United States Department of Labor
Employees' Compensation Appeals Board

O.C., Appellant	)	
and	)	**Docket No. 17-1175**
	)	**Issued: October 29, 2018**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, San Diego, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 8, 2017 appellant filed a timely appeal from a March 24, 2017 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 has met his burden of proof to establish a left lung condition causally related to the accepted August 31, 2016 employment incident.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 31, 2016 appellant, then a 40-year-old customs and border protection officer, filed a traumatic injury claim (Form CA-1) alleging that he developed a left lung injury earlier that evening while in the performance of duty due to inspecting merchandise, stretching, and lifting.

On August 31, 2016 the employing establishment provided an authorization for examination and/or treatment (Form CA-16). Appellant was transported to the Scripps Mercy Hospital emergency department *via* ambulance and was later admitted to the hospital where he remained until discharged on September 11, 2016.

In an August 31, 2016 hospital report, Dr. Martha D. Strauser, a Board-certified internist, indicated that appellant's admission diagnosis included recurrent and spontaneous left pneumothorax and he presented with left-sided chest tightness, which happened while at work. Appellant became short of breath with severe chest pain and discomfort. He had similar symptoms six months prior to admission at which time he also had spontaneous pneumothorax treated with a chest tube. Appellant had video-assisted thoracoscopic surgery (VATS) on September 2, 2016, with partial resection of the left upper lobe due to multiple bullae requiring two chest tubes postsurgery. On September 7, 2016 he developed a fever and Dr. Strauser found that an echocardiogram revealed a normal left ventricular function with an ejection fraction of 60 to 65 percent with no evidence of vegetations.

In a second August 31, 2016 hospital report, Dr. Kirk Raeber, an osteopath Board-certified in emergency medicine, noted that appellant was at work when he felt pain in his left chest. He reported that appellant had sustained a similar episode six months prior when he developed a pneumothorax and was hospitalized at Sharp Chula Vista, had a chest tube placed, and was hospitalized four to five days. Dr. Raeber found that a chest x-ray showed "a pneumothorax on the left side approximately 40 [percent]" and diagnosed left-sided pneumothorax.

In a third August 31, 2016 hospital report, Dr. Amanda R. Defour, an internist, noted that appellant was at work when he suddenly felt shortness of breath and chest tightness, but he knew right away that he had a pneumothorax because he had a very similar incident six months prior when he went to Sharp Chula Vista Hospital. She opined that the etiology of appellant's recurrent pneumothorax was unclear at that time.

A September 1, 2016 computerized tomography of the chest revealed a small predominantly anterior left-sided pneumothorax and a chest x-ray dated September 1, 2016, showed persistent left apical pneumothorax.

In a September 1, 2016 report, Dr. Michael P. Koumjian, a Board-certified cardiovascular surgeon, noted that appellant had a left-sided pneumothorax six months prior and had a recurrence on August 31, 2016. He diagnosed recurrent left pneumothorax and scheduled a left video-assisted thoracoscopic resection, which he performed on September 2, 2016.

A chest x-ray dated September 2, 2016, revealed a significant collapse of the left lung by approximately 60 percent of the left chest volume.

A September 3, 2016 x-ray of the chest showed no significant residual pneumothorax status post-left-chest-wall surgery with chest-tube placement.

A September 4, 2016 chest x-ray demonstrated postoperative thoracotomy with chest tubes and tiny apical residual right pneumothorax.

A September 5, 2016 chest x-ray showed that the heart and mediastinum were within normal limits, left thoracotomy tubes were in place, there was a small left pneumothorax with mild interval increased in size, there was basilar subsegmental atelectasis, and a small left pleural effusion.

A September 7, 2016 chest x-ray revealed small apical left pneumothorax and bibasilar atelectasis.

Two chest x-rays dated September 8, 2016, demonstrated residual tiny left apical pneumothorax measuring approximately 2.6 millimeter (mm) in diameter and left pneumothorax at the apex measuring 4.7 mm, previously measured at 2.6 mm.

A September 9, 2016 chest x-ray showed a stable to slightly smaller apical tiny left pneumothorax with chest tubes in place.

A venous duplex of the left upper extremity dated September 9, 2016 revealed occlusive thrombus throughout the cephalic vein from the level of the wrist to the antecubital fossa.

In a September 9, 2016 report, Dr. Shawn S. Koura, an internist, noted that appellant had a history of recurrent spontaneous pneumothoraxes "likely due to his body habitus who underwent VATS procedure and resection of his left superior segment with removal of blebs." He found that appellant was doing well, but then developed fevers and shaking chills due to methicillin-sensitive Staph aureus bacteremia. Dr. Koura diagnosed sepsis, septic thrombophlebitis, and recurrent pneumothorax.

