United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 22-0964**
	)	**Issued: November 15, 2022**
DEPARTMENT OF THE NAVY, FACILITIES MAINTENANCE SERVICES, Quantico, VA, Employer	)	

Appearances:
Alan J. Shapiro, 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
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On June 9, 2022 appellant, through counsel, filed a timely appeal from January 24 and May 13, 2022 merit decisions 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.

[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*.

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.

FACTUAL HISTORY

On July 9, 2020 appellant, then a 53-year-old building maintenance worker, filed an occupational disease claim (Form CA-2) alleging that he experienced breathing difficulties and cardiac arrest causally related to factors of his federal employment, including the inhalation of silica dust. He stopped work on June 24, 2020.

In a statement accompanying his claim, appellant related that in November 2018 he began experiencing breathing difficulties such as shortness of breath and coughing. He received treatment in the emergency department (ED). On January 11, 2019 appellant could not breath and began turning blue. He was transported to the hospital by ambulance. At the ED appellant went into cardiac arrest due to respiratory failure caused by fluid in his lungs and was placed on life support with sepsis and severe pneumonia. He asserted that, prior to his breathing difficulties, he had cut fire resistant insulating panels in the burn building of the employing establishment without any personal protective equipment (PPE). Another employee had contacted the Department of Labor's Occupational Safety and Health Administration (OSHA) about the issue. Appellant's work location was currently closed due to an OSHA investigation.

In a January 25, 2019 discharge summary, Dr. Roland A. Quaye, a Board-certified internist, diagnosed status post-acute respiratory distress syndrome, status post cardiac arrest, respiratory failure/pneumonia, sepsis, acute respiratory failure, status post delirium tremens (DT), and status post mechanical ventilation. He advised that appellant had been admitted to the hospital on January 11, 2019 for acute respiratory failure probably due to "aspiration pneumonia/respiratory failure and status post DT."

On June 24, 2020 Dr. Jorge Dolojan, a Board-certified pulmonologist, found that appellant should limit his exposure to dust and mold. On July 16, 2020 he advised that appellant must wear appropriate PPE.

In a development letter dated July 24, 2020, OWCP advised appellant of the type of evidence needed to establish his occupational disease claim, including a report from his attending physician addressing the causal relationship between his work exposure and the claimed conditions. It provided a questionnaire for his completion. In a separate letter of even date, OWCP requested that the employing establishment address the accuracy of appellant's allegations, describe his exposure to harmful substances, and provide the results of any air sample testing. It afforded both him and the employing establishment 30 days to respond.

Thereafter, appellant submitted a July 30, 2020 report from Dr. Dolojan, who reviewed the results of a computerized tomography (CT) scan of the chest. The CT scan, performed on July 21, 2020, indicated borderline enlarged subcarinal lymph nodes, low-level ground glass opacities in the lower lungs right more than left "possibly indicating a nonspecific respiratory bronchiolitis pattern," and no interlobular septa, bronchiectasis, or air trapping. Dr. Dolojan related that

appellant had "mild restrictive lung disease with respiratory symptoms that raise a concern for occupational exposure." He found that the CT scan showed respiratory bronchiolitis that was "likely from his prior exposure history." Dr. Dolojan diagnosed respiratory bronchiolitis interstitial lung disease and other nonspecific abnormal findings of the lung field. He referred appellant for a lung biopsy.

On July 31, 2020 Dr. Dolojan opined that appellant could not work. In a duty status report (Form CA-17) dated August 14, 2020, he indicated that appellant was unable to work.

In a response dated August 5, 2020, M.M., a supervisor, asserted that in Shop 34 employees were provided with PPE. He indicated that there was currently an ongoing OSHA investigation. M.M. related that there was no ventilation system in the burn building, but that it had doors and windows. He advised that panels should be cut outside or in a well-ventilated area. M.M. related that Shop 34 employees had also repaired leaks in a building that had had mold present.

In a statement received by OWCP on August 5, 2020, appellant asserted that he and his coworkers were never provided with PPE. He described his exposure to "silica dust, concrete dust, mold, mildew, and ash …" over a three-to-four-year period. Appellant noted that had a prior history of smoking two to three cigarettes a day.

In a September 4, 2020 memorandum of telephone call (Form CA-110), appellant related that he sometimes had masks, but no respirators or oxygen.

On June 10, 2020 OSHA issued a notice of unsafe or unhealthy working conditions at the fire training facility building of the employing establishment. It found a serious violation due to the employing establishment's failure on or before December 20, 2019 to furnish a place of employment free from "recognized hazards that caused or were likely to cause death or serious physical harm." OSHA indicated that the employees assigned to cut and install calcium silicate boards used as fire protection panels inside the burn building were "exposed to silica dust while removing old burnt panels and while cutting new panels (non-wet method) without ventilation or any PPE."

