United States Department of Labor
Employees' Compensation Appeals Board

V.N., Appellant	)	
	)	**Docket No. 16-0238**
and	)	**Issued: March 1, 2016**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Marion, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 23, 2015 appellant, through counsel, filed a timely appeal from a June 15, 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 lung condition causally related to factors of his federal employment.

FACTUAL HISTORY

On November 19, 2013 appellant, then a 46-year-old cook, filed an occupational disease claim (Form CA-2) alleging that on November 23, 2011 he first became aware of a six-millimeter mass on his bronchial tube. He stated that on May 17, 2012 he first realized that his

[1] 5 U.S.C. § 8101 *et seq.*

condition was caused or aggravated by inhaling bird feces and debris while cleaning a nest at work. In an undated narrative statement, appellant related that in 2009 his supervisor ordered him to remove bird nests and feces from windows in the food service courtyard. As he supervised an inmate crew removing bird nests and feces with paint scrapers, he inhaled the waste when the inmates threw the nests to the ground. Appellant noted that in October 2010 he was diagnosed with pneumonia. Three months later, on two occasions, he was again diagnosed with the same condition. A computerized axial tomography (CAT) scan revealed a mass on his right lung. Appellant related that on October 21, 2011 he underwent a lobectomy to remove a bronchial tube and one quarter of the tissue from his right lung.

By letter dated January 2, 2014, OWCP informed appellant of the deficiencies in his claim and afforded him 30 days to submit additional factual and medical evidence. It also requested that the employing establishment respond to appellant's allegations and submit pertinent evidence. Appellant did not submit the requested evidence.

In a March 17, 2014 decision, OWCP denied appellant's occupational disease claim. It found that he failed to submit any medical evidence to establish that he had a medical diagnosis in connection with the claimed event and/or work factors.

By letter dated March 21, 2014, appellant, through counsel, requested a telephone hearing with an OWCP hearing representative. The hearing was held on October 14, 2014. Appellant submitted additional evidence. In reports dated October 21, 2010 to February 16, 2012, Dr. James O. Alexander, a Board-certified family practitioner, provided appellant's history and examination findings. He diagnosed right middle lobe (RML) pneumonia, epididymitis on the right, left lateral epicondylitis, a right middle lobe mass that was likely inflammatory, noncardiac chest pain, gastroesophageal reflux disease (GERD), acute bronchitis, hypertension, vertigo, atypical chest pain, left arm paresthesias, left neck pain, and an endobronchial lesion/growth.

Appellant submitted various laboratory test results and diagnostic studies dated August 12 to December 14, 2011 that were either unsigned or from Dr. Chandrashek Padmalatha, a Board-certified pathologist, Dr. Justin R. Hodge, a Board-certified radiologist, or Dr. H.T. Youssef, a Board-certified radiologist. The reports addressed his lung, chest, abdomen, and pelvis conditions. Reports dated August 18, 2011 to January 3, 2012 from Southern Illinois Respiratory Disease Clinic contained illegible signatures. The reports provided examination findings and addressed appellant's lung conditions. Appellant also provided evidence from a nurse practitioner and physician assistants.

In a September 8, 2011 report, Dr. Kenneth E. Saum, a Board-certified thoracic surgeon, noted appellant's history of recurrent pneumonia over the past year, reviewed his medical records, including a CAT scan, and provided examination findings. He believed that appellant had a broncholith adjacent to his middle lobe bronchus. Dr. Saum recommended a referral to an infectious disease specialist. In reports dated September 8 and 9, 2011, he provided appellant's history and findings on examination. Dr. Saum provided an impression of broncholith, psuedonomas lung infection, pigeon lung exposure, and animal hide exposure. He addressed appellant's treatment plan. In letters dated October 19 and December 2, 2011, Dr. Saum noted that appellant was scheduled for surgery on October 21, 2011 and following this surgery, he would be off work until January 2, 2012. In a report dated October 25, 2011, he provided a

history that appellant initially presented with hemoptysis in 2010 and previous multiple bouts of pneumonia. Dr. Saum also provided a history of his medical treatment. He reported findings and a principle diagnosis of an October 21, 2011 fiber optic bronchoscopy with biopsies, a rigid bronchoscopy, and a right thoracotomy with a right middle lobectomy and multilevel intercostal nerve block. Dr. Saum's secondary diagnoses included broncholith, hemoptysis, cluster headaches, history of gastrointestinal bleed, nephropathy secondary to injury, and history of pneumonias. He listed appellant's discharge medications and instructions.

In a November 5, 2014 report, Dr. Erica E. Kaufman, a Board-certified internist, provided appellant's description of his work activities. She related that he was forced to clean up areas with a lot of pigeon feces without wearing a mask. Dr. Kaufman noted appellant's subjective complaints of recurrent pneumonia and approximately six episodes of coughing and shortness of breath within 12 months. She provided examination findings and diagnostic test results. Dr. Kaufman diagnosed recurrent pneumonia due to bronchial narrowing from a calcified lymph node. She advised that the calcification was presumably due to a prior Histoplasma infection. Appellant's pathology showed old granuloma without any organism seen. Dr. Kaufman opined that the described work activities were the direct and proximate cause of the diagnosed conditions.

By decision dated December 23, 2014, an OWCP hearing representative affirmed the March 17, 2014 decision, finding that the medical evidence submitted failed to establish a causal relationship between the claimed medical conditions and the established work exposure.

