United States Department of Labor
Employees' Compensation Appeals Board

T.M., Appellant	)	
and	)	**Docket No. 16-0022**
	)	**Issued: February 8, 2016**
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:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On October 7, 2015 appellant, through counsel, filed a timely appeal from a September 4, 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 a pulmonary condition causally related to his federal employment.

On appeal appellant's counsel asserts that the medical evidence of record establishes that appellant has an employment-related pulmonary condition or, in the alternative, that a conflict in medical evidence has been created, requiring evaluation by a referee physician.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On April 22, 2014 appellant, then a 62-year-old retired heavy equipment operator, filed an occupational disease claim (Form CA-2) alleging that work duties in his federal employment caused occupational pneumoconiosis with pulmonary asbestosis and a chronic cough. He indicated that he first became aware of the disease and its relationship to his federal employment on January 28, 2014. The employing establishment reported that appellant was last exposed to work conditions on October 4, 2013 and first reported the claimed condition on May 2, 2014.

In letters dated May 13, 2014, OWCP informed appellant of the evidence needed to support his claim and asked the employing establishment to reply to appellant's allegations by submitting exposure data and appellant's employment history.

In an undated statement, appellant related that he worked for the employing establishment as a heavy equipment operator from 1977 until he retired on October 4, 2013. He noted that he had never smoked and claimed employment exposure to coal dust and asbestos. Appellant indicated that after his retirement he worked in private industry as a crane operator where he was not exposed to coal dust. He attached a heavy equipment operator job description.

By report dated March 25, 2014, Dr. Glen Baker, Board-certified in internal medicine and pulmonary disease and a certified B-reader, described appellant's employment history where he was exposed to coal dust and asbestos. He advised that appellant had never smoked and had daily symptoms of cough, sputum production, wheezing, and sleep apnea. Dr. Baker reported appellant's height as 70 inches and weight of 272 pounds. He indicated that pulmonary function studies on March 21, 2014 revealed a mild restrictive ventilator defect with no significant improvement following bronchodilators, and that a November 26, 2013 chest x-ray demonstrated evidence of occupational pneumoconiosis, category 1/1, suggestive of pulmonary asbestosis. Lungs were clear to auscultation and percussion on physical examination. Dr. Baker diagnosed occupational pneumoconiosis with pulmonary asbestosis, category 1/1, secondary chronic cough, and mild restrictive ventilatory defect, secondary to pulmonary fibrosis as shown on the chest x-ray. He concluded that appellant's diagnoses were due to his occupational pulmonary asbestosis and his coal dust exposure.

In a May 14, 2014 statement, Mike Bradford, an industrial hygienist at the employing establishment, noted appellant's job history. He described current and historical data for coal dust and asbestos exposure, which he maintained was within the Office of Safety and Health Administration and the Environmental Protection Agency guidelines. Employing establishment physical examination reports dated August 1, 1977, February 8, 1988, and August 1, 2013 were submitted. The signatures on the reports were illegible.

In July 2014 OWCP referred appellant and the medical record to Dr. Harold D. Haller, Jr., Board-certified in internal medicine and pulmonary disease, for a second opinion evaluation. The statement of accepted facts contained in the record chronicled employment exposure to asbestos and coal dust from 1977 to 2013. In a July 21, 2014 report, Dr. Haller noted appellant's medical history as well as his employment history. He reported that appellant never smoked and described complaints of dyspnea on exertion and when lying down. Dr. Haller recorded a weight of 270.5 pounds and height of 70.5 inches. He opined that appellant was markedly obese. Chest

and lung examination demonstrated normal, clear breath sounds. Dr. Haller reported that spirometry was suggestive of restriction but demonstrated less than optimal inspiratory effort. Chest x-ray demonstrated mild degenerative changes in the thoracic spine. Lungs were clear with no definite infiltrates or masses, and slightly prominent interstitial markings which, Dr. Haller opined, could be due to body habitus as opposed to interstitial disease. An electrocardiogram demonstrated normal sinus rhythm. Dr. Haller advised that the etiology of appellant's dyspnea was unclear, finding it most likely due to his morbid obesity. He recommended a computerized tomography (CT) scan of the chest to determine if appellant had interstitial disease.

In an August 15, 2014 supplemental report, Dr. Haller noted that a high resolution chest CT scan was performed on August 12, 2014 and was interpreted by Dr. L. Sharon Smith, a Board-certified radiologist, as showing minimal chronic lung disease compatible with the patient's age, and that the study revealed no findings diagnostic of significant interstitial lung disease. He indicated that, based on the CT scan report and his history and examination, he did not believe appellant suffered from a primary pulmonary pathology, opining rather that appellant had thoracic restriction due primarily to his morbid obesity. Dr. Haller further noted that, since appellant had normal diffusion capacity and the CT scan did not demonstrate pulmonary vascular enlargement, it was unlikely that pulmonary hypertension was the cause of his dyspnea.[2]

On November 6, 2014 Dr. Eric Puestow, an OWCP medical adviser who is Board-certified in internal medicine and endocrinology, noted his review of Dr. Haller's report. He opined that he concurred with Dr. Haller's assessment that appellant's restrictive changes were due to obesity and that he had no evidence of any employment-related lung pathology.

