United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 26-0627**
	)	**Issued: October 27, 2026**
DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, FEDERAL AIR MARSHAL SERVICE, Coppell, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 26, 2026 appellant filed a timely appeal from an April 29, 2026 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees'

[1] Appellant submitted a timely request for oral argument before the Board. Pursuant to the Board's *Rules of Procedure,* oral argument may be held in the discretion of the Board. 20 C.F.R. § 501.5(a). Appellant indicated that he requested oral argument to present his case to ensure that the details of the matter were included. The Board, in exercising its discretion, denies appellant's request for oral argument because the arguments on appeal can adequately be addressed in a decision based on a review of the case record. Oral argument in this appeal would further delay issuance of a Board decision and not serve a useful purpose. As such, the oral argument request is denied, and this decision is based on the case record as submitted to the Board.

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.[3]

ISSUE

The issue is whether appellant has met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On January 23, 2024 appellant, then a 55-year-old former air marshal, filed an occupational disease claim (Form CA-2) alleging that he sustained pulmonary inflammation due to factors of his federal employment. In an accompanying statement, he noted that in compliance with a Presidential mandate, he received the COVID-19 vaccine on October 26, 2021 and experienced an adverse reaction almost immediately, with continuing respiratory findings during the following two years. He went on to say that, at a November 13, 2023 appointment, his physician indicated that it was possible that the vaccination caused persistent pulmonary inflammation. Appellant noted that he first became aware of his condition and realized its relationship to factors of his federal employment on November 13, 2023. On the reverse side of the claim form, the employing establishment noted that appellant had retired approximately two years previously.[4]

In a development letter dated January 25, 2024, OWCP notified appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence needed and allotted him 60 days to submit the necessary evidence. No additional evidence was received.

In a follow-up letter dated February 26, 2024, OWCP advised appellant that it had conducted an interim review and the evidence remained insufficient to establish his claim. It noted that he had 60 days from the January 25, 2024 letter to submit the necessary evidence. OWCP further advised that if the necessary evidence was not received during this time, it would issue a decision based on the evidence contained in the record.

OWCP subsequently received a January 17, 2024 report wherein Dr. Jeffrey Fritz, a Board-certified anesthesiologist, related that appellant received a COVID-19 vaccination on October 8, 2021 as required by the employing establishment, and developed increasing dyspnea, coughing, chest tightness, and hypoxemia. On examination, appellant had rales and decreased basilar breath sounds bilaterally. Dr. Fritz opined that the COVID-19 vaccination caused an adverse reaction

[2] 5 U.S.C. § 8101 *et seq*.

[3] The Board notes that following the April 29, 2026 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id*.

[4] Appellant retired from federal employment effective December 27, 2021.

resulting in idiopathic pulmonary fibrosis. He cited medical literature that supported causal relationship between pulmonary fibrosis and COVID-19 vaccination.

In a February 21, 2024 report, Dr. Fritz recounted that appellant received the first dose of an employing establishment mandated COVID-19 vaccine on October 8, 2021, with the onset of increased coughing and shortness of breath. He diagnosed adverse effect of other viral vaccines, interstitial pulmonary disease, chronic respiratory failure with hypoxia, and nonspecific interstitial pneumonitis. Dr. Fritz opined that the October 8, 2021 COVID-19 vaccination caused adverse effects, with computed tomography (CT) findings of mild peripheral septal thickening at the lung bases and also upper lung with features of nonspecific interstitial pneumonitis and mosaic infiltrations consistent with air trapping and superimposed fibrotic changes.[5] Dr. Fritz referenced additional medical literature supporting that COVID-19 vaccination contributed to the development of interstitial lung disease versus idiopathic pulmonary fibrosis.

By decision dated March 26, 2024, OWCP denied appellant's occupational disease claim finding that appellant had not established that the COVID-19 vaccination occurred within the performance of duty.

