United States Department of Labor
Employees' Compensation Appeals Board

R.P., Appellant	)	
and	)	**Docket No. 15-1893**
	)	**Issued: February 24, 2016**
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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 14, 2015 appellant, through counsel, filed a timely appeal from an August 3, 2015 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that his pulmonary condition was causally related to his employment.

FACTUAL HISTORY

On January 24, 2014 appellant, then a 56-year-old unit operator, filed an occupational disease claim (Form CA-2) alleging that he developed occupational pneumoconiosis and restrictive ventilatory defect as a result of his employment. He first became aware of his condition and realized it resulted from his employment on December 10, 2013. Appellant

[1] 5 U.S.C. § 8101 *et seq.*

explained that he first learned that he had an occupational lung disease when he reviewed the chest x-ray report of Dr. Glen Baker, a Board-certified pulmonary specialist and certified B-reader. He also noted that when he learned he had the disease he notified the employing establishment by letter dated December 10, 2013. Appellant indicated that he sometimes wore paper masks at work.

By letter dated February 19, 2014, OWCP advised appellant that the evidence submitted was insufficient to establish his claim. It requested that he provide additional factual evidence, including responses to a questionnaire, to describe what employment factors he believed contributed to his alleged injury and additional medical evidence to establish that he sustained a diagnosed condition causally related to his employment. A similar letter was sent to the employing establishment requesting information about appellant's employment duties.

On February 24, 2014 OWCP received the employing establishment's response to the development letter. It provided a December 10, 2013 letter from appellant advising the employing establishment that he would be filing a claim for federal workers' compensation. Appellant noted that his physician informed him that he had an occupational lung disease related to his employment. The employing establishment also provided a February 18, 2014 letter it sent to appellant advising him to submit a completed Tennessee Valley Authority (TVA) 9179 form.

The employing establishment submitted a list of appellant's duties and an assessment performed by an industrial hygienist regarding the potential for adverse health consequences resulting from appellant's employment. Appellant worked as a truck driver from May 1, 1978 to November 3, 1989; a fossil trainee from March 19, 1990 to December 28, 1992; an assistant unit operator from December 28, 1992 to November 20, 2000 and February 24, 2003 to October 14, 2005; and a unit operator from November 20, 2000 to February 24, 2003 and October 14, 2005 to October 4, 2013. The employing establishment provided position descriptions for appellant's various positions and pulmonary examination records by the employing establishment dated May 27, 1978 to August 24, 2012.

In a February 12, 2014 industrial assessment report, Mike Bradford, an industrial hygienist and health and safety consultant for the employing establishment, noted that while specific data of exposures to coal dust where appellant worked were unavailable in the employing establishment's data source he was able to examine the generic data for exposures to respirable coal dust and total dust between 1978 and 2013. He stated that the data consistently demonstrated that background exposure levels were below current permissible exposure limits (PEL). Mr. Bradford explained that as a unit operator, appellant was not exposed to coal dust because control room air was filtered. He reported that appellant could not have been exposed to asbestos from electrical boards, windings, and insulations because asbestos only became airborne by drilling, crushing, or pulverizing. Mr. Bradford noted that truck drivers, assistant unit operators, and unit operators did not remove insulation in the performance of their job duties, and accordingly, appellant could not have been exposed to airborne asbestos at or above the PEL. He related that an asbestos survey of the employing establishment was completed in the summer of 2011 and revealed that background levels of asbestos were below Occupational Safety and Health Administration (OSHA) and Environmental Protection Agency (EPA) guidelines for clean air. Mr. Bradford opined that by smoking one pack of cigarettes per day for five years, appellant experienced a self-imposed exposure to more than coal dust, asbestos, or any other contaminant. He pointed out that according to a 2004 report by the Department of

Health and Human Services, 90 percent of all deaths from chronic obstructive pulmonary diseases were attributable to cigarette smoking.

Mr. Bradford reported that measured background exposures to respirable dust and asbestos at the employing establishment were well under the applicable OSHA/EPA limits. He noted that the air was extensively monitored at the employing establishment and that personal protective equipment was provided to ensure that employee exposure stayed within acceptable OSHA/EPA limits. Mr. Bradford noted that appellant's job duties as a truck driver, assistant unit operator, and unit operator did not expose him above applicable air quality limits. He concluded that because exposure to respirable dust at work was consistently under the applicable OSHA limit, appellant's respiratory illness was mostly likely caused by appellant's five-year smoking history.

