmia.

[5] Appellant previously smoked one and a half to two packs of cigarettes per day, but for the past year he cut back to one pack per day.

pressure and appellant's lungs were clear. Dr. Haller characterized the examination as fairly unremarkable. He also indicated that appellant's chest x-ray was essentially unremarkable. An electrocardiogram showed sinus rhythm with some premature ventricular complexes. Dr. Haller also administered a PFS which revealed a diffusion deficit, but was otherwise normal. However, the PFS results were questionable given appellant's suboptimal and inconsistent effort.

Dr. Haller also reviewed Dr. Baker's July 6, 2012 findings. He noted that appellant's physician did not find significant pulmonary function abnormalities. Dr. Haller explained that the basis for Dr. Baker's finding was his chest x-ray interpretation of 1/0, which was a very subtle finding and open to interpretation. He recommended a high resolution computerized tomography (CT) scan for a more definitive answer regarding evidence of early interstitial disease. Based on his current examination, Dr. Haller did not find "any significant pulmonary disease, *i.e.,* evidence for asbestosis or pneumoconiosis."

A January 2, 2013 chest CT scan revealed extensive emphysematous changes and no evidence of interstitial lung disease.[6] Small calcified granulomas were observed and there was no evidence of calcification along the pleural surface.

In a January 10, 2013 supplemental report, Dr. Haller noted that he had reviewed the January 2, 2013 CT scan report. He reiterated the radiologist's findings and indicated that this certainly would explain appellant's diffusion deficit noted on PFS. Dr. Haller further indicated that there was no evidence of asbestosis or other occupational lung disease or any interstitial lung disease aside from the emphysema. He thought it very unlikely that appellant's occupational exposures accounted for his disease. Dr. Haller stated that appellant did not have evidence of asbestosis or other pneumoconiosis, and it was very likely his disease was primarily due to heavy cigarette abuse.

By decision dated January 18, 2013, OWCP denied the claim on the basis that appellant's diagnosed pulmonary condition was not work related. It accorded determinative weight to Dr. Haller's opinion in finding that appellant had not established causal relationship.

Appellant timely requested an oral hearing.

On April 25, 2013 appellant's counsel contacted Dr. Haller and asked that he address whether the documented employment exposure contributed to appellant's development of emphysema. In a May 1, 2013 response, Dr. Haller indicated that appellant's chronic obstructive pulmonary disease (COPD) was principally due to his tobacco abuse. He further explained that heavy dust exposure had been shown to cause COPD, and in the presence of tobacco abuse, dust exposure accelerated decline. Dr. Haller indicated that it was possible that some of appellant's work-related dust exposure contributed to his emphysema, but given his extensive smoking history, tobacco abuse clearly was the principle cause.

In a May 16, 2013 report, Dr. Baker indicated that he had reviewed Dr. Haller's findings. He noted that the reported reduced diffusion capacity would imply an abnormality in lung tissue

[6] Dr. Haller ordered the CT scan, which was interpreted by Dr. Abdelrahman M. Abdalla, a Board-certified diagnostic radiologist with a subspecialty in neuroradiology.

such as emphysema. Dr. Baker further stated that the emphysematous changes noted on appellant's CT scan could be due to his dust exposure as well as his cigarette smoking history, or more likely a combination of both. In conclusion, he stated that any respiratory impairment appellant had would be due, at least in part, to his dust exposure.

In an August 2, 2013 decision, the hearing representative affirmed OWCP' January 18, 2013 denial of benefits.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of establishing the essential elements of his or her 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.[7]

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 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.[8]

ANALYSIS

The Board finds that the case is not in posture for decision.

Appellant's physician, Dr. Baker, initially diagnosed mild bronchitis and occupational pneumoconiosis with pulmonary asbestosis, category 1/0. The latter diagnoses were based in part on Dr. Baker's interpretation of appellant's May 2, 2012 chest x-ray. Dr. Baker identified parenchymal abnormalities consistent with pneumoconiosis, but no pleural or other abnormalities. Small opacities were noted in the middle and lower zones of both lungs. Dr. Baker rated the film quality as grade 2, which is less than optimal.[9] He attributed appellant's bronchitis and occupational pneumoconiosis to asbestos exposure, as well as other employment-related dusts, odors and fumes. Dr. Baker also identified cigarette smoking as a contributing factor.

[7] 20 C.F.R. § 10.115(e), (f)(2012); *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). The fact that the etiology of a disease or condition is unknown or obscure does not relieve an employee of the burden of establishing a causal relationship by the weight of the medical evidence nor does it shift the burden of proof to OWCP to disprove an employment relationship. *Judith J. Montage*, 48 ECAB 292, 294-95 (1997).

[8] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[9] Dr. Baker's reason for not rating the film grade 1 is not entirely legible.

Appellant's January 2, 2013 CT scan, which was interpreted by a Board-certified radiologist, revealed extensive emphysematous changes and no evidence of interstitial lung disease. The absence of interstitial lung disease on the CT scan undermines Dr. Baker's positive interpretation of appellant's May 2, 2012 chest x-ray.

In his May 16, 2013 report, Dr. Baker indicated that the emphysematous changes noted on appellant's CT scan could be due to dust exposure as well as cigarette smoking history, or more likely a combination of both. Based on this latest report, Dr. Baker appears to have abandoned his previous diagnosis of occupational pneumoconiosis with pulmonary asbestosis.

Dr. Haller, who examined appellant at OWCP's request, found no evidence of asbestosis or pneumoconiosis based on his December 13, 2012 evaluation. When he subsequently reviewed appellant's CT scan, Dr. Haller indicated that appellant did not have evidence of asbestosis or other pneumoconiosis. He also noted that it was very likely that appellant's emphysema was primarily due to heavy cigarette abuse.

The Board finds that the evidence of record does not support a diagnosis of pneumoconiosis and/or asbestosis. However, there is ample evidence to support a diagnosis of emphysema. Appellant has a lengthy smoking history, which Dr. Haller identified as the primary or principle cause of his emphysema. The question remains as to whether appellant's accepted employment exposure also contributed to his emphysema. Dr. Baker indicated that appellant's emphysema was more likely due to a combination of his occupational dust exposure and cigarette smoking. When questioned by counsel, Dr. Haller indicated that appellant's COPD was principally due to his tobacco abuse, and it was possible that some of his work-related dust exposure contributed to his emphysema.

Appellant need not demonstrate that his occupational exposure was the sole or primary cause of his emphysema. The FECA Procedure Manual recognizes the following types of causal relationship: (1) direct causation; (2) aggravation (temporary or permanent); (3) acceleration; and (4) precipitation.[10] As noted, Dr. Haller stated that it was possible that some of appellant's work-related dust exposure contributed to his emphysema. While he did not definitively identify appellant's employment exposure as a contributing factor, Dr. Haller also did not rule it out.

Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[11] Under the circumstances, it should seek further information and clarification from Dr. Haller.[12] Consequently, the case shall be remanded for further development. After OWCP has developed the record to the extent that it deems necessary, a *de novo* decision shall be issued.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.2 (January 2013).

[11] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

[12] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.3f(2)(a) (July 2011).

CONCLUSION

The case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the August 2, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: March 5, 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