

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

M.S., Appellant)

and)

**DEPARTMENT OF LABOR, MINE SAFETY &
HEALTH ADMINISTRATION, Trinidad, CO,
Employer**)

**Docket No. 15-1465
Issued: March 14, 2016**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 29, 2015 appellant filed a timely appeal from an April 20, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 an occupational disease causally related to factors of his federal employment.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 20, 2014 appellant, then a 70-year-old retired mine inspector, filed an occupational disease claim (Form CA-2) alleging that working in underground mines with airborne dust caused breathing problems and chronic obstructive pulmonary disease (COPD).

In support of his claim, appellant submitted a February 2, 2010 report in which Dr. Cecile Rose, a Board-certified internist who was the medical director of the Miners Clinic of Colorado, provided a history that he had worked approximately 27 years as a coal miner with 8 years underground and 19 years above ground. Dr. Rose reported that when seen for a clinic visit on December 9, 2009 appellant complained of symptoms of cough, phlegm, and breathlessness. She described physical examination findings, noting normal lung sounds. Dr. Rose noted that appellant had difficulty performing a pulmonary function test, that his oxygen saturation was normal, and that a chest x-ray B-reading showed no evidence for dust disease (pneumoconiosis) of the lungs. She concluded that, based on the results of his evaluation, he did not appear to have a work-related lung disease at that time.

A January 17, 2014 chest x-ray at the Miners Clinic demonstrated linear opacities in the left lower lung zone, aortic atherosclerosis, and no radiographic evidence of an acute cardiopulmonary process. A pulmonary function study that day was interpreted as normal. In a March 5, 2014 report, Dr. Rose reported the results of appellant's January 17, 2014 evaluation, noting the normal pulmonary function test, and advised that his oxygen saturation was normal. She noted that the chest x-ray, read by a certified B-reader, showed no evidence of pneumoconiosis, but revealed an abnormal appearance of the diaphragm. Dr. Rose recommended a chest computerized tomography (CT) scan. She concluded that appellant did not appear to have a work-related lung disease at that time.

An April 16, 2014 CT scan of the chest demonstrated COPD and small mediastinal lymph nodes. Oxygen saturation testing on June 16, 2014 was five percent below baseline.

By letter dated December 18, 2014, OWCP informed appellant of the evidence needed to support his claim. This was to include a medical report with a physician's opinion supported by a medical explanation as to whether his work exposure caused a specific condition or diagnosis and, if so, an explanation of how the work exposure contributed to his condition. Appellant was asked to provide the information within 30 days.

In a January 3, 2015 response, appellant stated that, while working as a mine inspector he was exposed to many hazards such as coal dust. He stated that in the late 1990s he began to experience breathing problems and his energy level declined. Appellant maintained that he had no other exposure to irritants and had not worked since he retired.

In correspondence dated February 10 and 24, 2015, the employing establishment advised that appellant had retired approximately 15 years previously and that his duties as a mine inspector required him to travel into underground mines, and that he participated in an agency screening program for lung disease.

The employing establishment submitted medical reports dated from 1989 to 1996. An August 30, 1989 respirator fit test demonstrated normal breathing and deep breathing. A July 12, 1990 medical examination noted no problems.² A July 12, 1990 chest x-ray demonstrated no active disease. July 12, 1990 pulmonary function test results exceeded predicted. Dr. Francis T. Visconti, a family physician, performed a fitness-for-duty examination on July 22, 1993. He reported normal breath sounds on examination and advised that appellant had no limiting conditions for his job as mine inspector. An August 2, 1993 chest x-ray showed no active cardiopulmonary disease process. Pulmonary function test results that day exceed normal predictions. Dr. Sally Fabec, a Board-certified internist, performed an in-service physical examination on July 30, 1996. She reported no findings or recommendations. An unsigned July 31, 1996 resting electrocardiogram was read as abnormal. A chest x-ray that day was normal.

By decision dated April 20, 2015, OWCP denied the claim. It found that workplace exposure occurred and that COPD was diagnosed by x-ray. However, OWCP denied the claim because appellant had not submitted a report from a treating physician with a sufficient medical explanation of how the claimed conditions were causally related to factors of his federal employment.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden 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 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 and regardless of whether the asserted claim involves traumatic injury, or 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

² The signature of the examiner is illegible.

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

⁴ 20 C.F.R. § 10.5(ee).

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 found that appellant established that he had workplace exposure and that an April 16, 2014 x-ray diagnosed COPD, but denied the claim because he failed to submit medical evidence sufficient to establish a causal relationship between the work exposure and a diagnosed medical condition.

The medical evidence includes a number of medical reports from the employing establishment dated 1989 to 1996. None of these reports, however, indicated that appellant had an employment-related health condition. While a July 31, 1996 resting electrocardiogram was read as abnormal, the report did not contain a signature and, more importantly did not describe of a cause of the observed abnormality. A medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a “physician” as defined in section 8102(2) of FECA. Medical reports that lack proper identification, such as unsigned treatment notes, do not constitute probative medical evidence.⁹ Likewise, 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.¹⁰

Appellant submitted reports dated February 2, 2010 and March 5, 2014 from Dr. Rose, medical director of the Miners Clinic of Colorado. In each of these reports Dr. Rose concluded that based on the results of December 9, 2009 and January 17, 2014 evaluations which included pulmonary function studies and B-reader x-ray findings, he did not appear to have a work-related lung disease at that time. Attached were appropriate chest x-rays and pulmonary functions

⁵ *Supra* note 3.

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

⁷ *Leslie C. Moore*, 52 ECAB 132 (2000).

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

⁹ 5 U.S.C. § 8101(2) of FECA provides as follows: (2) physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State Law. *See B.B.*, Docket No. 09-1858 (issued April 16, 2010); *supra* note 3.

¹⁰ *Willie M. Miller*, 53 ECAB 697 (2002).

studies for the 2014 examination, each interpreted as normal. While an April 16, 2014 CT scan showed COPD and a June 16, 2014 oxygen saturation test was five percent below baseline, these reports did not include any medical opinion as to what caused the reported conditions. As noted above, 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.¹¹

In a December 18, 2014 letter, OWCP informed appellant that he should provide a medical report with a physician's opinion describing how employment exposure contributed to his diagnosed condition. Appellant did not do so. There is, therefore, no medical evidence of record from a physician explaining how his workplace exposure caused or contributed to a diagnosed medical condition.

It is appellant's burden to establish that the claimed COPD or difficulty breathing were causally related to factors of his federal employment. He submitted insufficient evidence to show that he sustained a lung or other condition caused by workplace exposure.

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 did not meet his burden of proof to establish an occupational disease causally related to factors of his federal employment.

¹¹ *Id.*

ORDER

IT IS HEREBY ORDERED THAT the April 20, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 14, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

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