In a letter dated February 24, 2014, appellant responded to OWCP's development letter. He stated that he began work for the employing establishment as a truck driver in 1978. Appellant related that he was exposed to gypsum dust when he dumped dust, rock dust from the roads, and coal dust from the coal stock pile. He reported that in March 1990 he began work as an assistant unit operator and was exposed to coal dust, fly ash, flue gas, arsenic, and asbestos. Appellant noted that he could see the dust on his skin, clothing, and on all of the equipment. He indicated that the asbestos came from the insulation that would deteriorate and fall from the pipes. Appellant related that he then worked in the control room for six years. He was exposed to dust from air moving through the control room. Appellant then worked in coal handling for eight years. He was exposed to coal dust where he worked in the facility that handled the coal. Appellant was exposed to asbestos that would come from the older electrical boards, windings, shields, and insulation. He worked eight hours a day, five days a week. Appellant noted that his last day of work was on October 4, 2013.

Appellant further stated that he worked for Cowden from 1977 to 1978 in the shipping and receiving department, for Emerson Electric from 1976 to 1977, and for Wettereau in 1989 for one month. He had no exposure to dust other than some cloth dust during this employment. Appellant also worked for Brewer Machine from 1986 to 1988 performing welding and fabrication. He had exposure to welding fumes, smoke, and some metal dust. Appellant indicated that he had noticed some shortness of breath for the past 10 years that had gradually worsened over time and had occasional coughing and wheezing. He reported that he smoked cigarettes at the rate of one pack per day for 5 years, but he quit smoking 32 years ago. Appellant noted that he was including a medical report by Dr. Baker.

On January 9, 2014 appellant was evaluated by Dr. Baker for a possible occupational-induced lung disease secondary to his occupation. He noted that appellant had worked for the employing establishment for 23½ years as an assistant unit operator and as a unit operator. Dr. Baker reported that appellant was exposed to coal dust, ash, flue gas, and asbestos that were present in many areas in which he worked. He related that appellant also worked in construction for 7½ years, in a machine shop for 2 years, and other occupations for short periods of time. Dr. Baker noted that appellant last worked for the employing establishment on October 4, 2013. He pointed out that appellant smoked about 5 years at the rate of one pack per day but had quit 32 years ago. Dr. Baker reported that appellant had been short of breath primarily with dyspnea for the past 10 years and had an occasional cough and wheezing. He indicated that appellant's symptoms were aggravated by exertion, cold air, and exposure to various dust, odors, and fumes.

Dr. Baker reviewed appellant's history, including diagnostic studies. He related that a chest x-ray dated November 12, 2013 showed changes consistent with occupational pneumoconiosis and a January 4, 2014 pulmonary function studies demonstrated a mild restrictive ventilatory defect with a mild-to-moderate improvement following bronchodilators. Dr. Baker diagnosed occupational pneumoconiosis, category 2/1, with history of exposure to both coal dust and asbestos, and mild restrictive ventilatory defect based on pulmonary function testing. He reported that appellant had 10 percent impairment according to the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. Dr. Baker opined that appellant had a long history of exposure to coal dust, flue gas, ash, and asbestos for approximately 23½ years. He reported that appellant had changes consistent with occupational pneumoconiosis which would be due to his exposure to asbestos, and to some extent, his coal dust exposure. Dr. Baker concluded that appellant's mild restrictive defect was due to 23½ years of exposure to asbestos and coal dust as well as other fumes and dust that he was exposed to in his occupation. Dr. Baker provided FVC & FEV_2 testing dated January 4, 2014, which revealed mild restrictive ventilator defect on both pre and post with mild improvement following bronchodilators.

On June 16, 2014 OWCP prepared a statement of accepted facts in which it accepted that appellant was exposed to rock dust, gypsum dust, coal dust, ash, flue gas, and asbestosis during his 31 years of work at the employing establishment.

OWCP referred appellant's claim to Dr. Harold Dale Haller, Jr., Board-certified in pulmonary disease and a second-opinion examiner, along with a statement of accepted facts, to determine the relationship between his claimed condition and factors of his employment.