The employing establishment advised that air sampling results from June 18, 2020 did not exceed exposure limits for silica dust, cristobalite, and quartz silica.[3]

On September 15, 2020 OWCP referred appellant along with a statement of accepted facts (SOAF), the medical record, and a series of questions to Dr. Peter Birk, a Board-certified internist and pulmonologist, for a second opinion examination.

In an attending physician's report (Form CA-20) dated August 14, 2020, Dr. Dolojan diagnosed a respiratory condition due to external agents. He checked a box marked "Yes" that the condition was caused or aggravated by an employment activity and provided as a rationale that appellant was exposed to mold and fumes.

[3] In a letter dated October 29, 2020, the employing establishment advised that air sample results obtained on September 9, 2020 showed samples of cristobalite and quartz silica dust within acceptable limits.

In a report dated October 8, 2020, Dr. Birk discussed appellant's history of exposure to dust and fumes at work and symptoms of exertional dyspnea beginning July 2020. He noted that appellant had smoked a half pack for 25 years prior to quitting in 2019. Dr. Birk noted no objective findings on examination. He advised that the subjective findings consisted of appellant's exertional dyspnea "consistent with his obesity and deconditioning." Dr. Birk found that he had no work-related condition. Dr. Birk noted that appellant was scheduled for an open lung biopsy later in the month and that he would review this result.

In an October 27, 2020 pathology report from appellant's open lung biopsy, Dr. Ying-Chun Lo, a pathologist, found airway-centric chronic inflammation, cellular histiocytic interstitial pneumonia, and emphysema. He advised that lymph node sections showed "abundant anthracotic pigments" and advised that appellant's "history of airway exposure, including occupational and smoking-related, are noted and correlated with the pigment findings." Dr. Lo found airway-centric chronic inflammation and cellular histiocytic interstitial pneumonia and findings of a hypersensitivity pneumonia-like pattern. He noted that the lack of giant cell identification was not typical for hypersensitivity pneumonia and that other etiologies should be ruled out.

On November 4, 2020 Dr. Dolojan related that appellant's pulmonary function test (PFT) showed apparent asthma that may represent an interstitial lung abnormality given his exposure history. He further found that his chest CT scan showed evidence "of respiratory bronchiolitis, likely from his prior exposure history." Dr. Dolojan indicated that appellant's lung biopsy showed a hypersensitivity pneumonitis-like pattern.

In a supplemental report dated December 10, 2020, Dr. Birk reviewed the pathology report and advised that his opinion had not changed. He indicated that appellant's examination had not shown hypersensitivity pneumonitis. Dr. Birk related, "While he does have moderate emphysema and the presence of pigmented macrophages, there was no evidence of impairment of lung function" on his walk test or PFT. He found that the changes on the CT scan were limited and should not result in a loss of function.

By decision dated January 7, 2021, OWCP denied appellant's occupational disease claim, finding that the evidence was insufficient to establish that he sustained a medical condition causally related to the accepted work exposure.

Thereafter, OWCP received a December 10, 2020 report from Dr. John T. Sherwood, Board-certified in general and thoracic surgery. Dr. Sherwood noted that Dr. Dolojan was treating appellant "for possible occupational exposure with complaints of shortness of breath that is worse with exertion." He reviewed the results of his July 2020 CT scan and discussed his surgical biopsy of the lung. Dr. Sherwood noted that pathology had revealed a hypersensitivity pneumonia-like pattern with an atypical lack of identification of giant cells, with other etiological possibilities that included aspiration, infection, connective tissue disease, and an adverse drug effect.

A January 12, 2021 PFT showed a mild obstructive lung defect.

In a report dated January 13, 2021, Dr. Dolojan reviewed the PFT results and diagnosed pleural effusion, respiratory conditions due to external agents, mild restrictive lung disease with respiratory symptoms raising a concern for occupational exposure, dyspnea, and snoring.

On January 15, 2021 appellant, through counsel, requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

A chest CT scan, obtained on January 22, 2021, showed a small right pleural effusion and stable mediastinal lymphadenopathy but worsening lymphadenopathy when compared to the prior study.

On May 11, 2021 Dr. Kenneth S. Haft, a Board-certified pulmonologist, advised that appellant had a "history of occupational lung disease and an open lung biopsy from October 21, 2020 revealing airway centric chronic inflammation with cellular histiocytic interstitial pneumonia." He noted that a CT scan had shown mediastinal lymphadenopathy and persistent right pleural effusion, and that his PFT showed "moderately severe restrictive lung disease with moderate severe reduction in diffusion capacity."

A telephonic hearing was held on November 10, 2021. Appellant described his work duties, including cutting silica panels to use as fire insulation. The employing establishment did not provide respirators, but they were told to use masks as part of COVID-19 precautions.

By decision dated January 24, 2022, OWCP's hearing representative affirmed the January 7, 2021 decision.