A chest x-ray dated September 10, 2016, showed no pneumothorax status post chest tube removal and no significant change in airspace opacities.

On September 12, 2016 Dr. Koumjian found that appellant's left pneumothorax had resolved and discharged him home with antibiotics.

In a September 19, 2016 work excuse note, Dr. Koumjian advised that appellant was under his care for post-thoracic surgery for pneumothorax and was disabled for work for the period August 31 to November 2, 2016.

On October 3, 2016 Jerome Glincosky, a physician assistant, diagnosed bacteremia associated with intravascular line, recurrent spontaneous pneumothorax, essential and other specified form of tremor, and anxiety disorder due to a general medical condition with panic attack.

In an October 6, 2016 report, Dr. Tifani Gleeson, a Board-certified occupational medicine specialist, indicated that she had reviewed available medical reports and claim documentation, but had not spoken with or examined appellant, who had reported a second spontaneous

pneumothorax. She noted that appellant had an initial onset of chest pain at work on June 1, 2016 and that appellant reported that he continued to work and sought care in the emergency room after he left work for the day. Appellant was hospitalized until June 6, 2016, and returned to full duty on June 14, 2016. On August 31, 2016 he was at work inspecting merchandise when he had a second onset of chest pain and was diagnosed with recurrent spontaneous pneumothorax. Appellant underwent a VATS procedure for resection of multiple blebs and pleurodesis and was discharged home with home health and antibiotics to treat an infection of his intravenous line while in the hospital. Dr. Gleeson noted that a spontaneous pneumothorax occurred with a sudden onset of chest pain or shortness of breath without a precipitating event in an individual with no known lung disease, but most often occurred from the rupture of an unrecognized pleural bleb. Pleural blebs could occur in young, healthy individuals with no known risk factors or they could be attributed to risk factors such as smoking, family history, and certain systemic medical conditions. Dr. Gleeson found that there was no indication that appellant had any additional contributing medical conditions and he most reasonably had a spontaneous rupture of previously unrecognized pleural blebs that had since been treated appropriately. She opined that there was "no rationale provided by a treating physician to indicate any association with work" and there was "no indication that the underlying causative pathophysiology, (pleural blebs) and resultant condition" was related to work activities.

In an October 17, 2016 claim development letter, OWCP advised appellant of the deficiencies of his claim and afforded him 30 days to submit additional factual information and medical evidence.

In response, appellant submitted a June 2, 2016 chest x-ray and hospital report from Dr. William Contreras, a Board-certified internist at Sharp Chula Vista Medical Center, who diagnosed spontaneous pneumothorax and history of essential tremor.

Appellant also submitted two chest x-rays dated September 1, 2016, which revealed approximately 40 percent left-sided pneumothorax and a left-sided chest tube placed with improved left-sided pneumothorax and residual at the left apex.

A September 6, 2016 chest x-ray showed a new second chest tube in the left hemi thorax with reduced left pneumothorax.

On October 31, 2016 Dr. Koumjian released appellant to full-time, full-duty work effective November 2, 2016.

By decision dated November 18, 2016, OWCP accepted that the August 31, 2016 employment incident occurred as alleged, but denied the claim because the medical evidence of record failed to establish a causal relationship between appellant's diagnosed conditions and the August 31, 2016 work incident.

On December 27, 2016 appellant requested reconsideration.

In a November 7, 2016 response to OWCP's factual questionnaire, appellant indicated that at around 4:00 p.m. on August 31, 2016 he conducted a routine inspection of the cab of a commercial truck and lifted a bed frame and mattress weighing approximately 40 pounds above his head while kneeling on the floor. As he lifted it overhead, he felt a sharp pain on the left side

of his chest. Appellant continued to work, but after beginning a shift in traffic control, the pain became unbearable and he experienced shortness of breath. At that time, he left work and went to the hospital *via* ambulance.

A September 8, 2016 echocardiogram revealed that the left ventricle was grossly normal in size and the ejection fraction was 60 to 65 percent by visual estimation. In a December 7, 2016 report, Dr. Jose Lira, a Board-certified pulmonary disease specialist, diagnosed recurrent spontaneous pneumothorax, lung bullae, and history of thoracotomy. He indicated that, in June 2016, appellant was hospitalized at Sharp Chula Vista Hospital with complete left lung collapse due to spontaneous pneumothorax and was treated with chest tube drainage for two days. A month later, appellant again developed shortness of breath, and this time he underwent resection of bulla and decortication of the left lung at Scripps Chula Vista Hospital. Dr. Lira found that appellant's complete pulmonary function testing was within normal limits. He opined that exposure to truck fumes for 10 years "may have trigger[ed] rupture of bullae."