In a July 22, 2014 report, Dr. Haller reviewed the statement of accepted facts and Dr. Baker's report. He described appellant's employment history and exposure to various elements. Dr. Haller related appellant's complaints of respiratory problems for 10 years, including shortness of breath. He noted that before appellant began work at the employing establishment he smoked one pack or less of cigarettes per day for less than five years before quitting. Dr. Haller reviewed appellant's medical history and conducted an examination. Inspection of the nose and sinuses revealed no mucus present and normal septum. Dr. Haller reported that bilateral frontal sinuses had no tenderness. Examination of the chest and lungs demonstrated no use of accessory muscles in breathing and normal and clear breath sounds. Dr. Haller noted that appellant had dyspnea. He indicated that he was not convinced that appellant had any lung disease. Dr. Haller explained that lung function testing, with some questionable effort, revealed at most minimal restriction and with 100 percent normal diffusion, would suggest restrictive changes related to thoracic cavity, not pulmonary parenchyma. He believed that Dr. Baker based his diagnosis of occupational pneumoconiosis on a chest x-ray and explained that, although he was not a B-reader, he did not think the x-ray suggested pneumoconiosis. Dr. Haller recommended a computerized tomography (CT) chest examination. He reported that once the CT was done and the examination forwarded to him he would gladly addend his report. Regarding appellant's dyspnea, Dr. Haller opined that appellant had many possible explanations including obesity and deconditioning, heart disease, and pulmonary hypertension.

In a September 19, 2014 addendum report, Dr. Haller related that he reviewed appellant's August 27, 2014 chest CT scan and noted that the examination revealed no intrinsic interstitial

lung disease or bronchiectasis, no obvious air trapping, and no significant abnormalities in the chest. He also reported sensitivity limited due to poor expiratory effort and diffuse hepatic steatosis. Dr. Haller explained that the CT scan confirmed that there was no evidence of pneumoconiosis or other interstitial lung disease. He opined that the etiology of appellant's dyspnea was likely that as described in his previous report.

In a decision dated October 9, 2014, OWCP denied appellant's claim. It accepted that he had been exposed to hazardous materials at work, including asbestos, but denied his claim finding that the medical evidence was insufficient to show that he sustained a medical condition causally related to the exposure at work. OWCP determined that the weight of the medical evidence rested with the opinion of Dr. Haller, the second-opinion physician.

On October 22, 2014 OWCP received appellant's request, through counsel, for a hearing before an OWCP hearing representative. On May 18, 2015 a telephone hearing was held. Appellant's counsel was present. Appellant stated that he worked for the employing establishment as a truck driver from 1978 to 1985 and was exposed to dust from the roads, gypsum, and coal dust. He worked eight hours a day, five days a week, and did not wear a mask. Appellant next worked as an assistant unit operator for approximately 12 years. He asserted that he was exposed to dust throughout the powerhouse, coal feeders, ash hoppers, and dust hoppers because he was constantly cleaning them. Appellant noted that he was also exposed to coal dust in the air due to the high velocity of air that circulated throughout the units. He stated that he was also exposed to asbestos on several occasions from piping and components throughout the plant. Appellant worked rotating shifts of 8, 12, and 16 hours. He noted that he wore paper masks on occasion. Appellant then worked as a unit operator for six years. He alleged that he was still exposed to dust in the control rooms due to the large volume of air that was being circulated in the control rooms. Appellant worked four 10-hour shifts a week along with some overtime. He indicated that he retired from the employing establishment on October 4, 2013. Appellant stated that he smoked approximately 1 pack of cigarettes a day for approximately 5 years but he quit over 32 years ago. He explained that he first noticed a problem with his breathing approximately 10 years ago and that his breathing gradually worsened.

