United States Department of Labor
Employees' Compensation Appeals Board

D.B., Appellant	)	
and	)	**Docket No. 20-1142**
	)	**Issued: December 31, 2020**
TENNESSEE VALLEY AUTHORITY, COAL & GAS OPERATIONS, PARADISE FOSSIL PLANT, Drakesboro, KY, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge

JURISDICTION

On May 12, 2020 appellant, through counsel, filed a timely appeal from a November 11, 2019 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 this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish a pulmonary condition causally related to the accepted 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.*

FACTUAL HISTORY

On October 25, 2018 appellant, then a 68-year-old boilermaker, filed an occupational disease claim (Form CA-2) alleging that he developed occupational pneumoconiosis due to factors of his federal employment. He indicated that he first became aware of his condition and its relation to his federal employment on July 26, 2018.

In support of his claim, appellant submitted a statement dated July 26, 2018, asserting that he had just been advised by a physician that he had an occupational lung disease that was related to his employment at the employing establishment. He noted that he last worked at the employing establishment in 2005.

Appellant also submitted a copy of his marked responses and answers to FECA Bulletin No. 85-22 "Evidence Required in Supporting a Claim for Asbestos-Related Illness," where he indicated that he began working at the employing establishment on September 28, 1978 as a boilermaker in the Paradise fossil fuel steam generating plant and was exposed to coal dust, asbestos from insulation, welding smoke, welding fumes, and grinding dust eight hours a day, five days a week. He noted that he wore a paper mask except while welding. Appellant also indicated that he worked in the powerhouse where he was exposed to coal dust, asbestos from pipelines and boilers, flue gas, fly ash, welding fumes, grinding dust, and smoke. He used asbestos blankets while welding. Prior to his federal employment, appellant noted that he worked as a welder in the private sector from 1969 to September 27, 1978 and asserted that he was exposed to grinding dust, welding fumes, and welding smoke. Appellant also indicated that he smoked one or two packs of cigarettes per day for 15 to 20 years.

In an August 31, 2018 report, Dr. Glen Baker, a Board-certified pulmonologist and a National Institute for Occupational Safety and Health certified B reader, indicated that he examined appellant for possible dust-induced lung disease secondary to his federal employment. He noted appellant's history of federal and private sector employment exposure and appellant's smoking history. Dr. Baker listed appellant's symptoms of shortness of breath with dyspnea on exertion and shortness of breath during the night, almost daily cough, with no wheezing, and sleep apnea. On physical examination he found that appellant had 18 respirations per minute and that his lungs were clear to auscultation and percussion. Dr. Baker reviewed appellant's June 15, 2018 chest x-ray and found parenchymal abnormalities consistent pneumoconiosis in both lungs with a profusion of 1/1. He also provided the findings of August 31, 2018 pulmonary function studies and interpreted these findings as mild restrictive ventilatory defect. Dr. Baker diagnosed occupational pneumoconiosis secondary to coal dust exposure and asbestos exposure during his federal employment as well as mild restrictive ventilator defect due to occupational pneumoconiosis. He noted that appellant had a long history of dust exposure at the employing establishment and had x-ray changes consistent with either coal dust exposure or asbestos. Dr. Baker observed that appellant's x-ray changes were very similar to that of coal workers' pneumoconiosis in terms of the irregular opacities in the lower zones. He provided a permanent impairment rating of two percent.

In an October 30, 2018 development letter, OWCP requested that appellant submit additional evidence in support of his claim. It advised him of the type of factual and medical evidence needed and provided a questionnaire of his completion. By separate letter of even date, OWCP also requested additional information from the employing establishment. It afforded both parties 30 days to respond.

On December 4, 2018 the employing establishment responded and noted that appellant was employed for approximately 27 years. It noted that data of exposure to asbestos and coal dust for him was not available, but that assessments for boilermakers as the Paradise Fossil Plant consistently demonstrated that personal exposures experienced by all workers were below occupational exposure limits. The employing establishment indicated that appellant did not perform insulating/abatement duties of asbestos as a boilermaker. It further noted that his position did not routinely require the use of respirators because dust levels were well below Occupational Safety and Health Administration established limits. On January 3, 2019 the employing establishment disputed appellant's allegations of dust or asbestos exposure. However, it further noted that there was occasional work within the duties and responsibilities of a boilermaker where particulate levels could be elevated. The employing establishment indicated that boilermakers were expected to wear respiratory protection as needed.

On February 26, 2019 OWCP referred appellant, a statement of accepted facts (SOAF), and a list of questions to Dr. Harold Dale Haller, Jr., a Board-certified pulmonologist, for a second opinion examination.