On March 20, 2025, appellant requested reconsideration.

OWCP subsequently received a November 13, 2024 chart note, wherein Dr. Wael Tello, a Board-certified internist specializing in pulmonology, opined that as appellant had "underlying good respiratory status after he had COVID and having received the vaccine and having the symptoms one week after that, there is a higher likelihood that this is the culprit." He diagnosed interstitial lung disease due either to nonspecific interstitial pneumonia (NSIP) or, with a greater likelihood, the COVID vaccine, and desaturation upon ambulation.

OWCP also received a February 20, 2025 report and associated after-visit summary wherein Dr. Craig S. Glazer, Board-certified in pulmonology, occupational medicine, and critical care medicine, opined that appellant's pulmonary fibrosis was most likely caused by idiopathic disease, NSIP, usual interstitial pneumonia (UIP), disease from the COVID-19 vaccine, autoimmune disease, medication induced disease, or less likely, hypersensitivity pneumonitis.

OWCP also received a March 17, 2025 report wherein Dr. Fritz noted that appellant's new pulmonologist opined that the COVID-19 vaccine caused pulmonary hyperinflammation that resulted in organizing pneumonia and contributed to the development of interstitial lung disease as indicated by appellant's prior pulmonologist. Dr. Fritz further explained that appellant had two consenting medical opinions that he sustained interstitial pulmonary fibrosis secondary to his preexisting chronic obstructive pulmonary disease as the vaccination contributed to the

[5] A March 17, 2022 CT scan of the chest demonstrated scattered subtle ground glass opacity within the lungs in a possible mosaic-type attenuation, and subpleural reticulation throughout the lungs which can be seen with chronic interstitial change. A November 21, 2022 CT scan of the chest demonstrated scattered, nonspecific subpleural reticular opacities, no bronchiectasis ground glass opacities, or honeycombing, chronic scarring versus early manifestations of interstitial lung disease, evidence of air trapping within the right middle lobe on expiratory phase imaging suggestive of small vessel or airway disease, and an unchanged mildly prominent prevascular lymph node, possibly reactive. A March 6, 2023 CT scan of the chest demonstrated mild peripheral septal thickening similar to the prior study, indeterminate for usual interstitial pneumonia based on the absence of bronchiectasis or honeycombing.

development of hyperinflammation in the lungs, resulting in "an acute exacerbation of his preexisting condition that left him with interstitial lung disease and subsequent interstitial pulmonary fibrosis causing his symptoms and resulting in his current condition.

In a development letter dated April 14, 2025, OWCP notified appellant that it had accepted that he received the October 2021 COVID vaccine while in the performance of duty; however, that the medical evidence of record was insufficient to establish causal relationship between the vaccine and a diagnosed condition. It requested that he submit medical records contemporaneous to the October 2021 vaccination.

OWCP subsequently received August 3, 2021 progress notes, wherein Dr. J. Mark Anderson, Board-certified in family practice, found appellant's lungs clear to auscultation bilaterally.

OWCP also received a November 5, 2021 report wherein Dr. Cesar Torres, a family practitioner, recounted appellant's two-week history of cough and nasal congestion. He assessed cough, and other specified respiratory disorders.

In a November 24, 2021 report, Cindi Peters, a nurse practitioner recounted appellant's history of pneumonia diagnosed two weeks previously. Appellant's x-rays demonstrated bilateral ground glass opacities suspicious for COVID. Ms. Peters diagnosed pneumonia of both lower lobes due to infectious organism.

OWCP also received an incomplete December 6, 2021 report wherein Dr. Terrence Feehery, an osteopath Board-certified in family practice, diagnosed pneumonia and cough due to infectious organism.

In a June 12, 2025 report, Dr. Fritz provided an assessment of interstitial pulmonary disease, unspecified, and adverse effects of other viral vaccines.