Appellant's counsel related that appellant was exposed to coal dust, fly ash, flue gas, asbestos, and some arsenic in his employment with the employing establishment for 30 plus years. He noted that the industrial assessment report from Mr. Bradford verified that there was exposure in appellant's workplace regardless of the fact that the exposure was below permissible exposure limits. Counsel also pointed out that Mr. Bradford admitted that he did not evaluate specific dust samples from appellant. He reported that there were numerous employees at the employing establishment who received workers' compensation for occupational lung diseases and provided their names. Counsel stated that Dr. Baker was a Board-certified pulmonary specialist who was certified by the National Institute of Occupational Safety and Health (NIOSH) and was a B-reader who was qualified to read chest x-rays for purposes of determining the existence of occupational lung diseases. He alleged that Dr. Baker was better qualified than most physicians to interpret x-rays for purposes of determining the existence of occupational lung diseases. Counsel asserted that Dr. Haller's report should not carry the weight of medical evidence since he was not a B-reader and could not accurately read appellant's chest x-rays. He also noted that, while Dr. Haller's report relied on an August 27, 2014 CT scan report, the report was not available. Counsel further alleged that, if Dr. Baker's report did not carry the weight of medical opinion, it at least created a conflict in medical opinion regarding the cause of

appellant's pulmonary condition. He stated that he would include a report from Dr. Vuskovich regarding the use of CT scans in these types of cases.

In a May 6, 2008 report, Dr. Matthew A. Vuskovich, Board-certified in preventive medicine, explained that as a "B" reader he did not interpret CT scan images for the appearances of coal workers' pneumoconiosis. He reported that CT scans effectively "wash out" the pneumoconiosis lesions because they visualize a thin slice of the tissue. Accordingly, the "false negative" rate for CT scans was prohibitively high. Dr. Vuskovich reported that CT imaging should not be used to establish a positive pneumoconiosis diagnosis and to accurately determine the severity of the disease chest CT scan.

On June 19, 2015 the employing establishment provided comments to the hearing transcript. It alleged that there was no evidence to demonstrate that appellant was ever exposed to coal dust or any other substance in the air at a level in excess of the OSHA permissible exposure limit. The employing establishment noted that the assessment report by Mr. Bradford confirmed that appellant was never exposed to respirable coal dust or asbestos at a level that exceeded permissible exposure limits. It noted that in the case, *M.W.*,[2] the Board determined that exposures below the PEL could not be deemed a cause of a diagnosed condition. The employing establishment related that appellant had no exposure when working as a unit operator in the control rooms as the air was filtered, and half and full-face respirators for protection, not simply paper masks. It explained that paper masks were provided as a courtesy but only to individuals who had no chance of being exposed above OSHA's PEL limits. In addition, the employing establishment disagreed that Dr. Baker's reliance on a chest x-ray for a diagnosis of pneumoconiosis was proper. It explained that according to the NIOSH, chest radiograph findings alone were insufficient to confirm the diagnosis of pneumoconiosis. The employing establishment asserted that CT scans, as Dr. Haller requested, should be considered in addition to a chest x-ray.

In a letter dated July 7, 2015, appellant's counsel again contended that Mr. Bradford did not test the actual dust samples to which appellant was exposed. He further reported that even though exposure levels were below PEL, there was no safe level of exposure to asbestos according to the Department of Labor's "Safety and Health Topics, Asbestos" page. Counsel alleged that the fact that the studies provided by the employing establishment showed the presence of asbestos, this indicated that exposure was possibly and probably harmful. He also distinguished the facts of appellant's case from *M.W.* Counsel disagreed that the case held that exposure levels below PEL could not be deemed a cause of a diagnosed condition. Counsel again reiterated Dr. Baker's qualifications and alleged that his report should bear the weight of medical evidence.

By decision dated August 3, 2015, an OWCP hearing representative denied modification of the October 9, 2014 decision. She found that appellant had not submitted the necessary medical evidence to establish a diagnosed condition causally related to the accepted employment factors.

[2] 57 ECAB 710 (2006).

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[4] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[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 condition and the specific employment factors identified by the employee.[7]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[8] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[9] When there exists 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.[10]

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[3] *J.P.,* 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

[4] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.,* 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[5] *R.H.,* 59 ECAB 382 (2008); *Ernest St. Pierre,* 51 ECAB 623 (2000).

[6] *I.R.,* Docket No. 09-1229 (issued February 24, 2010); *D.I.,* 59 ECAB 158 (2007).

[7] *I.J.,* 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[8] 5 U.S.C. § 8123(a); *see R.S.,* Docket No. 10-1704 (issued May 13, 2011); *S.T.,* Docket No. 08-1675 (issued May 4, 2009).