By letter dated March 26, 2015, appellant, through counsel, requested reconsideration and submitted additional medical evidence. In a May 17, 2012 letter, Dr. Kaufman reiterated her diagnosis of recurrent pneumonia and appellant's frequency of episodes associated with this condition. She noted that a bronchoscopy showed a mass in the right middle bronchus. Dr. Kaufman noted Dr. Saum's finding that the mass was due to a calcified lymph node from an old histoplasmosis infection. She advised that appellant was succumbing to recurrent pneumonias due to the bronchial narrowing. Operative room cultures from his October 21, 2011 right middle lobectomy showed only methicillin resistant staphylococcus aureus. Appellant's urine Histoplasma antigen was negative. He took 12 weeks of Iitraconazole as his clinical picture was most suspicious for a previous Histoplasma infection that caused a calcified lymph node, which caused postobstructive pneumonias. Dr. Kaufman noted that Histoplasma was endemic to the area and associated with bird and bat droppings. Appellant reported to her that he was required to clean up areas at work that had a large amount of bird droppings. Dr. Kaufman concluded that he was doing well postoperatively and no further infectious disease consultation was required. In a February 22, 2015 questionnaire, she reiterated her prior findings and opinion on causal relationship. Dr. Kaufman maintained that the most common cause of a calcified lymph node in the bronchial area, given appellant's work exposure, was Histoplasma.

In a June 15, 2015 decision, OWCP denied modification of the December 23, 2014 decision. It found that the medical evidence submitted did not contain a rationalized medical opinion to establish a causal relationship between appellant's diagnosed condition and the established work exposure.

On appeal counsel contends that OWCP's decision is contrary to fact and law.

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 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]

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 employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable 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.[4]

ANALYSIS

OWCP accepted the work factors that appellant supervised the cleaning and removal of bird nests and feces while working as a cook. The Board finds, however, that the medical evidence of record is insufficient to establish that he sustained a lung condition caused or aggravated by the accepted work factors.

Dr. Kaufman's May 17, 2012 and November 5, 2014 reports and a February 22, 2015 questionnaire found that appellant had recurrent pneumonia as a result of cleaning up areas with pigeon feces. She reasoned that, given his work exposure, the diagnosed condition was due to bronchial narrowing from a calcified lymph node which was presumably due to a prior Histoplasma infection. However, Dr. Kaufman failed to explain the mechanism of injury by detailing how the established work factors would cause the diagnosed condition. The Board has consistently held that a medical opinion not fortified by rationale is of limited probative value.[5]

[2] *C.S.*, Docket No. 08-1585 (issued March 3, 2009); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[3] *S.P.*, 59 ECAB 184 (2007); *Victor J. Woodhams*, 41 ECAB 345 (1989); *Joe D. Cameron*, 41 ECAB 153 (1989).

[4] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams, id.*

[5] *M.H.*, Docket No. 12-733 (issued September 5, 2012).

Dr. Alexander's reports dated October 21, 2010 to February 16, 2012 found that appellant had RML pneumonia, epididymitis on the right, left lateral epicondylitis, a right middle lobe mass that was likely inflammatory, noncardiac chest pain, GERD, acute bronchitis, hypertension, vertigo, atypical chest pain, left arm paresthesias, left neck pain, and an endobronchial lesion/growth. He did not provide any specific opinion addressing whether appellant's diagnosed conditions were caused or aggravated by the established employment factors. Medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value.[6]

Dr. Saum indicated an impression of broncholith, psuedonomas, lung infection, and pigeon lung exposure. Similarly, his reports and the diagnostic test results from Drs. Padmalatha, Hodge, and Youssef are of limited probative value. The physicians addressed appellant's medical conditions, including his lung conditions and disability for work, but failed to provide an opinion addressing whether the diagnosed conditions were caused or aggravated by the established employment factors.[7]

The reports from the physician assistants and a nurse practitioner have no probative medical value as physician assistants and nurse practitioners are not considered physicians as defined under FECA.[8]

Likewise, the unsigned laboratory test results and reports dated August 18, 2011 to January 3, 2012 from Southern Illinois Respiratory Disease Clinic with illegible signatures have no probative medical value. Reports that are unsigned or bear illegible signatures, lack proper identification, and cannot be considered probative medical evidence because they lack proper identification.[9]

Appellant's belief that factors of employment caused or aggravated his condition is insufficient, by itself, to establish causal relationship.[10] The issue of causal relationship is a medical one and must be resolved by probative medical opinion from a physician. The Board finds that there is insufficient medical evidence of record to establish that appellant's lung condition was caused or aggravated by the established employment factors. Appellant did not meet his burden of proof.

On appeal counsel contends that OWCP's decision is contrary to fact and law. For the reasons stated above, the Board finds that counsel's argument is not substantiated.

---

[6] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[7] *Id.*

[8] The term physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. 5 U.S.C. § 8101(2). *See L.B.*, Docket No. 13-1253 (issued September 18, 2013) (physician assistants, physical therapists, and nurse practitioners do not qualify as physicians under FECA and, therefore, their medical reports do not qualify as probative medical evidence, unless such medical reports are countersigned by a physician).

[9] *Thomas L. Agee*, 56 ECAB 465 (2005); *Richard F. Williams*, 55 ECAB 343 (2004).

[10] 20 C.F.R. § 10.115(e); *Phillip L. Barnes*, 55 ECAB 426, 440 (2004).

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 a lung condition causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the June 15, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 1, 2016
Washington, DC

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

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

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