United States Department of Labor
Employees' Compensation Appeals Board

D.K., Appellant	)	
and	)	**Docket No. 16-0859**
	)	**Issued: October 14, 2016**
TENNESSEE VALLEY AUTHORITY, Chattanooga, TN, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 22, 2016 appellant, through counsel, filed a timely appeal from a February 2, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant established that he suffered from a pulmonary condition causally related to factors of his federal employment.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel contends that an OWCP hearing representative totally ignored the well-rationalized opinion of appellant's physician when analyzing appellant's claim. He further contends that the weight of the medical evidence rests with the opinions of appellant's treating physicians, and that at a minimum, appellant should have been referred to an impartial medical examiner to resolve a conflict in medical opinion evidence between appellant's physicians and the physician who conducted the second opinion for OWCP.

FACTUAL HISTORY

On September 19, 2014 appellant, then a 63-year-old boilermaker, filed an occupational disease claim (Form CA-2) alleging that he suffered from occupational pneumoconiosis with pulmonary asbestosis and chronic obstructive pulmonary disease (COPD) as a result of his federal employment. He did not indicate on the claim form that he had stopped work and he did not submit any evidence with his claim.

By letter dated October 7, 2014, OWCP informed appellant that further information, including medical evidence, was necessary to support his claim. It afforded him 30 days to submit this information.

Appellant submitted a statement detailing his work assignments for the employing establishment and elsewhere for the Boilermakers Union since 1978. He noted that his work exposed him to coal dust on a daily basis, as well as asbestos, flue gas, fly ash, welding smoke, fumes and grinding dust. Appellant indicated that he has had shortness of breath and has used inhalers since approximately 2006. He also noted that he smoked cigarettes for 30 years at the rate of one and one-half to two packs a day, but indicated that he quit smoking 14 years ago. A copy of appellant's work record was submitted that supported his statement regarding his employment history.

In an August 26, 2014 medical report, Dr. Glen Baker, a physician Board-certified in internal medicine and pulmonary disease, noted appellant's work history as a boilermaker for 26 years and listed appellant's various job assignments. He noted that appellant would occasionally wear a paper mask, or a more substantial mask, but that he did not wear a mask at all times. Dr. Baker noted that appellant had been short of breath for the past 15 to 16 years, primarily with dyspnea on exertion. He interpreted a chest x-ray as showing occupational pneumoconiosis category 1/0. Dr. Baker also found mild obstructive ventilatory defect on pulmonary function testing. He stated that with appellant's FEV_1 of 77 percent he would have a class 1 B, 4 percent impairment based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (2009). Dr. Baker concluded that appellant worked as a boilermaker for 26 years with exposure to asbestos coal dust as well as other dusts, fumes, and odors of unclear etiology. He noted that appellant had x-ray changes consistent with early pulmonary asbestosis and that his pulmonary function studies were mildly reduced. Dr. Baker noted that appellant ceased cigarette smoking 14 years ago. He opined that appellant's impairment was due to a combination of his COPD and pulmonary asbestosis that was due to his 26-year work history, although he noted that his tobacco exposure contributed to his COPD. Appellant also submitted Dr. Baker's pulmonary function study, spirometry report and x-ray report.

Mike Bradford, an industrial hygienist for the employing establishment prepared an undated report concerning appellant's claim. He discussed appellant's employment history and challenged his assertion that he used a paper mask, as the employing establishment required Half Mask Air Purifying Respirators, at a minimum. Mr. Bradford also contended that appellant spent approximately 80 percent of his working career at various assignments for the Boilermaker Union, and that the employing establishment could not attest to his exposure or protection during this employment. He discussed appellant's smoking history. Mr. Bradford concluded that given the exposure to coal dust at the employing establishment was consistently under the OSHA guidelines, appellant's smoking history was the likely causative factor in his respiratory illness and would be unrelated to the work for the employing establishment. He noted that the employing establishment continued to have a very strong respiratory protection program for workers exposed to airborne hazards.

On December 22, 2014 OWCP referred appellant to Dr. Allan Goldstein, a physician Board-certified in pulmonology and internal medicine, for a second opinion. In a January 12, 2015 report, Dr. Goldstein noted that he had reviewed appellant's record and had conducted a physical examination. He concluded that appellant did not have asbestosis. Dr. Goldstein noted that appellant's x-rays showed no evidence of pneumoconiosis. He related that appellant's pulmonary functions showed an obstructive defect with a slight increase in residual volume that did not improve with a bronchodilator, and the small airways decreased in volume with bronchodilators suggesting some irritation of the airway. Dr. Goldstein noted that the diffusion capacity was reduced but normalized for alveolar volume. He opined that although appellant had been exposed to asbestos and did have an appropriate latency period, he did not meet the American Thoracic Society criteria for asbestosis. Dr. Goldstein explained that appellant's chest x-ray did not show a profusion of 1/0, that the criteria required a restrictive defect on pulmonary function. He also related that, while appellant had an obstructive defect, he did not have rales on examination, and that, while his diffusion was abnormal, it was corrected for alveolar volume. Dr. Goldstein noted that appellant did have COPD, but that this is related to his smoking. He opined that, although appellant has been exposed to asbestos based on history, he does not have asbestosis. Dr. Goldstein noted that appellant did not give a history that would be consistent with occupational asthma, and that his pulmonary functions were not consistent with reversible airways disease and were not consistent with restrictive defect. The objective tests supporting Dr. Goldstein's report were also submitted to the record.

By decision dated March 17, 2015, OWCP denied appellant's claim as it determined that the medical evidence of record did not demonstrate that his chronic obstructive pulmonary disease was the result of his accepted exposure to asbestosis during his federal employment.

By letter dated March 26, 2015, postmarked March 27, 2015, appellant requested a hearing before an OWCP hearing representative.