In an April 8, 2019 report, Dr. Haller noted appellant's employment exposure and symptoms. He reviewed the spirometry from Dr. Baker dated August 31, 2018 and found that, on review of the flow volume loops, the loops were inconsistent and demonstrated wholly unacceptable patient effort and should not be interpreted based on poor effort. On physical examination Dr. Haller found that appellant had difficulty breathing while lying down, awakened exhausted, had bloody sputum, experienced chest discomfort/tightness and excessive daytime sleepiness. He found it very unlikely that appellant had any significant pulmonary disease. Dr. Haller determined that appellant's spirometry both at Dr. Baker's office and on his examination were completely "unsatisfactory for interpretation due to inadequate effort." He found that the loops were totally variable and not consistent which was seen with lung disease. Dr. Haller opined that the pattern appellant presented was usually seen with test done for secondary gain. He noted that he did resistance and conductance maneuvers and that conductance was within normal limits suggesting no significant obstruction was present. Dr. Haller found on lung volume testing that appellant's lung capacity was 105 percent of predicted which essentially ruled-out restriction. He opined that the interpretation of restriction by Dr. Baker was incorrect as it was based on spirometry alone rather than after formal lung volume testing. Dr. Haller determined that despite the suboptimal efforts from appellant there was no evidence of significant lung disease. He also disagreed with Dr. Baker's finding of occupational pneumoconiosis category 1/1 on x-rays. Dr. Haller did not agree and recommended a high resolution chest computerized tomography (CT) scan. He noted that he did not find evidence on examination, lung function testing, or chest radiographs of asbestosis or asbestos exposure as he did not see evidence of physical changes or disease related to asbestos exposure. Dr. Haller concluded that appellant did not have any significant pulmonary disease and thus no work-related pulmonary conditions.

Dr. Haller included appellant's spirometry which included test comments indicating good patient effort and cooperation and that the test met standards for reproducibility. The test concluded that appellant's reduced volumes indicated a restrictive process. It noted that although flow rates were within normal limits, the over inflation and response to bronchodilators was characteristic of reactive airways.

By decision dated April 22, 2019, OWCP denied appellant's occupational disease claim finding that he had not established a causal relationship between his diagnosed pulmonary disease

and his accepted work factors. It found that Dr. Haller's August 8, 2019 report established that appellant exhibited inadequate effort and no evidence of significant lung disease due to asbestosis or asbestos exposure. On May 2, 2019 appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

A hearing was held on September 11, 2019. Appellant testified that he began working at the employing establishment as a boilermaker in the coal handling portion of the employing establishment where he was exposed to coal dust, grinding dust, and welding smoke on a daily basis. Appellant testified that he then worked in the powerhouse where he was exposed to fly ash, flue gas, coal dust, and grinding dust, welding fumes, and welding smoke, as well as asbestos. He used asbestos blankets for three or four years and was required to tear asbestos on the steam lines to weld them.

On September 5, 2019 appellant submitted a May 31, 2019 report from Dr. James B. Crum, an osteopath and B reader. Dr. Crum reviewed appellant's June 15, 2018 x-rays and found classifiable parenchymal abnormalities consisting of small opacities in both lungs throughout the upper, middle, and lower zones with a profusion of 1/0. He determined that the shape was primarily "p" and secondarily "q" or rounded. Dr. Crum found no classifiable pleural abnormalities. He indicated that appellant's x-rays demonstrated an atherosclerotic aorta and calcification in small pneumoconiosis opacities.

By decision dated November 22, 2019, OWCP's hearing representative found that appellant had not established a causal relationship between his diagnosed pulmonary conditions and his accepted employment exposure. He found that the weight of the evidence was accorded to Dr. Haller.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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 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 or medical condition for which compensation is claimed is causally related to the employment injury.[4] These are the essential elements of every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or

[3] *Id.*

[4] *K.V.*, Docket No. 18-0947 (issued March 4, 2019); *M.E.*, Docket No. 18-1135 (issued January 4, 2019).

[5] *Id.*; *see also Elaine Pendleton*, 40 ECAB 1143 (1989).

condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.[6]

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

Section 8123(a) of FECA in pertinent part 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 (known as a referee physician or impartial medical specialist) who shall make an examination.[10] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[11] When there exist opposing reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[12]

ANALYSIS

The Board finds that this case is not in posture for decision.

Drs. Baker and Crum, in reports dated August 31, 2018 and May 31, 2019, respectively, reviewed appellant's June 15, 2018 x-rays and found classifiable parenchymal abnormalities consisting of small opacities in both appellant's lungs. Dr. Haller disagreed with the finding of pneumoconiosis category 1/1 on x-rays. He recommended a high resolution chest CT scan.

The Board finds that a conflict in the medical evidence exists between appellant's treating physicians Drs. Baker and Crum, who found classifiable parenchymal abnormalities on x-rays and Dr. Haller, who disagreed. These reports are of equal probative value. Drs. Baker and Crum offered their assessments of appellant's chest x-rays. Consequentially, the case must be referred

[6] *R.G.*, Docket No. 19-0233 (issued July 16, 2019); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[7] *T.H.*, 59 ECAB 388, 393 (2008); *Robert G. Morris*, 48 ECAB 238 (1996).

[8] *M.V.*, Docket No. 18-0884 (issued December 28, 2018).

[9] *Victor J. Woodhams*, *supra* note 6.

[10] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[11] 20 C.F.R. § 10.321; *R.C.*, 58 ECAB 238 (2006).

[12] *S.T.*, Docket No. 16-1911 (issued September 7, 2017); *G.B., widow of R.B.*, Docket No. 16-1363 (issued March 2, 2017); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

to an impartial medical specialist to resolve the existing conflict in the medical opinion evidence regarding whether appellant's chest x-rays demonstrated parenchymal abnormalities.

On remand OWCP shall refer appellant, along with the case file and a SOAF, to an appropriate specialist for an impartial medical evaluation and a report including a rationalized opinion as to whether appellant's diagnosed pulmonary conditions are causally related to the accepted employment factors. Following this and other such further development as OWCP deems necessary, it shall issue a *de novo* decision regarding his claim for an employment-related pulmonary condition.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the November 11, 2019 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: December 31, 2020
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board