On September 25, 2025, OWCP referred appellant, the case record, a statement of accepted facts (SOAF), and a series of questions to Dr. William Brady, III, Board-certified in occupational medicine, for a second opinion evaluation.

In a November 14, 2025 report, Dr. Brady reviewed the medical record and the SOAF. On examination, he found appellant's lungs clear on auscultation, oxygen saturation at 94 percent on room air, and no respiratory distress. Dr. Brady noted that there were no objective abnormalities consistent with symptomatic interstitial lung disease. He opined that appellant's pulmonary function test results were consistent with early interstitial lung disease and diffusion defect with no specific etiology. Dr. Brady diagnosed idiopathic interstitial pneumonia, with NSIP more likely than UIP, and small airways disease with early interstitial lung disease. He also listed less probable diagnoses of micro aspiration from reflux, age-related early fibrotic lung disease, autoimmune lung disease, and hypersensitivity pneumonitis. Dr. Brady excluded vaccine-induced chronic interstitial lung disease as it was not recognized in medical literature, and post-COVID fibrosis, as it was inconsistent with mild initial illness. He opined that "[t]o a reasonable degree of medical probability, the … COVID-19 vaccine did not cause [appellant's] pulmonary findings, interstitial lung disease, restrictive lung defect, diffusion impairment, or oxygen desaturation." Dr. Brady explained that appellant's presentation was most consistent with early idiopathic interstitial

pneumonia with coexisting small airways disease. He noted that no medical literature supported chronic interstitial lung disease as a complication of adenoviral-vector COVID-19 vaccination.

By decision dated December 31, 2025, OWCP modified the March 26, 2024 decision to find that appellant had received the mandated COVID-19 vaccination in the performance of duty. However, the claim remained denied as the medical evidence of record was insufficient to establish causal relationship between the COVID-19 vaccine and the diagnosed pulmonary conditions.

OWCP subsequently received a September 11, 2025 report wherein Dr. Fritz reiterated his prior findings and diagnoses.

On April 8, 2026, appellant requested reconsideration.

OWCP subsequently received progress notes dated September 26, 2024 through January 19, 2026, wherein Dr. Tello noted appellant's history of interstitial lung disease approximately one month following an October 2021 COVID-19 vaccine. He diagnosed unspecified interstitial pulmonary disease, unspecified cough, shortness of breath, and idiopathic sleep-related nonobstructive alveolar hypoventilation.

OWCP also received an October 18, 2024 pulmonary function test with spirometry within normal limits, and nocturnal desaturation, and a November 5, 2024 CT scan report of the chest which revealed peripheral septal and ground glass opacities in the upper and lower lungs which could reflect atelectasis, edema, or fibrosis, with infectious etiology less likely.

OWCP also received a March 23, 2026 report wherein Dr. Fritz referenced medical literature supporting causal relationship between post-infectious COVID-19 interstitial lung disease, and COVID-19 vaccine-associated drug-induced interstitial lung disease. He opined that "[w]hile uncommon, these reports establish biologic plausibility that COVID-19 vaccination may trigger interstitial pneumonitis in susceptible individuals." Dr. Fritz explained that appellant's presentation was consistent with the reported pattern of a temporal association between vaccination and onset of respiratory symptoms, ground glass opacities, interstitial pneumonitis progressing to chronic interstitial lung disease, and development of chronic hypoxic respiratory failure. He diagnosed adverse effect of other viral vaccines, interstitial pulmonary disease, nonspecific interstitial pneumonitis, and chronic respiratory failure with hypoxia, causally related to the mandatory COVID-19 vaccination.

By decision dated April 29, 2026, OWCP denied modification of the December 31, 2025 decision.