In an October 5, 2015 x-ray report, Dr. Matthew A. Vuskovich, a physician Board-certified in occupational medicine, interpreted appellant's radiograph and determined that appellant had category 2/1 pneumoconiosis.

Appellant requested a hearing. At the hearing held on November 18, 2015, appellant testified and described the duties of a boilermaker and described his duties at each of his job

assignments for the employing establishment and his exposure to asbestos. He noted that the dust got in his nose and that he would blow it out his nose and cough up dust. Appellant described his breathing problems. He noted that it has been 15 years since he smoked. Counsel discussed the medical evidence. He argued that as there was a conflict in the medical evidence between appellant's treating physician and the second opinion physician, appellant should have been referred for an impartial medical examination.

In a December 22, 2015 letter, the employing establishment contended that the exposure to coal dust that appellant and counsel allege was not accurate, and that there was no quantitative analysis showing this alleged exposure to dust. It stated that appellant was never exposed to an airborne hazard identified by air sampling, and therefore there was no requirement for him to wear the enhanced protection. However, if a hazard existed, more protective equipment would have been required. This letter also noted that only trained personnel (insulators) with proper personal protective equipment were allowed to perform insulating abatement duties, and that appellant did not perform insulating/abatement duties as a boilermaker during his tenure at the employing establishment.

In a January 5, 2016 letter to the hearing representative, counsel responded to the employing establishment's letter, arguing that the employing establishment clearly noted data regarding appellant's exposure to respirable dust was not available. However, admittedly, dust was present at the plants where appellant worked. Counsel argued that one negative report, that of Dr. Goldstein, could not represent the weight of the evidence.

By decision dated February 2, 2016, the hearing representative found that appellant had not submitted any detailed rationalized medical evidence to support that his claimed condition was due to factors of his employment, and accordingly affirmed the March 17, 2015 decision.

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, that an injury was sustained in the performance of duty as alleged and that any disabilities and/or specific conditions for which compensation is claimed are causally related to the employment injury.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[5] To establish fact of injury in an occupational disease claim, an employee must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the

[3] *Elaine Pendleton*, 40 ECAB 1143 (1989).

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

[5] *See S.P.*, 59 ECAB 184, 188 (2007).

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.[6]

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is evidence which includes a physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background, 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.[7]

ANALYSIS

The Board finds that this case is not in posture for decision as there is an unresolved conflict in medical opinion. OWCP determined that appellant had established that he was exposed to respirable dust during his federal employment. Further, the evidence established that appellant was diagnosed with pulmonary issues, including COPD.

However, OWCP denied appellant's claim, finding that he failed to establish a causal relationship between the accepted factors of his federal employment and the medical diagnosis. In reaching this conclusion, the hearing representative determined that appellant had not submitted any detailed rationalized medical evidence to support that the claimed condition is due to factors of his federal employment. Although she mentioned the report of appellant's physician, Dr. Baker, when discussing the factual history of the case, the hearing representative did not discuss Dr. Baker's report when analyzing the medical evidence. Instead, the hearing representative found that Dr. Goldstein, the second opinion physician, opined that appellant's condition was not related to his federal employment, and she denied benefits based on this report.

The Board notes that the hearing representative's statement that appellant failed to submit rationalized medical evidence to support that he suffered a medical diagnosis causally related to the accepted factors of his federal employment is incorrect. Appellant submitted a report by Dr. Baker, a physician who is Board-certified in internal medicine and pulmonary disease. Dr. Baker conducted objective studies. He noted that appellant's chest x-ray was consistent with early pulmonary asbestosis and that his pulmonary function studies were mildly reduced. Dr. Baker discussed appellant's employment-related exposure to dust, noted his smoking history, and concluded that appellant's impairment was due to a combination of his COPD and pulmonary asbestosis that was due to his 26-year work history as a boilermaker, although he did note that appellant's tobacco exposure contributed to his COPD. Dr. Baker diagnosed occupational pneumoconiosis with pulmonary asbestosis category 1/0 and mild obstructive ventilatory defect on pulmonary function testing.

[6] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *see also P.W.*, Docket No. 10-2402 (issued August 5, 2011).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

OWCP referred appellant to Dr. Goldstein for a second opinion, and Dr. Goldstein disagreed with the diagnoses of Drs. Baker and Vuskovich. Dr. Goldstein, who is also Board-certified in pulmonology and internal medicine, concluded that appellant's x-rays showed no evidence of pneumoconiosis, and that his pulmonary functions and blood gas studies also were not supportive of asbestosis. He found that appellant's pulmonary functions were not consistent with reversible airways disease and were not consistent with a restrictive defect. Rather, Dr. Goldstein determined that appellant suffered from COPD related to his prior smoking history.

The Board finds that the reports of Drs. Baker and Goldstein are of virtually equal weight and rationale.[8] Both physicians are Board-certified in internal medicine and pulmonology. Both physicians support their respective conclusions with objective studies, discussion of appellant's employment history, and physical examination findings. Because there is an unresolved conflict in medical opinion, pursuant to 5 U.S.C. § 8123(a), the case will be remanded to OWCP for referral to an impartial medical examiner to determine whether appellant has a pulmonary condition causally related to the accepted factors of his federal employment. After OWCP has developed the case record consistent with the Board's directive, a *de novo* decision shall be issued.

CONCLUSION

This case is not in posture for decision due to an unresolved conflict in the medical evidence.

[8] *See Darlene R. Kennedy*, 57 ECAB 414, 416 (2006); *see also D.S.*, Docket No. 16-0174 (issued April 11, 2016).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 2, 2016 is set aside, and the case is remanded for further action consistent with this decision.

Issued: October 14, 2016
Washington, DC

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

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

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