[9] 20 C.F.R. § 10.321.

[10] *Darlene R. Kennedy,* 57 ECAB 414 (2006); *Gloria J. Godfrey,* 52 ECAB 486 (2001).

ANALYSIS

Appellant alleges that he sustained a pulmonary condition as a result of exposure to coal dust, gypsum, and asbestos at his employment. OWCP accepted that he had been exposed to rock dust, gypsum dust, coal dust, ash, flue gas, and asbestosis in his federal employment. However, it denied appellant's claim finding insufficient medical evidence to establish that he sustained a diagnosed condition causally related to his employment duties. OWCP determined that the weight of the medical evidence regarding this matter rested with the opinion of Dr. Haller, an OWCP referral physician, who found that appellant had not sustained occupational pneumoconiosis as a result of his employment.

The Board finds that this case is not in posture for decision regarding whether appellant has an employment-related pulmonary condition due to a conflict in medical opinion evidence.

In support of his claim, appellant submitted a January 9, 2014 report by Dr. Baker. He related that appellant had worked for the employing establishment for 23½ years and was exposed to coal dust, ash, flue gas, and asbestos in many areas that he worked in. Dr. Baker reported that appellant had been short of breath primarily with dyspnea for the past 10 years and had an occasional cough and wheezing. He indicated that appellant had lung disease secondary to his occupation. Dr. Baker reviewed appellant's history and conducted an examination. He diagnosed occupational pneumoconiosis, category 2/1, with history of exposure to both coal dust and asbestos, and mild restrictive ventilatory defect based on pulmonary function testing. Dr. Baker reported that appellant had changes consistent with occupational pneumoconiosis which would be due to his exposure to asbestos, and to some extent, his coal dust exposure. He concluded that appellant's mild restrictive defect was due to 23½ years of exposure to asbestos and coal dust as well as other fumes and dust that he was exposed to in his occupation.

In contrast to Dr. Baker's opinion, however, Dr. Haller, the OWCP referral physician, opined in reports dated July 22 and September 19, 2014 that appellant did not have occupational pneumoconiosis as a result of his employment. He reviewed appellant's history and conducted an examination. Dr. Haller noted that appellant had dyspnea. He was not convinced that appellant had any lung disease. Dr. Haller explained that lung function testing, with some questionable effort, revealed at most minimal restriction and, with 100 percent normal diffusion, which would suggest restrictive changes in the thoracic cavity not pulmonary parenchyma. In a September 19, 2014 report, he explained that a CT scan confirmed that there was no evidence of pneumoconiosis or other interstitial lung disease. Dr. Haller opined that appellant had many possible explanations for his dyspnea, including obesity and deconditioning, heart disease, and pulmonary hypertension.

As previously stated, when there are opposing medical reports of virtually equal weight and rationale, the case must be referred to a referee physician to resolve the conflict in the medical evidence.[11]

The Board found in a factually similar case, *R.H.*[12] That a conflict existed in the medical opinion between Dr. Baker, a certified B-reader and Board-certified pulmonologist, who

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[11] *Supra* note 8.

[12] Docket No. 14-0452 (issued June 18, 2014).

diagnosed occupational pneumoconiosis based upon x-ray examination, and Dr. Haller, a Board-certified pulmonologist, who found no evidence of pneumoconiosis, or interstitial lung disease based upon CT evaluation.

In this case, the Board finds that there is a conflict of opinion between Dr. Baker, appellant's treating physician, and Dr. Haller, the OWCP referral physician, with respect to whether appellant has occupational pneumoconiosis as a result of his employment.[13] Furthermore, the Board notes that while Dr. Haller mentioned reviewing an August 27, 2012 CT scan the record does not contain this report. On remand, OWCP should refer appellant's case and the complete case record, including the August 27, 2012 CT scan report, to an impartial medical examiner, who is an appropriate B-reader, for resolution of the conflict in accordance with section 8123(a) of FECA and the implementing regulations.[14] After such further development as OWCP deems necessary, it should issue an appropriate decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the August 3, 2015 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: February 24, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

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[13] *See T.R.,* Docket No. 14-1919 (issued May 7, 2015).

[14] *Supra* note 12.