By decision dated March 24, 2017, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

A claimant seeking benefits under FECA[2] 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, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[3]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether "fact of injury" has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[4] The second component is whether the employment incident caused a personal injury.[5] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[6]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[7] A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be

[2] *Id.*

[3] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

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

[5] *John J. Carlone*, 41 ECAB 354 (1989).

[6] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[7] *Robert G. Morris*, 48 ECAB 238 (1996).

based on a complete factual and medical background.[8] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[9]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[10]

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[11] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[12]

ANALYSIS

OWCP accepted that the August 31, 2016 employment incident occurred as alleged, and also accepted that there was a medical diagnosis in connection with the employment incident. However, it denied appellant's traumatic injury claim as the medical evidence of record was insufficient to establish a causal relationship between the diagnosed condition(s) and the accepted employment exposure. The issue is whether appellant's left lung condition resulted from the accepted August 31, 2016 employment incident. The Board finds that appellant has not met his burden of proof to establish causal relationship.

The diagnostic testing of record confirmed the diagnosis of left-sided pneumothorax. However, the diagnostic studies do not address the etiology of appellant's left lung condition and are thus insufficient to meet appellant's burden of proof.[13] Appellant also submitted evidence from a physician assistant. This document does not constitute competent medical evidence because a physician assistant is not considered a "physician" as defined under FECA.[14] In her October 6, 2016 report, Dr. Gleeson found that appellant had been diagnosed with recurrent spontaneous pneumothorax, but no rationale was provided by a treating physician to indicate that his condition

[8] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[9] *Id.*

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

[11] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[12] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician. *Supra* note 10 at Chapter 2.805.3a(1) (January 2013).

[13] *See L.C.*, Docket No. 17-1788 (issued September 19, 2018).

[14] *See supra* notes 11-12.

was related to work activities. Consequently, the above-noted evidence is insufficient to satisfy appellant's burden of proof with respect to causal relationship.[15]

Dr. Koumjian noted that appellant had a left-sided pneumothorax six months prior and a recurrence on August 31, 2016. He diagnosed recurrent left pneumothorax and performed a VATS procedure on September 2, 2016. Dr. Koumjian found that appellant's left pneumothorax had resolved as of September 12, 2016, and discharged him home with antibiotics. He advised that appellant was disabled for work for the period August 31 to November 2, 2016, and then released him to full-time, full-duty work effective November 2, 2016. The Board finds that Dr. Koumjian did not provide any medical rationale explaining how appellant's left lung condition was caused or aggravated by inspecting merchandise on August 31, 2016. The need for rationale is particularly important as the evidence indicates that appellant had a preexisting condition.[16] Therefore, the Board finds that the reports from Dr. Koumjian are insufficient to establish causal relationship.

In his September 9, 2016 report, Dr. Koura noted that appellant had a history of recurrent spontaneous pneumothoraxes "likely due to his body habitus." In his December 7, 2016 report, Dr. Lira diagnosed recurrent spontaneous pneumothorax, lung bullae, and history of thoracotomy and opined that exposure to truck fumes for 10 years "may have trigger[ed] rupture of bullae." The Board finds that the opinions of Drs. Koura and Lira regarding the cause of appellant's left lung condition are speculative and equivocal in nature.[17] They fail to sufficiently explain the reasons why diagnostic testing and examination findings led them to conclude that appellant's left lung condition was employment related. A physician's opinion must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[18] The fact that a condition manifests itself during a period of employment is insufficient to establish causal relationship.[19] Temporal relationship alone will not suffice.[20] Thus, the Board finds that the reports from Drs. Koura and Lira fail to establish that appellant sustained a left lung condition causally related to the August 31, 2016 employment incident.

In their reports, Drs. Contreras, Strauser, Raeber, and Defour diagnosed left-sided pneumothorax. Nevertheless, the Board finds that these reports are of limited probative value because they all fail to address whether the accepted August 31, 2016 employment incident caused the diagnosed condition. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of no probative value on the issue of causal

[15] *See supra* notes 6-9, 11-12.

[16] *See supra* note 10.

[17] Medical opinions that are speculative or equivocal in character are of little probative value. *See Kathy A. Kelley*, 55 ECAB 206 n.8 (2004).

[18] *Supra* note 8.

[19] 20 C.F.R. § 10.115(e).

[20] *See D.I.*, 59 ECAB 158, 162 (2007).

relationship.[21] Therefore, this evidence is insufficient to establish that appellant sustained an employment-related injury.

As appellant has not submitted any rationalized medical evidence to support his claim that he sustained a left lung injury causally related to the August 31, 2016 employment incident, he has failed to meet his burden of proof to establish entitlement to compensation benefits.

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 that his left lung condition is causally related to the accepted August 31, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the March 24, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 29, 2018
Washington, DC

Christopher J. Godfrey, 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

[21] *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).