LEGAL PRECEDENT

The employee seeking benefits under FECA[6] 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 timely filed within the applicable time

[6] *Supra* note 2.

limitation of FECA,[7] 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.[8] 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.[9]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (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 identified employment factors.[10]

The medical evidence required to establish causal relationship between a diagnosed condition and the accepted employment factors is rationalized medical opinion evidence.[11] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 specific employment factors identified by the employee.[12]

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.[13]

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 examiner (IME)) who

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[7] *F.H.,* Docket No. 18-0869 (issued January 29, 2020); *J.P.,* Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron,* 41 ECAB 153 (1989).

[8] *L.C.,* Docket No. 19-1301 (issued January 29, 2020); *J.H.,* Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.,* 40 ECAB 312 (1988).

[9] *P.A.,* Docket No. 18-0559 (issued January 29, 2020); *K.M.,* Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett,* 41 ECAB 992 (1990).

[10] *S.R.,* Docket No. 24-0839 (issued October 30, 2024); *T.W.,* Docket No. 20-0767 (issued January 13, 2021); *L.D.,* Docket No. 19-1301 (issued January 29, 2020); *S.C.,* Docket No. 18-1242 (issued March 13, 2019).

[11] *S.S.,* Docket No. 19-0688 (issued January 24, 2020); *A.M.,* Docket No. 18-1748 (issued April 24, 2019); *Robert G. Morris,* 48 ECAB 238 (1996).

[12] *T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Y.S.,* Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams,* 41 ECAB 345, 352 (1989).

[13] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (version 1.1, issued April 24, 2026); *M.B.,* Docket No. 20-1275 (issued January 29, 2021); *see R.D.,* Docket No. 18-1551 (issued March 1, 2019).

shall make an examination.[14] For a conflict to arise the opposing physicians' viewpoints must be of virtually equal weight and rationale.[15]

ANALYSIS

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

In a report dated November 14, 2025, Dr. Brady, OWCP's second opinion physician, diagnosed idiopathic interstitial pneumonia, and small airways disease with early interstitial lung disease. He asserted that appellant had no objective findings of symptomatic interstitial lung disease. Dr. Brady opined that there was no medical literature which supported a causal relationship between adenoviral-vector COVID-19 vaccination and the development of interstitial lung disease.

Conversely, in reports dated January 17, 2024 through March 23, 2026, Dr. Fritz, appellant's treating physician, opined that the October 2021 COVID-19 vaccinations caused an adverse reaction resulting in idiopathic pulmonary fibrosis, with CT findings of septal thickening at the lung bases and upper lung with nonspecific interstitial pneumonitis and mosaic infiltrations. He explained in a March 17, 2025 report that the COVID-19 vaccination exacerbated preexisting chronic obstructive pulmonary disease, resulting in interstitial lung disease with subsequent interstitial pulmonary fibrosis. In a March 23, 2026 report, Dr. Fritz asserted that medical literature supported that in susceptible individuals, the COVID-19 vaccine may trigger interstitial pneumonitis progressing to chronic interstitial lung disease, interstitial pneumonitis, and chronic respiratory failure.

As Dr. Brady, OWCP's second opinion physician, and Dr. Fritz, appellant's attending physician, disagreed as to whether the diagnosed pulmonary conditions were causally related to the accepted employment-related COVID-19 vaccination, the Board finds that there is an unresolved conflict in the medical opinion evidence. The case must therefore be remanded for referral to an IME, pursuant to 5 U.S.C. § 8123(a), to resolve the conflict.[16] Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

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[14] 5 U.S.C. § 8123(a).

[15] 20 C.F.R. § 10.321; *M.K.*, Docket No. 26-0551 (issued September 9, 2026); *P.B.,* Docket No. 20-0984 (issued November 25, 2020); *R.C.,* 58 ECAB 238 (2006); *Darlene R. Kennedy,* 57 ECAB 414 (2006); *Gloria J. Godfrey,* 52 ECAB 486 (2001); *James P. Roberts,* 31 ECAB 1010 (1980).

[16] *Supra* notes 14-15.

ORDER

IT IS HEREBY ORDERED THAT the April 29, 2026 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: October 27, 2026
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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