In a report dated February 10, 2022, Dr. Dolojan related that he had treated appellant since 2019 for occupational lung disease. He advised that he had reviewed appellant's medical history including the results of objective tests. Dr. Dolojan found that appellant had no other risk factors for his condition. He opined that his lung biopsy had shown abundant anthracitic pigments and that his occupational and smoking lung disease were consistent with the findings. Dr. Dolojan related, "After a review of the pertinent records, it is my professional opinion that it is HIGHLY LIKELY that [appellant's] condition is a direct result of his occupational exposure from his occupation." (Emphasis in the original).

On February 14, 2022 appellant, through counsel, requested reconsideration.

Subsequently, OWCP received a July 21, 2020 chest CT scan showing low-level ground glass opacities in the subpleural locations of the right more than left lobes. An April 28, 2021 chest CT scan revealed postsurgical changes in the right lung with a persistent small right pleural effusion and hepatic steatosis.

Appellant submitted an article about a jury verdict and settlement finding Dr. Birk and a radiologist jointly and severally liable for failure to diagnose lung cancer by chest x-ray.

In a report dated March 2, 2022, Dr. Dolojan provided similar findings from his February 10, 2022 report. He advised that appellant should not return to work due to the environmental hazards.

By decision dated May 13, 2022, OWCP denied modification of its January 24, 2022 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] has the burden of proof to establish the essential elements of his or her claim, including 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 period of FECA,[5] that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[6] 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.[7]

In an occupational disease claim, appellant's burden of proof requires submission of 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 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.[8]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical opinion evidence.[9] 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 claimant.[10]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall

[4] *Supra* note 2.

[5] *S.M.*, Docket No. 21-0937 (issued December 21, 2021); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[6] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[7] *M.T.*, Docket No. 20-1814 (issued June 24, 2022); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[8] *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[9] *K.R.*, Docket No. 21-0822 (issued June 28, 2022); *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388 (2008).

[10] *G.S.*, Docket No. 22-0036 (issued June 29, 2022); *M.V.*, Docket No. 18-0884 (issued December 28, 2018); *I.J.*, 59 ECAB 408 (2008).

make an examination.[11] 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.[12]

ANALYSIS

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

OWCP referred appellant to Dr. Birk for a second opinion evaluation. In an October 8, 2020 report, Dr. Birk found that appellant had no objective findings of a pulmonary condition. He attributed appellant's exertional dyspnea to obesity and deconditioning. In a supplemental report dated December 10, 2020, Dr. Birk reviewed the results from appellant's lung biopsy and advised that his opinion had not changed. He noted that appellant did have moderate emphysema and pigmented macrophages that did not cause a loss of pulmonary function.

In a February 10, 2022 report, Dr. Dolojan advised that he had treated appellant beginning in 2019 for occupational lung disease. He related that he had reviewed appellant's medical history and the results of objective testing. Dr Dolojan opined that appellant's lung biopsy had shown abundant anthracitic pigments consistent with his occupational lung disease and lung disease from smoking. He attributed appellant's condition to his occupational exposure, emphasizing that such relationship was highly likely.[13]

The Board finds that there exists a conflict in the medical opinion evidence between Dr. Dolojan, appellant's treating physician, and Dr. Birk, the second opinion physician, regarding whether appellant sustained a work-related pulmonary condition.[14] Section 8123 of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[15] Consequently, the case must be remanded to an impartial medical examiner

[11] 5 U.S.C. § 8123(a); *C.F.*, Docket No. 20-0222 (issued December 21, 2020); *M.W.*, Docket No. 19-1347 (issued December 5, 2019); *Y.A.*, 59 ECAB 701 (2008).

[12] *S.S.*, Docket No. 19-1658 (issued June 24, 2019); *C.W.*, Docket No. 18-1536 (issued June 24, 2019).

[13] The Board has previously found that whether terms such as probably, most likely, or more likely constitute a speculative opinion depends upon the contest of usage. *See Michael D. Tillman-Lonergan*, Docket No. 01-1095 (issued February 20, 2002) (where the Board remanded the case for further development after appellant's attending physician found that it was highly likely that he sustained hepatitis C due to a needle stick in the performance of duty). Further, OWCP's procedures provides that the terms "could," "may" and "might be" are speculative in nature. It further provides, "The "terms 'probably' and 'most likely' are less speculative and should be viewed the context of the rest of the medical report and the factual evidence, since sometimes this could mean that the physician is expressing an opinion based on reasonable medical certainty, as opposed to absolute certainty." Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.6a(5) (September 2010).

[14] *See D.S.*, Docket No. 21-1388 (issued May 12, 2022); *S.M.*, Docket No. 19-0397 (issued August 7, 2019).

[15] *Id*.

(IME) to resolve the existing conflict in the medical opinion evidence regarding whether appellant has an occupational lung condition as a result of his federal employment.[16]

On remand OWCP shall refer appellant to an IME for resolution of the conflict in accordance with section 8123(a) of FECA and the implementing regulations. 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 the case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the May 13 and January 24, 2022 decisions of the Office of Workers' Compensation Programs are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: November 15, 2022
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board

[16] *See B.T.*, Docket No. 20-1665 (issued July 2, 2021).