By decision dated November 6, 2014, OWCP found that appellant had been exposed to dust and asbestos, but denied the claim based on Dr. Haller's opinion as supported by OWCP's medical adviser that a medical condition was not causally related to the employment exposure.

Appellant, through counsel, timely requested a hearing before an OWCP hearing representative. He submitted a May 3, 2015 report in which Dr. Matthew A. Vuskovich, Board-certified in occupational medicine and a B-reader, read the November 26, 2013 x-ray. Dr. Vuskovich indicated that appellant had 1/1 small opacities and no pleural abnormalities. He attached a May 6, 2008 report in which he opined that, as a B-reader, he did not interpret CT scans for pneumoconiosis as there were no standard images. Dr. Vuskovich further noted that high resolution CT scans effectively washed out pneumoconiosis lesions because they visualized a thin slice of tissue and this resulted in prohibitively high false negatives. He concluded that to establish a positive pneumoconiosis diagnosis and to accurately determine the severity of the disease, chest CT scan imaging should not be utilized.

At the hearing, held on June 11, 2015, appellant testified regarding his federal employment and exposure to coal dust and asbestos and described complaints of coughing and shortness of breath. Counsel noted that neither Dr. Haller nor Dr. Puestow were B-readers and

[2] Dr. Smith's August 12, 2014 CT scan of the chest was submitted to OWCP on November 7, 2014. She advised that the study demonstrated minimal chronic lung disease compatible with the patient's age. There were no findings diagnostic of significant interstitial lung diseases.

asserted that the reports of Dr. Baker and Dr. Vuskovich established that appellant had an employment-related pulmonary condition.

In correspondence dated July 17, 2015, Mike Patty, an employing establishment analyst, discussed appellant's employment exposure. He maintained that the November 6, 2014 decision should be affirmed. On July 23, 2015 counsel disagreed with Mr. Patty's assertions and reiterated his argument that the claim should be accepted or a conflict in medical evidence should be found.

On September 4, 2015 an OWCP hearing representative affirmed the November 6, 2014 decision, finding that Dr. Haller's opinion constituted the weight of the medical evidence.

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/or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves a traumatic injury or an occupational disease, an employee must satisfy this burden of proof.[3]

OWCP 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 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

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

[4] 20 C.F.R. § 10.5(ee).

[5] *Supra* note 3.

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

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]

Section 8123(a) of FECA provides that 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.[9]

ANALYSIS

The Board finds that this case is not in posture for decision as a conflict in medical evidence has been created between the opinions of Dr. Baker, appellant's physician, and Dr. Haller, an OWCP referral physician, regarding whether appellant has established an employment-related pulmonary condition.

In his March 25, 2014 report, Dr. Baker, a Board-certified pulmonologist and certified B-reader, described appellant's employment exposure of asbestos and coal dust, his pulmonary symptoms, and provided physical examination findings. He reviewed pulmonary function studies and November 26, 2013 x-ray findings. Based on these studies, Dr. Baker diagnosed occupational pneumoconiosis with pulmonary asbestosis, category 1/1, secondary chronic cough, and mild restrictive ventilatory defect, secondary to pulmonary fibrosis. He concluded that appellant's diagnoses were due to his occupational exposure to asbestos and his coal dust.

Likewise, Dr. Haller is Board-certified in pulmonology. In his initial report dated July 21, 2014, Dr. Haller noted appellant's history of employment exposure to coal dust and asbestos and his complaints. He provided physical examination findings and reviewed pulmonary function studies and his chest x-ray of July 21, 2014. At that time Dr. Haller advised that the etiology of appellant's dyspnea was unclear and recommended a CT scan of the chest to determine if appellant had interstitial disease. In an August 15, 2014 report, he noted that a high resolution CT scan of the chest, performed on August 12, 2014, showed minimal chronic lung disease compatible with the patient's age, and revealed no findings diagnostic of significant interstitial lung disease. Dr. Haller indicated that, based on the CT scan report and his history and examination, he did not believe that appellant had a primary pulmonary pathology, but rather that appellant had thoracic restriction due primarily to his morbid obesity.

As previously noted, if there is disagreement between an OWCP physician and the employee's physician, OWCP will appoint a third physician who shall make an examination.[10] For a conflict to arise, the opposing physician's viewpoints must be of virtually equal weight and rationale.[11] The Board finds the opinions of Dr. Baker and Dr. Haller to be of equal weight.

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

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

[9] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[10] *Id.*

[11] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

Both physicians are Board-certified in pulmonology. The Board finds that a conflict in medical opinion evidence has been created regarding whether appellant met his burden of proof to establish an employment-related pulmonary condition. The Board will set aside the September 4, 2015 decision and remand the case for OWCP to refer appellant to an appropriate impartial medical specialist to resolve the conflict. After such further development as it deems necessary, OWCP shall issue a *de novo* decision regarding whether appellant met his burden of proof to establish an employment-related pulmonary condition.

CONCLUSION

The Board finds this case is not in posture for decision regarding whether appellant met his burden of proof to establish an employment-related pulmonary condition. A conflict in medical evidence has been created which requires further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the September 4, 2015 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: February 8, 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